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DIVISION 1

PROCEDURAL RULES GOVERNING RULEMAKING AND HEARINGS

General Provisions

436-001-0003
Applicability and Purpose

(1) This rule division establishes supplemental procedures governing rulemaking and hearings, and carries out the provisions of ORS Chapters 183 and 656.

(2) These rules apply to hearings on matters within the director's jurisdiction that are held on or after January 2, 2006. In general, the rules of the Workers' Compensation Board, in OAR chapter 438, apply to the conduct of hearings, unless these rules provide otherwise.

(3) These rules apply to all division rulemaking on or after January 17, 2006.

(4) Unless otherwise obligated by statute, the director may waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704, 183 & OL 2005, Ch. 26
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06; WCD 1-2006, f. 1-13-06, cert. ef. 1-17-06

436-001-0004
Definitions

The following definitions apply to these rules, unless the context requires otherwise.

(1) "Administrative law judge" or "ALJ" means an administrative law judge appointed by the Workers' Compensation Board, as defined in OAR 438-005-0040.

(2) "Administrator" means the administrator of the Workers' Compensation Division or the administrator's designee.

(3) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(4) "Delivered" means physical delivery to the division's Salem office during regular business hours.

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

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

(7) "Division" means the department's Workers' Compensation Division.

(8) "Filed" means mailed, faxed, e-mailed, or delivered to the division.

(9) "Final order" means a final, written action of the director.

(10) "Mailed" means correctly addressed, with sufficient postage and placed in the custody of the U. S. Postal Service.

(11) "Party" may include, but is not limited to, a worker, an employer, an insurer, a self-insured employer, a managed care organization, a medical provider, or the division.

(12) "Proposed and final order" means an order subject to revision by the director which becomes final unless exceptions are timely filed or the director issues a notice of intent to review the proposed and final order.

(13) Matters within the director's jurisdiction are matters other than those concerning a claim, as defined by ORS 656.704.

(14) Other words and phrases have the same meaning as given in ORS 183.310, where applicable.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704, 183 & OL 2005, Ch. 26
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0005
Model Rules of Procedure Governing Rulemaking

The Model Rules of Procedure, OAR 137-001-0005 through 137-001-0100, in effect on January 1, 2006, as promulgated by the Attorney General of the State of Oregon under the Administrative Procedures Act are adopted as the rules of procedure for rulemaking actions of the Workers' Compensation Division.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the agency.]

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.325 - 183.410 & 656.704(2)
Hist.: WCD 5-1977(Admin)(Temp), f. & ef. 11-7-77; WCD 3-1978(Admin), f. & ef. 3-6-78; WCD 2-1982(Admin), f. 1-20-82, ef. 1-21-82; Renumbered from 436-090-0110 thru 436-090-0180, 5-1-85; WCD 3-1986, f. & ef. 5-15-86; WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 1-2005, f. & cert. ef. 1-14-05; WCD 1-2006, f. 1-13-06, cert. ef. 1-17-06

Rulemaking

436-001-0009
Notice of Agency Action Concerning Rules

(1) Except when adopting a temporary rule, the division will give prior public notice of the proposed adoption, amendment, or repeal of any rule by:

(a) Publishing notice of the proposed action in the Secretary of State's Oregon Bulletin at least 21 days prior to the effective date of the action; and

(b) Notifying interested persons and organizations on the division's notification lists of proposed rulemaking actions under ORS 183.335.

(2) The division will add a person or organization to its notification list if the person or organization:

(a) Subscribes to the division's e-mail notification service, through the division's Web site at wcd.oregon.gov; or

(b) Requests in writing to receive hard-copy notification, and includes the person or organization's full name and mailing address.

Stat. Auth.: ORS 656.726 (4)
Stats. Implemented: ORS 183.335 & 84.022
Hist.: WCB 16-1975, f. & ef. 10-20-75; WCD 4-1977(Admin)(Temp), f. & ef. 11-7-77; WCD 4-1978(Admin), f. & ef. 3-6-78; Renumbered from 436-090-0505, 5-1-85; WCD 3-1986, f. & ef. 5-15-86; WCD 9-1992, f. & cert. ef. 5-22-92; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; Renumbered from 436-001-0000, WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

Hearings

436-001-0019
Requests for Hearing

(1) A request for hearing on a matter within the director's jurisdiction must be filed with the administrator no later than the filing deadline. The date and time of receipt for electronic filings is determined under ORS 84.043. Filing deadlines will not be extended except as provided in section (6) of this rule. The requesting party must send a copy of the request to all known parties and their legal representatives, if any.

(2) A request for hearing must be in writing. A party may use the division's Form 2839. A request for hearing must include the following information, as applicable:

(a) The identity, name, address, and phone number of the party making the request;

(b) The division's administrative order number;

(c) The worker's name, address, and phone number;

(d) The name, address, and phone number of the worker's attorney, if any;

(e) The date of injury;

(f) The insurer or self-insured employer claim number;

(g) The division's file number; and

(h) The reason for requesting a hearing.

(3) A request for hearing may be e-mailed to wcd.hearings@state.or.us, the division's hearing electronic mail address. If the request for hearing is an attachment to the e-mail, it must be in a format that Microsoft Word 2000®, (.doc, .txt, .rtf) or Adobe Reader®, (.pdf) can open. Image formats that can be viewed in Internet Explorer®, (.tif, .jpg) are also acceptable. The division will acknowledge receipt of the e-mail. A party filing a request for hearing by e-mail consents and agrees to conduct the request for hearing transaction electronically. The party's electronic mailing address qualifies as its electronic signature.

(4) A request for hearing may be faxed, provided the document transmitted indicates that it has been delivered by fax, is sent to the correct fax number, and indicates the date the document was sent.

(5) The director will refer timely requests for hearing to the board for a hearing before an administrative law judge. The director may withdraw a matter that has been referred if the request for hearing is premature, if the issues in dispute become moot, or if the director otherwise determines that the matter is not appropriate for hearing at that time.

(6) The director will deny requests for hearing that are filed after the filing deadline. The party may request a limited hearing on the denial of the request for hearing within 30 days after the mailing date of the denial. The request must be filed with the administrator. At the limited hearing, the administrative law judge may only consider whether:

(a) The denied request for hearing was filed timely; or

(b) If good cause existed that prevented the party from timely requesting a hearing on the merits. For the purpose of this rule, "good cause" includes, but is not limited to, mistake, inadvertence, surprise, or excusable neglect.

Stat. Auth.: ORS 656.726(4) & 84.013
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; Renumbered from 436-001-0155, WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0023
Other Filings and Submissions

(1) Except as provided in section (3) of this rule, any filing, motion, request, document, or correspondence filed or submitted in a matter within the director's jurisdiction must be filed or submitted:

(a) To the division before the dispute is referred to the board;

(b) To the administrative law judge after the dispute is referred to the board but before the ALJ issues a proposed and final order; and

(c) To the division after the ALJ issues a proposed and final order, unless it is a request for correction of errors in the proposed and final order under OAR 436-001-0246(6).

(2) A copy of any filing, motion, request, document, or correspondence must be sent to the other parties, or their legal representatives, at the same time it is filed or submitted to the division or administrative law judge.

(3) A party must notify the division and the other parties of any changes in the party's mailing address or legal representation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0027
Timeliness; Calculation of Time

(1) Timeliness of any document required by these rules to be filed or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or e-mailed, it must be received by the division by 11:59 p.m. Pacific time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(2) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0030
Role of the Workers' Compensation Division

(1) In any hearing, the director may request to:

(a) Receive notice of all matters;

(b) Receive copies of all documents; and

(c) Present evidence, testimony, and argument.

(2) The director may appear by providing the administrative law judge and parties with an entry of appearance in the hearing. The director may be represented by an agency representative, assistant attorney general, or special assistant attorney general as authorized by the Department of Justice. If the director enters an appearance, all notices and documents in the hearing must be provided to the director's representative.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 180.220(2), 180.235 & 656.704
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98 ; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0170
Duties and Powers of the Administrative Law Judge

(1) The administrative law judge may conduct the hearing in any manner, consistent with these rules, that will achieve substantial justice.

(2) Unless provided otherwise by statute or administrative rule, any order issued by an administrative law judge regarding a matter within the director's jurisdiction is a proposed and final order subject to review by the director under OAR 436-001-0246.

(3) Notwithstanding section (2), an administrative law judge may issue a final order of dismissal when the requesting party withdraws the request for hearing and no cross-request for hearing has been filed.

(4) If the parties settle as provided in OAR 436-001-0296(3), the administrative law judge may issue a proposed and final order of dismissal. If the parties settle as provided in OAR 436-001-0296(1) or (2), the director will dismiss the request for hearing.

(5) Where appropriate, the administrative law judge may remand a dispute to the director for further administrative action.

(6) The administrative law judge may consolidate matters in which there are common parties or common issues of law or fact.

(7) The administrative law judge may separate matters which will promote efficient disposition of the matters.

(8) Consolidation of matters under section (6) of this rule or under ORS 656.704(3)(c) (Oregon Laws 2005, chapter 26, section 15) is only for the purpose of hearing. The administrative law judge must issue a separate order for matters other than those concerning a claim.

(9) On the motion of a party, the division, or the administrative law judge, the ALJ may continue a hearing to allow the presentation of oral or written legal argument by the Department of Justice.

(10) The administrative law judge may send the division a written question regarding which rules or statutes apply to the matter, or regarding the division's interpretation of the rules and statutes. If the administrative law judge sends such a question, the ALJ must provide a written summary of the context in which the question arises, provide a reasonable time for the division to respond, and send a copy to all parties.

(11) The administrative law judge may conduct a hearing by telephone if all parties agree.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0225
Scope of Review/Limitations on the Record

(1) Except for the matters listed in sections (2) and (3), the administrative law judge reviews all matters within the director's jurisdiction de novo, unless otherwise provided by statute or administrative rule.

(2) In medical service and medical treatment disputes under ORS 656.245, 656.247(3)(a), and 656.327, and managed care disputes under ORS 656.260(16), the administrative law judge may modify the director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. New medical evidence or issues may not be admitted or considered.

(3) In vocational assistance disputes under ORS 656.340, new evidence may be admitted and considered. Under ORS 656.283(2), the administrative law judge may modify the director's order only if it:

(a) Violates a statute or rule;

(b) Exceeds the director's statutory authority;

(c) Was made upon unlawful procedure; or

(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.247, 656.260, 656.283, 656.327 & 656.704
Hist.: WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0240
Exhibits and Evidence

(1) Within 21 days after referral of the request for hearing to the board, the division will provide the parties and the administrative law judge legible copies of all exhibits that were relied upon in the underlying action or order, together with an index.

(2) Not less than 28 days before the hearing, or within seven days of receipt of the division's document index and documents, whichever is later, the petitioner(s) must provide legible copies of any additional exhibits that they will offer at hearing to the other parties, the director's representative, and the administrative law judge. The additional exhibits must be marked and accompanied by a supplemental exhibit index, numbered to coincide in chronological order with the division's exhibits and exhibit list. For example, an exhibit which is chronologically between the division's exhibits 5 and 6 would be marked as "Exhibit 5a" or "Ex. 5a."

(3) Not less than 14 days before the hearing, the respondent(s)/cross-petitioner(s) must provide legible copes of any additional exhibits that they will offer at hearing to the other parties, the director's representative, and the administrative law judge. The exhibits must be marked and indexed in the same manner as provided in section (2).

(4) Unless withdrawn, all exhibits offered will be part of the record in the case, whether or not admitted into evidence.

(5) At the discretion of the administrative law judge, an accurate description or photograph of an object or real evidence may be substituted for the object or real evidence. The party offering the evidence is responsible for providing the description or photograph, and for retaining custody of the object until the case is closed.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0246
Proposed and Final Orders — Exceptions, Correction, Director Review

(1) Under ORS 656.704(2)(a) (Oregon Laws 2005, chapter 26, section 15), a party must seek director review of a proposed and final order before petitioning for judicial review under ORS 183.482.

(2) The parties or the division may initiate director review of a proposed and final order by filing exceptions as follows:

(a) Written exceptions must be filed with the administrator within 30 days of the mailing date of the proposed and final order;

(b) A written response to the exceptions must be filed within 20 days of the date the exceptions were filed;

(c) A written reply to the response, if any, must be filed within 10 days of the date the response(s) was filed.

(3) If exceptions are timely filed, the director may issue a final order or an amended proposed and final order, request the administrative law judge to hold further hearing, or remand the matter for further administrative action.

(4) Within 30 days of the mailing date of the proposed and final order, the director may issue a notice of intent to review the proposed and final order, even if no exceptions are filed.

(5) All proposed and final orders must contain language notifying the parties of their right to file exceptions, how to file, and the timeframes.

(6) The administrative law judge may withdraw a proposed and final order for correction of errors within 10 calendar days of the mailing date of the order. The time for filing exceptions begins on the date the corrected proposed and final order is mailed.

(7) If no exceptions are timely filed or if no notice of intent to review is issued, the proposed and final order will become final 30 days after the mailing date of the order.

(8) Any requests for review or requests for reconsideration of a proposed and final order filed with the administrative law judge or board within 30 days of the mailing date of the order will be forwarded to the director and treated as timely exceptions under this rule.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; Renumbered from 436-001-0275, WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0252
Stay of Director and Administrative Review in Consolidated Matters

(1) If matters are consolidated under ORS 656.704(3)(c) (Oregon Laws 2005, chapter 26, section 15), and a party requests board review of the order for those matters concerning a claim, and a party files exceptions on the proposed and final order for matters other than those concerning a claim, the director may stay director review of the proposed and final order. If director review is stayed, the parties will be provided the opportunity to file a written response and reply as provided in OAR 436-001-0246, and director review will then be stayed until the board issues an order for those matters concerning a claim.

(2) If matters are consolidated under ORS 656.704(3)(c) (Oregon Laws 2005, chapter 26, section 15), and a party requests board review of the order for those matters concerning a claim, and the administrative law judge remands the matters other than those concerning a claim to the director for further administrative action, the director may stay further administrative action until the board issues an order for those matters concerning a claim.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0259
Ex Parte Communication

An ex parte communication is an oral or written communication to the administrator or administrator's designee during director review of the matter not made in the presence of all parties to the dispute, concerning a fact in issue, but does not include communication from division staff or the Department of Justice about legal issues or facts in the record. Ex parte communications received during director review will be promptly disclosed to all parties, and the parties will be allowed a reasonable opportunity to respond.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0265
Attorney Fees

(1) In cases where the director or administrative law judge is required to assess an attorney fee under ORS 656.385(1):

(a) The fee must be based on the factors listed in ORS 656.385(1).

(b) Absent a showing of extraordinary circumstances or unless otherwise agreed by the parties, the fee may not exceed $2,000 nor fall outside the ranges provided in the following matrix:

Estimated Benefit Achieved — Professional Hours Devoted
* * * * * — 1–2 hours — 2.1–4 hours — 4.1–6 hours — 6.1–8 hours — Over 8 hours
$1–$2000 — $100–400 — 200–700 — $300–750 — $600–1000 — 800–1250
$2001–$4000 — $200–500 — $400–800 — $600–900 — $800–1300 — $1050–1500
$4001–$6000 — $300–700 — $600–1000 — $800–1250 — $1000–1450 — $1300–1750
Over $6000 — $400–900 — $800–1300 — $1050–1600 — $1350–1800 — $1550–2000

(c) Extraordinary circumstances are not established by merely exceeding eight hours or exceeding a benefit of $6000.

(d) In cases under ORS 656.245, 656.247, 656.260, or 656.327, the factors listed in OAR 436-010-0008(13) may also be considered.

(e) In cases under ORS 656.340, the factors listed in OAR 436-120-0008(2) may also be considered.

(2) Except as provided in section (3), in cases where the administrative law judge or director assesses an attorney fee, the following factors may also be considered:

(a) The complexity of the issue(s) involved;

(b) The quality of the legal representation;

(c) The value of the interest involved;

(d) The nature of the proceedings;

(e) The risk in a particular case that an attorney's efforts may go uncompensated;

(f) The assertion of frivolous issues or defenses;

(g) A statement of services, if submitted within seven days of the hearing date, unless the administrative law judge instructs otherwise; and

(h) Any other relevant consideration deemed appropriate by the administrative law judge or director.

(3) In cases under ORS 656.262(11) where the issue is solely the assessment and payment of a penalty and attorney fee, OAR 438-015-0110 applies.

(4) If an attorney fee has been assessed by an administrative law judge in a proposed order, the opposing parties may file written exceptions to the fee under OAR 436-001-0275.

Stat. Auth.: ORS 656.385(1) & 656.726(4)
Stats. Implemented: ORS 656.262, 656.385, 656.388 & 656.704
Hist.: WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0296
Settlements and Dismissals

(1) If, after a request for hearing is filed but before a proposed and final order is issued, an agreement under ORS 656.236 or 656.289(4) is approved that resolves all issues in the matter within the director's jurisdiction, the party that filed the request for hearing must notify the director in writing that the request for hearing may be dismissed by the director.

(2) If, after a request for hearing is filed but before a proposed and final order is issued, the parties reach agreement on all issues in the matter within the director's jurisdiction, and only those issues, the parties must submit a written settlement agreement, signed by the parties, to the director for approval.

(3) If the matter within the director's jurisdiction is consolidated with matters concerning a claim and the parties reach agreement on all issues in the matter within the director's jurisdiction prior to issuance of a proposed and final order, the administrative law judge may issue a proposed and final order approving the agreement and dismissing the request for hearing.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704 & OL 2005, Ch. 26
Hist.: WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-001-0300
Alternative Dispute Resolution

(1) The director may offer the parties to a matter within the director's jurisdiction alternative dispute resolution as a way to resolve the matter prior to a hearing.

(2) If the parties consent to attempt alternative dispute resolution before the director after referral of the matter to the board for hearing, the director will notify the administrative law judge that the parties have agreed to attempt resolution, and that the hearing should be deferred until the process is complete. If the parties do not settle, the director will notify the administrative law judge to proceed with the hearing.

(3) If the parties settle the matter within the director's jurisdiction through alternative dispute resolution before the director, the director will issue an order dismissing the request for hearing.

(4) Nothing in this rule prevents the parties from participating in the board's mediation program for those matters within the director's jurisdiction.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.502, 656.704 & OL 2005, Ch. 26
Hist.: WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

DIVISION 9

OREGON MEDICAL FEE AND PAYMENT RULES

436-009-0001
Authority for Rules

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.248.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01

436-009-0002
Purpose

The purpose of these rules is to establish uniform guidelines for administering the payment for medical services to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96

436-009-0003
Applicability of Rules

(1) These rules apply to all services rendered on or after the effective date of these rules.

(2) Applicable to these rules, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-009-0004
Adoption of Standards

(1) The director adopts, by reference, the columns titled "CPT/HCPCS," "Mod," "Year 2007 Transitional Non-Facility Total," "Year 2007 Transitional Facility Total," and "Global" in the Centers for Medicare & Medicaid Services (CMS) 2007 Medicare Resource-Based Relative Value Scale (RBRVS) Addendum B and Addendum C, 71 Federal Register No. 231, December 1, 2006, as the basis for the fee schedule for payment of medical service providers except as otherwise provided in these rules. The director does not adopt the definitions, status indicators, alpha codes, edits, processes, policies or philosophies of CMS, such as the National Correct Coding Initiative.

(2) The director adopts, by reference, the *American Society of Anesthesiologists ASA*, *Relative Value Guide 2007* as a supplementary fee schedule for payment of anesthesia service providers except as otherwise provided in these rules for those anesthesia codes not found in the Federal Register.

(3) The director adopts, by reference, the *American Medical Association's (AMA) The Physicians' Current Procedural Terminology (CPT® 2007)*, Fourth Edition Revised, 2006, for billing by medical providers except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(4) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 16, Issue 12 2006, as a supplement for determining the level of service described by the CPT® manual guidelines. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual shall be the controlling resource to determine the level of service.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS *Healthcare Common Procedure Coding System* (HCPCS) December 21, 2006, to be used when billing for services only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code. The director does not adopt the edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(6) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in Addenda B and C, 71 Federal Register, No. 231, December 1, 2006, ASA Relative Value Guide 2007, CPT® 2007, CPT® Assistant, or HCPCS 2007.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.248 & 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0005
Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made part of these rules.

(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) ANSI means the American National Standards Institute.

(b) CMS means Centers for Medicare & Medicaid Services.

(c) CPT® means Current Procedural Terminology published by the American Medical Association.

(d) DME means durable medical equipment.

(e) DRG means diagnosis related group.

(f) EDI means electronic data interchange.

(g) HCPCS means Healthcare Common Procedure Coding System published by CMS.

(h) IAIABC means International Association of Industrial Accident Boards and Commissions.

(i) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(j) MCO means managed care organization.

(k) NPI means National Provider Identifier.

(l) OSC means Oregon specific code.

(m) PCE means physical capacity evaluation.

(n) RBRVS means Medicare Resource-Based Relative Value Scale published by CMS.

(o) RVU means relative value unit.

(p) WCE means work capacity evaluation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-009-0006
Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and OAR chapter 436, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06

436-009-0008
Administrative Review Before the Director

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical services including treatment, medical fees and non-payment of compensable medical bills. The director may, on the director's own motion, initiate a medical service review at any time. A party need not be represented to participate in the administrative review before the director.

(b) Any party may request the director provide voluntary alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, the director will put the agreement in writing; or the parties shall put any agreement in writing for approval by the director. If the dispute is not resolved through alternative dispute resolution, the director will issue an order.

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims where a party disagrees with an action or decision of the MCO, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 30 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. Administrative review by the director must be requested within 60 days of issuance of the MCO's final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director.

(b) For all claims not enrolled in an MCO, or for disputes which do not involve an action or decision of the MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

(c) When an insurer determines it has overpaid a provider for a medical service, it may request review by the director within 90 days of the date payment was issued.

(d) Under ORS 656.704(3)(c), when there is a formal denial of the underlying condition or a denial of the causal relationship between the medical service and the accepted condition, the issue may first be decided by the Hearings Division of the Workers' Compensation Board.

(3) Parties must submit requests for administrative review to the director in the form and format prescribed by the director. When an insurer or the worker's representative submits a request without the required information, at the director's discretion the administrative review may not be initiated until the information is submitted. Unrepresented workers may contact the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker's name, date of injury, insurer, and claim number.

(b) Specify the issues in dispute and the relief sought.

(c) Provide the specific dates of the unpaid disputed treatment or services.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original CMS bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that they have provided all involved parties a copy of:

(A) The request for review; and

(B) Any attached supporting documentation; and

(C) If known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(4) The division will investigate the matter upon which review was requested.

(a) The investigation may include, but not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider's peers.

(b) Upon receipt of a written request for additional information, the party must respond within 14 days.

(c) A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement.

(5) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party may also request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed to the director before the administrative order becomes final.

(6) Hearings before an administrative law judge: Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(7) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as described in OAR 436-010-0008(14).

(8) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (7) of this rule, according to these rules, may request administrative review by the director as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.248, 656.704 & OL 2005, Ch. 26
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0901, 5-1-85 WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-89, (Former sections (3), (4), & (7) Renumbered to 436-010-0130); WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90;WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0110; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 7-2005, f. 10-20-05, cert. ef.

1-2-06; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0010
General Requirements for Medical Billings

(1) Only treatment that falls within the scope and field of the practitioner's license to practice will be paid under a worker's compensation claim.

(2) Billings must include the worker's full name and date of injury, the employer's name and, if available, the insurer's claim number and the provider's NPI. If the NPI is not available, then the provider must provide its license number and FEIN. For provider types not licensed by the state, "999999" must be used. All medical providers must submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a completed current UB-04 (CMS 1450) or CMS 1500 form, except for:

(a) Dental billings, which must be submitted on American Dental Association dental claim forms;

(b) Pharmacy billings, which must be submitted on the most current National Council for Prescription Drug Programs (NCPDP) form; and

(c) EDI transmissions of medical bills under OAR 436-009-0030(3)(c).

(d) Computer-generated reproductions of forms referenced in subsections (2)(a) and (b) may also be used.

(3)(a) All original medical provider billings must be accompanied by legible chart notes documenting services which have been billed and identifying the person performing the service and license number of the person providing the service. Medical providers are not required to provide their license number if they are already providing a national identification number.

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) When billing for medical services, a medical service provider must use codes listed in CPT® 2007 or Oregon Specific Codes (OSC) that accurately describe the service. If there is no specific CPT® code or OSC, a medical service provider must use the appropriate HCPCS code, if available, to identify the medical supply or service. Pharmacy billings must use the National Drug Code (NDC) to identify the drug or biological billed. A "zz" modifier must be used when billing electronically for services that use an OSC.

(a) If there is no specific code for the medical service, the medical service provider shall use the appropriate unlisted code from HCPCS or the unlisted code at the end of each medical service section of CPT® 2007 and provide a description of the service provided.

(b) Any service not identifiable with a code number must be adequately described by report.

(5) Medical providers must submit billings for medical services in accordance with this section.

(a) Bills must be submitted within:

(A) 60 days of the date of service.

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

(b) A medical service billing submitted later than the time frames in subsection(a) of this section may be payable in full if the provider establishes good cause for submitting the bill late. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(c) A bill rendered over twelve months after the date of service is not payable, except when a provision of subsection (a) of this section is the reason the billing was rendered after twelve months.

(6) When rebilling, medical providers must indicate that the charges have been previously billed.

(7) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law which require providers to bill other than their usual fee.

(8) Medical providers shall not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for prepayment for a deposition is not considered false or fraudulent.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, costs must be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but no later than 30 days following receipt of the request. Thereafter, worker copies must be furnished during the regular billing cycle.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.245, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 8-2001, f. 9-13-01, cert. ef. 9-17-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-009-0015
Limitations on Medical Billings

(1) An injured worker is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 90-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director under OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental.

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3) of this rule.

(3) The medical provider may not charge a fee for the preparation of a written treatment plan and the supplying of progress notes that document the services billed as they are integral parts of the fee for the medical service.

(4) No fee is payable for the completion of a work release form or completion of a PCE form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or for a Worker Requested Medical Examination. Except as provided in OAR 436-009-0070(9)(d) and (10)(d), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider shall be paid at 50 percent of the examination or testing fee.

(6) Under ORS 656.245(3), the director has excluded from compensability the following medical treatment. While these services may

be provided, medical providers shall not be paid for the services or for treatment of side effects.

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface EMG (electromylography) tests;

(d) Rolfing;

(e) Prolotherapy; and

(f) Thermography.

(7) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician or authorized nurse practitioner: once near the beginning, once near the middle, and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient.

(9)(a) When a physician or authorized nurse practitioner provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's or authorized nurse practitioner's office, such services shall be identified by CPT® codes and paid according to the fee schedule.

(b) When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital fee schedule.

(10) Physician assistant, authorized nurse practitioner, or out-of-state nurse practitioner fees shall be paid at the rate of 85 percent of a physician's allowable fee for a comparable service. The bills for services by these providers must be marked with modifier "-81". Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(11) Except as otherwise provided in OAR 436-009-0070, when a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, an insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT® codes such as 99080. Refer to specific code definitions in the CPT® for other applicable codes. The billing should include documentation of the actual time spent reviewing the records or reports.

[Publications: Publications referenced are available from the agency.
Stat. Auth.: ORS 656.245, 656.252 & 656.254
Stats. Implemented: ORS 656.245, 656.252 & 656.254
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 8-2001, f. 9-13-01, cert. ef. 9-17-01; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0020
Hospital Fees

(1) Hospital inpatient charges billed to insurers must include ICD-9-CM diagnostic and procedural codes. Hospitals must include their NPI on all bills. Unless otherwise provided for by a governing MCO contract, insurers must pay hospitals for inpatient services using the current adjusted cost/charge ratio (see Bulletin 290). For purposes of this rule, hospital inpatient services include, but are not limited to, those bills coded "111" through "118" in space #4 on the UB-04 billing form. The audited bill must be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers must include revenue codes, ICD-9-CM diagnostic and procedural codes, CPT® codes, HCPCS codes, and National Drug Codes (NDC), where applicable. Hospitals must include their NPI on all bills. Unless otherwise provided for by a governing MCO contract, insurers must pay hospitals for outpatient services according to the following: the insurer must first separate out and pay charges for services by physicians and other licensed medical service providers assigned a code under the CPT® and assigned a value in RBRVS for physician fees as identified by the revenue codes indicating professional services. These charges must be subtracted from the total bill and the adjusted cost/charge ratio applied only to the balance. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Year 2007 transitional non-facility total column. All other charges billed using both the hospital name and tax identification number will be paid as if provided by the hospital.

(3) Each hospital's CMS 2552 form and financial statement shall be the basis for determining its adjusted cost/charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost/charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost/charge ratio or the hospital's cost/charge ratio based on estimated data.

(a) The basic cost/charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (b), by the total patient revenues from Worksheet G-2.

(b) The net expenses for allocation derived from Worksheet A shall be modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(c) The basic cost/charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost/charge ratio calculated in subsection (3)(a) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(e) The factors resulting from subsections (3)(c) and (3)(d) of this rule will be added to the ratio calculated in subsection (3)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(f) The adjusted cost/charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of their CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Management Division, Department of Consumer and Business Services. The adjusted cost/charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(g) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division shall determine an adjusted cost/charge ratio for the hospital based upon the adjusted cost/charge ratios of a group of hospitals of similar size or geographic location.

(h) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost/charge ratio to allow equitable payment.

(i) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost/charge ratio to reflect the data developed subsequent to the initial calculation.

(j) Notwithstanding subsections (c) through (i) of this section the payment to out-of-state hospitals, may be negotiated between the insurer and the hospital.

(A) Any agreement for payment less than the billed amount must be in writing and signed by a hospital and insurer representative.

(B) The agreement must include language that the hospital will not bill the worker any remaining balance and that the negotiated amount is considered payment in full.

(C) If the insurer and the hospital are unable to reach agreement within 60 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(k) Notwithstanding sections (1) and (2) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost/charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index, as originally developed by Dr. William Cleverley. All rural hospitals having a financial flexibility index at or below the median for hospitals nationwide with a bond rating of BBB+, BBB, or BBB- will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost/charge ratio.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4), 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248, 656.252, 656.256, sec. 2, Ch. 771, OL 1991
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0701, 5-1-85; WCD 3-1985(Admin)(Temp), f. & ef. 9-4-85; WCD 4-1985(Admin)(Temp), f. & ef. 9-11-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1986(Admin)(Temp), f. 2-5-86, ef. 2-6-86; WCD 2-1986(Admin), f. 3-10-86, ef. 3-17-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 2-1989, f. 8-21-89, cert. ef. 9-1-89; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 15-1990, f. & cert. ef. 8-7-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 18-1995(Temp), f. & cert. ef. 12-4-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0090; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1997, f. 4-21-97, cert. ef. 7-1-97; Administrative correction 6-18-97; WCD 8-1997(Temp), f. & cert. ef. 7-9-97; WCD 16-1997, f. & cert. ef. 12-15-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-009-0022
Ambulatory Surgical Center Fees

(1) An ambulatory surgical center (ASC) is any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(a) Any ASC outside of Oregon must meet similar licensing requirements, or be certified by Medicare or a nationally recognized agency.

(b) Bills from an ASC shall be submitted on CMS 1500 form. The modifier "SG" shall be used to identify facility charges.

(2) Fees shall be paid at the provider's usual fee, or in accordance with the fee schedule, whichever is less. For all MCO enrolled claims, payment of fees shall be as provided by the MCO contract, at the provider's usual fee, or according to the fee schedule, whichever is less.

(3) Payment shall be made using the Medicare ASC groups, except:

(a) Arthroscopies (CPT® codes 29819 through 29898 except 29888 and 29889) are paid as Group 6.

(b) Arthroscopies (CPT® codes 29888 and 29889) are paid as Group 7.

(c) Services not listed in the Medicare ASC groups 1 through 9 shall be paid at the provider's usual rate.

(4) The ASC fee schedule is:

Group 1 — $ 853.28
Group 2 — $ 1,143.88
Group 3 — $ 1,307.68
Group 4 — $ 1,616.75
Group 5 — $ 1,838.68
Group 6 — $ 2,108.00
Group 7 — $ 2,551.95
Group 8 — $ 2,485.78
Group 9 — $ 3,444.43

(5) The ASC fee includes services, such as:

(a) Nursing, technical, and related services;

(b) Use of the facility where the surgical procedure is performed;

(c) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of the surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

(e) Administrative, record-keeping, and housekeeping items and services;

(f) Materials for anesthesia;

(g) Supervision of the services of an anesthetist by the operating surgeon.

(6) The ASC fee does not include services, such as physicians' services, laboratory, x-ray or diagnostic procedures not directly related to the surgical procedure, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services. The insurer shall pay for prosthetic devices, orthotic devices, and DME as provided in OAR 436-009-0080.

(7) When multiple procedures are performed, the highest payment group shall be paid at 100% of the maximum allowed fee. Each additional procedure shall be paid at 50% of the maximum allowed fee.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248 & 656.252
Hist.: WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0025
Reimbursement of Related Services Costs

(1) The insurer shall notify the worker in writing at the time of claim acceptance that claim-related services, not otherwise addressed by these rules, paid by the worker will be reimbursed by the insurer as provided in this rule. The notification must include notice to the worker of the two year time limitation to request reimbursement.

(a) The worker must request reimbursement from the insurer in writing.

(b) The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed. If additional information is needed, the time needed to obtain the information is not counted in the 30 day time frame for the insurer to issue reimbursement.

(c) Notwithstanding subsections (a) and (b) of this section, in deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance and shall be paid within 14 days. In a claim for aggravation or a new medical condition, reimbursement of related services is not due and payable until the aggravation or new medical condition is accepted. If the claim is denied, requests for reimbursement shall be returned to the worker within 14 days.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle shall be reimbursed as provided in this section. The maximum rate of reimbursement is limited to the rate of reimbursement for State of Oregon classified employees, as published in Bulletin 112. When a worker has documentation of the expense which includes the date of the expense, he or she may be entitled to reimbursement for:

(a) Any meal reasonably required by necessary travel to a claim-related appointment.

(b) Lodging based on the need for overnight travel to attend the appointment. Reimbursement may exceed the maximum rate where special lodging was required or where the worker was unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(c) Mileage when using a personal vehicle based on the beginning and ending addresses. Reimbursement may exceed the maximum if special transportation is required. Public transportation will be reimbursed based on actual cost.

(d) Prescriptions and other claim-related expenses will be reimbursed based on actual cost.

(3) Requests for reimbursement of claim-related services costs must be received by the insurer within two years of the date the costs were incurred or within two years of the date the claim or medical condition is finally determined compensable, whichever date is later. The insurer may disapprove requests for reimbursement received beyond the two year period as being untimely requested.

(4) Requests for reimbursement denied as unreasonable or not related to the accepted compensable injury or disease shall be returned to the worker within 30 days of the date of receipt by the insurer. The insurer shall provide the worker an explanation of the reason for non-payment and advise the worker of the right to appeal the insurer's decision by requesting administrative review before the director, under OAR 436-009-0008.

(5) Pursuant to ORS 656.325(1)(f) and 436-060-0095(5)(f), the insurer shall reimburse the worker for costs related to the worker's attendance at an independent medical examination regardless of the acceptance, deferral, or denial of the claim.

Stat. Auth.: ORS 656.245, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.245, 656.704 & 656.726(4)
Hist.: WCB 6-1969, f. 10-23-69, ef. 10-29-69; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0270, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02, Renumbered from 436-060-0070; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0030
Insurer's Duties and Responsibilities

(1) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(2) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0070(1). If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(3) Insurers must date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was not paid or what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2), and insurer action, for any non-payment or fee reduction other than a fee schedule reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due. The insurer must provide the specific reason(s) for non-payment or reduced payment of the billing, in writing, to the submitting medical provider.

(b) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided.

(c) When a medical provider submits a bill electronically, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(5) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(6) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code. Resolution of billing disputes, including possible overpayment disputes, must be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(7) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(8) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit shall be continuous and shall include no fewer than 10 percent of medical bills. The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(9) The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a disputed claim settlement (DCS) were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(10) Insurers that had at least 100 accepted disabling claims in the previous calendar year, as determined by the director, are required to submit detailed medical bill payment data to the Information Management Division of the Department of Consumer and Business Services at 350 Winter St NE, Room 300, PO Box 14480, Salem OR 97309-0405.

Once an insurer has reached the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. The director will notify the affected insurers when they reach the minimum. If the insurer drops below the 100 disabling claim level or encounters other significant hardships, the insurer may apply to the director for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The transmission data and format requirements are included in Appendices A and B, which the director adopts by reference. To determine which appendix applies to required reporting insurers, see below.

(b) Each insurer must continue to report according to Appendix A until successfully completing IAIABC ANSI 837 testing. Once successfully completing testing, the insurer may only report via IAIABC ANSI 837.

(c) Group 1 is all required reporting insurers who are currently reporting data via IAIABC ANSI 837 in another jurisdiction. Each insurer in Group 1 must begin testing on July 1, 2008.

(d) Group 2 is the State Accident Insurance Fund Corporation. Group 2 must begin testing on April 1, 2009.

(e) Group 3 is all other required reporting insurers. Each insurer in Group 3 must begin testing on October 1, 2009.

(11) An insurer may request, in writing, additional time to report the requested data elements according to Appendix B. The insurer must demonstrate that the date to begin testing creates an undue hardship. The request must include a plan to begin testing within 12 months of the group's testing date, and may not extend beyond January 1, 2010.

(12) Undue hardship is demonstrated by providing the total required expenses to begin testing; the reporting cost per bill if trans-

mitted directly by the insurer; and the total cost per bill if reported by a vendor.

(13) If the director allows additional time, the insurer must continue to report all medical billing data under Appendix A during the testing.

(14) The director may audit an insurer's actual payments reported for individual claims. An insurer is subject to a civil penalty if an audit determines that the insurer's error rate is 15 percent or higher in any field.

[ED. NOTE: Appendix referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260 & 656.264

Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1997, f. 4-21-97, cert. ef. 7-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-009-0035
Interim Medical Benefits

(1) Interim medical benefits are not due on claims:

(a) When the worker is enrolled in an MCO prior to claim acceptance pursuant to ORS 656.245(4)(b)(B).

(b) When the insurer denies the claim within 14 days of the employer's notice.

(c) With dates of injury prior to January 1, 2002.

(2) Interim medical benefits include:

(a) Diagnostic services required to identify appropriate treatment or prevent disability.

(b) Medication required to alleviate pain.

(c) Services required to stabilize the worker's claimed condition and to prevent further disability. Examples of such services may include, but are not limited to: antibiotic or anti-inflammatory medication; physical therapy and other conservative therapies; and necessary surgical procedures.

(3) If the medical service provider has knowledge that the worker filed a work related claim, the medical service provider shall not collect health benefit plan co-payment from the worker.

(4) The medical service provider shall submit a copy of the bill to the workers' compensation insurer in accordance with OAR 436-009-0010, and the health benefit plan(s) in accordance with the plan's requirements.

(5) The insurer shall notify the medical service provider when an initial claim is denied.

(6) When the claim is denied, the medical service provider shall first bill the health benefit plan(s) with a copy of the workers' compensation denial letter.

(7) After payment is received from the health benefit plan(s), the medical service provider may bill the workers' compensation insurer, according to OAR 436-009-0010, for any remaining balance. The provider shall include a copy of the health benefit plan(s)' explanation of benefits with the bill. If the worker has no health benefit plan, the workers' compensation insurer is not required to pay for interim medical benefits.

(8) The workers' compensation insurer shall pay in accordance with the Oregon fee rules, any amount not reimbursed by the health benefit plan within 45 days of receipt of the bill with the health plan's explanation of benefits, in accordance with OAR 436-009-0030(6).

Stat. Auth.: ORS 656.245, 656.704, 656.726(4)

Stats. Implemented: ORS 656.247

Hist.: WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06

436-009-0040
Calculating Medical Provider Fees

(1) The insurer must pay for medical services at the provider's usual fee or in accordance with the fee schedule whichever is less. Insurers must pay for medical services that have no fee schedule at the provider's usual fee. For all MCO enrolled claims, the insurer must pay for medical services at the provider's usual fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract. Where there is no maximum payment established by the fee schedule, an insurer may challenge the reasonableness of a provider's billing on a case by case basis by asking the director to review the billing under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances.

(2)(a) When using RBRVS, the RVU is determined by reference to the appropriate CPT® code. Where the procedure is performed inside the medical service provider's office, use Year 2007 transitional non-facility total column. Where the procedure is performed outside the medical service provider's office, use Year 2007 transitional facility total column. Use the global column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Year 2007 transitional non-facility total column. No other column applies.

(b) When an Oregon Specific Code is assigned, the RVU for multidisciplinary program services is found in OAR 436-009-0060(5), or for other services in OAR 436-009-0070(12).

(c) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate Anesthesia code. The anesthesia value includes the basic unit value, time units, and modifying units.

(3) Payment according to the fee schedule must be determined by multiplying the assigned RVU or basic unit value by the applicable conversion factor. Where the code is designated by an RVU of "0.00" or IC (individual consideration) for Anesthesia codes, the insurer must pay at the provider's usual rate.

(4) The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical providers.

Service Categories Conversion Factors
Evaluation / Management — $59.79
Anesthesiology — $53.45
Surgery — $93.66
Radiology — $68.00
Lab & Pathology — $60.00
Medicine — $75.04
Physical Medicine and Rehabilitation — $65.79
Multidisciplinary and Other Oregon-Specific Codes — $60.00

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248

Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-009-0050
CPT® Sections

Each CPT® section has its own schedule of relative values, completely independent of and unrelated to any of the other sections. The definitions, descriptions, and guidelines found in CPT® shall be used as guides governing the descriptions of services, except as otherwise provided in these rules. The following provisions are in addition to those provided in each section of CPT®.

(1) Evaluation and Management services.

(2) Anesthesia services.

(a) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(b) Anesthesia basic unit values are to be used only when the anesthesia is personally administered by either a licensed physician or certified nurse anesthetist who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

(c) When a regional anesthesia is administered by the attending surgeon, the value shall be the "basic" anesthesia value only without added value for time.

(d) When the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the modifier "NT" (no time) shall be noted on the bill.

(e) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the relative value unit for the surgical procedure.

(3) Surgery services.

(a) When a worker is scheduled for elective surgery, the pre-operative visit, in the hospital or elsewhere, necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed global value of the surgical procedure. If the procedure is not elective, the physician is entitled to payment for

the initial evaluation of the worker in addition to the global fee for the surgical procedure(s) performed.

(b) When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

(c) Multiple surgical procedures performed at the same session shall be paid as follows:

(A) When multiple surgical procedures are performed by one surgeon, the principal procedure is paid at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures are paid at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid accordingly.

(B) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures paid at 50 percent of the value listed.

(C) When more than one surgeon performs surgery, each procedure shall be billed separately. The maximum allowable fee for each procedure, as listed in these rules, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation, each is entitled to an additional fee of 20 percent of the other surgeon's allowable fee as an assistant's fee. When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' allowable fees.

(D) When a surgeon performs surgery following severe trauma that requires considerable time, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. Such a request must be accompanied by written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(E) When a surgical procedure is performed bilaterally, the modifier "-50" shall be noted on the bill for the second side, and paid at 50% of the fee allowed for the first side.

(d) Physician assistants or nurse practitioners shall be paid at the rate of 15 percent of the surgeon's allowable fee for the surgical procedure(s). The bills for services by these providers shall be marked with a modifier "-81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The operation report shall document who assisted.

(4) Radiology services.

(a) In order to be paid, x-ray films must be of diagnostic quality and include a report of the findings. Billings for 14" x 36" lateral views shall not be paid.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), the technical component for the first area examined shall be paid at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent under these rules. The discount applies to multiple studies done within 2 days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days. No reduction is applied to multiple areas for the professional component.

(5) Pathology and Laboratory services.

(a) The laboratory and pathology conversion factor applies only when there is direct physician involvement.

(b) Laboratory fees shall be billed in accordance with ORS 676.310. If any physician submits a bill for laboratory services that were performed in an independent laboratory, the bill shall show the amount charged by the laboratory and any service fee that the physician charges.

(6) Medicine services.

(7) Physical Medicine and Rehabilitation services.

(a) Increments of time for a time-based CPT® code shall not be prorated.

(b) Payment for modalities and therapeutic procedures shall be limited to a total of three separate CPT®-coded services per day. CPT® codes 97001, 97002, 97003, or 97004 are not subject to this limit. An additional unit of time (15 minute increment) for the same CPT® code is not counted as a separate code.

(c) All modality codes requiring constant attendance (97032, 97033, 97034, 97035, 97036, and 97039) are time-based. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day.

(d) CPT® codes 97010 through 97028 shall not be paid unless they are performed in conjunction with other procedures or modalities which require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by a machine, device or table there shall be a notation on the bill that treatments were provided simultaneously by a machine, device or table and there shall be one charge.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0060
Oregon Specific Code, Multidisciplinary Services

(1) Services provided by multidisciplinary programs not otherwise described by CPT® codes shall be billed under Oregon Specific Codes. Electronic billings shall include a "zz" modifier as provided in OAR 436-009-0010.

(2) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program shall not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(a) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to 6 months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(b) Notwithstanding OAR 436-009-0010(4), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(c) All job site visits and ergonomic consultations must be preauthorized by the insurer.

(3) When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for an injured worker, he or she must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Billings using the multidisciplinary codes must include copies of the treatment record which specifies the type of service rendered, the medical provider who provided the service, whether treatment was individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(5) The table below lists the **Oregon Specific Codes for Multidisciplinary Services**.

Codes — Relative Value — Description
97642 — 0.91 — Physical conditioning - group - 1 hour. Conditioning exercises and activities, graded and progressive.
97643 — 0.46 — Each additional 30 minutes.
97644 — 1.45 — Physical conditioning - individual 1 hour. Conditioning exercises and activities, graded and progressive.
97645 — 0.73 — Each additional 30 minutes.
97646 — 0.91 — Work simulation - group 1 hour. Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors.
97647 — 0.46 — Each additional 30 minutes.
97648 — 1.50 — Work simulation - individual 1 hour. Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors.
97649 — 0.75 — Each additional 30 minutes.
97650 — 0.81 — Therapeutic education - individual 30 minutes. Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals.
97651 — 0.41 — Each additional 15 minutes.
97652 — 0.54 — Therapeutic education - group 30 minutes. Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals.
97653 — 0.28 — Each additional 15 minutes.

97654 — 0.41 — Professional Case Management - Individual 15 minutes. Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).
97655 — 0.39 — Brief Interdisciplinary Rehabilitation Conference - 10 minutes. A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits.
97656 — 0.78 — Intermediate Interdisciplinary Rehabilitation Conferences - 20 minutes. A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits.
97657 — 1.35 — Complex Interdisciplinary Rehabilitation Conferences - 30 minutes. A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits.
97658 — 0.68 — Each additional 15 minutes Complex conference - up to 1 hour maximum.
97659 — 1.72 — Job site visit -1 hour (includes travel) - must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.
97660 — 0.86 — Each additional 30 minutes.
97661 — 2.32 — Ergonomic consultation - 1 hour (includes travel) — must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.
97662 — 0.94 — Vocational evaluation - 30 minutes. Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options.
97663 — 0.47 — Each additional 15 minutes.
97664 — 1.27 — Nursing evaluation - 30 minutes. Nursing assessment of medical status and needs in relationship to rehabilitation.
97665 — 0.63 — Each additional 15 minutes.
97666 — 1.02 — Nutrition evaluation - 30 minutes. Evaluation of eating habits, weight and required modifications in relationship to rehabilitation.
97667 — 0.52 — Each additional 15 minutes.
97668 — 1.07 — Social worker evaluation - 30 minutes. Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.
97669 — 0.54 — Each additional 15 minutes.
97670 — 6.70 — Initial Multidisciplinary conference - up to 30 minutes.
97671 — 7.56 — Initial Complex Multidisciplinary conference - up to 60 minutes.
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06

436-009-0070
Oregon Specific Code, Other Services

(1) Except for records required in OAR 436-009-0010(3), copies of requested medical records shall be paid under OSC-R0001.

(2) A brief narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status, and, if requested, brief answers to one to five specific questions related to the attending physician's or authorized nurse practitioner's current or proposed treatment, shall be paid under OSC-N0001.

(3) A complex narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, attending physician's or authorized nurse practitioner's treatment to date, current status, impairment, prognosis, and medically stationary information, shall be paid under OSC-N0002.

(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable payment shall be as follows:

(a) FIRST LEVEL PCE: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level requires not less than 45 minutes of actual patient contact. A first level PCE shall be paid under OSC-99196 which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(b) SECOND LEVEL PCE: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level requires not less than two hours of actual patient contact. The second level PCE shall be paid under OSC-99197 which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(c) WCE: This is a residual functional capacity evaluation which requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE shall be paid under OSC-99198 which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g. cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report. Special emphasis should be given to:

(A) The ability to perform essential physical functions of the job based on a specific job analysis as related to the accepted condition;

(B) The ability to sustain activity over time; and

(C) The reliability of the evaluation findings.

(5) When an attorney requires a consultation with a medical provider, the medical provider shall bill under OSC-D0001.

(6) The fee for a deposition shall be billed under OSC-D0002. This code should include time for preparation, travel and deposition. Upon request of one of the parties, the director may limit payment of the provider's hourly rate to a fee charged by similar providers.

(7) When an insurer obtains an Independent Medical Examination (IME):

(a) The medical service provider doing the IME shall bill under OSC-D0003. This code shall be used for a report, file review or examination;

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider shall bill for the time spent reviewing and responding using OSC-D0019. Billing should include documentation of time spent.

(8) The fee for interpretive services shall be billed under OSC-D0004.

(9) Fees for all arbiters and panel of arbiters used for director reviews pursuant to OAR 436-030-0165 shall be established by the director. This fee determination will be based on the complexity of the examination, the report requirements and the extent of the record review. The level of each category is determined by the director based on the individual complexities of each case as compared to the universe of claims in the medical arbiter process. When the examination is scheduled, the director shall notify the medical arbiter and the parties of the authorized fee for that medical arbiter review based on a combination of separate components.

(a) Level 1 — OSC-AR001 Exam:
Level 2 — OSC-AR002 Exam
Level 3 — OSC-AR003 Exam
Limited — OSC-AR004 Exam
As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors. A limited exam generally involves a newly accepted condition, or some other partial exam.

(b) Level 1 — OSC-AR011 Report:
Level 2 — OSC-AR012 Report
Level 3 — OSC-AR013 Report
As determined by the director, a level 1 report generally includes standard questions. A level 2 report generally includes questions regarding complicating factors. A level 3 report generally includes questions regarding multiple complicating factors.

(c) Level 1 — OSC-AR021 File Review:
Level 2 — OSC-AR022 File Review
Level 3 — OSC-AR023 File Review
Level 4 — OSC-AR024 File Review
Level 5 — OSC-AR025 File Review
As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of a large record or disability evaluation without an exam. A level 4 file review generally includes an extensive record. A level 5 file review generally includes an extensive record with unique factors.

(d) The director will notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review. If a worker fails to appear for a medical arbiter examination without giving each medical arbiter at least 48 hours notice, each medical arbiter shall be paid at 50 percent of the examination or testing fee. A medical arbiter must also be paid for any file review completed prior to cancellation.

(e) If the director determines that a supplemental medical arbiter report is necessary to clarify information or address additional issues, an additional report fee may be established. The fee is based on the

complexity of the supplemental report as determined by the director. The additional fees are established as follows:

Limited — OSC-AR031
Complex — OSC-AR032

(f) Prior to completion of the reconsideration process, the medical arbiter may request the director to redetermine the authorized fee by providing the director with rationale explaining why the physician believes the fee should be different than authorized.

(g) The director may authorize testing which shall be paid according to OAR 436-009.

(h) Should an advance of costs be necessary for the worker to attend a medical arbiter exam, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(10) A single physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under OSC-P0001 for the examination and under OSC-P0003 for the report.

(b) Physicians selected under OAR 436-010-0008, to serve on a panel of physicians shall each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. Each physician shall bill for the record review and panel examination under OSC-P0002. The panel member who prepares and submits the panel report shall receive an additional payment under OSC-P0003.

(c) The director may in a complex case requiring extensive review by a physician pre-authorize an additional fee. Complex case review shall be billed under OSC-P0004.

(d) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician shall bill under OSC-P0005. The insurer must pay the physician for the appointment time and any time spent reviewing the record completed prior to the examination time. The billing must document the physician's time spent reviewing the record.

(e) Should an advance of costs be necessary for the worker to attend an exam under ORS 656.327 or 656.260, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(11) The fee for a Worker Requested Medical Examination shall be billed under OSC-W0001. This code shall be used for a report, file review, or examination.

(12) The table below lists the Oregon Specific Codes for Other Services.

Codes — RelativeValue — Description
R0001 — — Copies of medical records when requested shall be paid at $10.00 for the first page and $.50 for each page thereafter and identified on billings
N0001 — 1.71 — Brief narrative by the attending physician or authorized nurse practitioner
N0002 — 3.41 — Complex narrative by the attending physician or authorized nurse practitioner
99196 — 3.00 — First Level PCE
99197 — 5.36 — Second Level PCE
99198 — 11.31 — WCE
99193 — 0.77 — Additional 15 minutes
D0001 — 0.00 — Attorney consultation time
D0002 — 0.00 — Deposition time
D0003 — 0.00 — Independent Medical Examination (IME) and report
D0004 — 0.00 — Interpretive services
D0019 — 0.00 — Medical service provider review and response to IME report
AR001 — 5.12 — Level 1 arbiter exam
AR002 — 6.82 — Level 2 arbiter exam
AR003 — 8.53 — Level 3 arbiter exam
AR004 — 2.56 — Level 4 arbiter exam
AR011 — 0.88 — Level 1 arbiter report
AR012 — 1.32 — Level 2 arbiter report
AR013 — 1.77 — Level 3 arbiter report
AR021 — 0.88 — Level 1 arbiter file review
AR022 — 2.21 — Level 2 arbiter file review
AR023 — 5.30 — Level 3 arbiter file review
AR024 — 10.23 — Level 4 arbiter file review
AR025 — 13.65 — Level 5 arbiter file review
AR031 — 0.88 — Limited arbiter report
AR032 — 1.77 — Complex arbiter report
P0001 — 4.27 — Director single medical review/exam
P0002 — 4.27 — Director panel medical review/exam
P0003 — 2.17 — Director single medical review/report
P0004 — 5.12 — Director complex case review/exam
P0005 — 2.17 — Failure to appear director required examination
W0001 — 0.00 — Worker Requested Medical Examination and report

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0080
Durable Medical Equipment and Medical Supplies

(1) Durable medical equipment (DME) is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and not generally useful to a person in the absence of an illness or injury. For example: Transcutaneous Electrical Nerve Stimulation (TENS), MicroCurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc. Fees for durable medical equipment shall be paid as follows:

(a) The insurer shall pay for the purchase of all compensable DME that are ordered and approved by the physician, at 85% of the manufacturer's suggested retail price (MSRP). If no MSRP is available or the provider can demonstrate that 85% of the MSRP is less than 140% of the actual cost to the provider, the insurer shall pay the provider 140% of the actual cost to the provider for the item as documented on a receipt of sale.

(b) The DME provider is entitled to payment for any labor and reasonable expenses directly related to any subsequent modifications other than those performed at the time of purchase, or repairs. A subsequent modification is one done other than as a part of the initial set-up at the time of purchase. The insurer shall pay for labor at the provider's usual rate.

(c) The provider may offer a service agreement at an additional cost.

(d) Rental of all compensable DME shall be billed at the provider's usual rate. Within 90 days of the beginning of the rental, the insurer may purchase the DME or device at the fee provided in this rule, with a credit for rental paid up to 2 months.

(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. For example: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer shall pay the fee for a prosthetic at the provider's usual rate.

(a) Testing for hearing aids must be done by a licensed audiologist or an otolaryngologist.

(b) Based on current technology, the preferred types of hearing aids for most workers are programmable BTE, ITE, and CIC multi channel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

(c) Without approval from the insurer or director, hearing aids should not exceed $5000 for a pair of hearing aids, or $2500 for a single hearing aid.

(3) An orthosis is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. For example: brace, splint, shoe insert or modification, etc. The insurer shall pay the fee for an orthosis at the provider's usual rate.

(4) Medical supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags. The insurer shall pay the fees for medical supplies at the provider's usual rate.

(5) The worker may select the service provider, except for claims enrolled in a managed care organization (MCO) where service providers are specified by the MCO contract.

(6) Except as provided in subsection (2)(c) of this rule, this rule does not apply to a worker's direct purchase of DME and medical supplies, and does not limit a worker's right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(7) DME, medical supplies and other devices dispensed by a hospital (inpatient or outpatient) shall be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07

436-009-0090
Pharmacy Fees

(1) Except for in-patient hospital charges, the insurer shall pay for pharmacy fees at the provider's usual rate or the maximum allowable fee established by this rule, whichever is the lower.

(a) The Average Wholesale Price (AWP) effective on the day the drug was dispensed shall be used to determine the maximum allowable fee.

(b) The maximum allowable fee is determined as follows:

(A) For generic drugs and for brand name drugs without a generic equivalent, 88% of the AWP for the dispensed drug plus $8.70 dispensing fee.

(B) For brand name drugs with a generic equivalent, if the prescribing medical service provider writes "Do not substitute" or a similar notation on the prescription, 88% of the AWP for the dispensed drug plus $8.70 dispensing fee.

(C) For brand name drugs with a generic equivalent, if the prescribing medical service provider did not write "Do not substitute" or a similar notation on the prescription, the lower of 88% of the AWP for the dispensed drug plus $8.70 dispensing fee, or 88% of the average AWP for the class of generic drugs plus $8.70 dispensing fee, or, in the event that the pricing guides have not established an average AWP, 88% of the calculated average AWP of the generic drugs listed in the pricing guide plus $8.70 dispensing fee.

(c) All providers who are licensed to dispense medications in accordance with their practice must be paid similarly regardless of profession.

(2) All prescription medications are required medical services and do not require prior approval under the palliative care provisions of OAR 436-010-0290.

(3) Under ORS 689.515(2) licensed providers may dispense generic drugs to injured workers.

(4) Payment for Oxycontin and COX-2 inhibitors is limited to an initial five-day supply unless the prescribing medical service provider writes a clinical justification for prescribing that drug rather than a less costly drug with a similar therapeutic effect.

(a) The clinical justification may accompany the prescription and be submitted by the pharmacist or may be given directly to the insurer by the medical provider.

(b) Clinical justification means a written document from the medical service provider stating the reason he or she believes the drug ordered is the one the patient should have. The justification may be included on the prescription itself and may simply be a brief statement. Insurers and self-insured employers cannot challenge the adequacy of the clinical justification. However, they can challenge whether or not the medication is excessive, inappropriate, or ineffectual in accordance with ORS 656.327.

(c) An additional clinical justification is not necessary for refills of that medication.

(5) Insurers shall use the prescription pricing guide published by First DataBank Inc, Thomson Healthcare, Inc., or Facts & Comparisons (a Wolters Kluwer Health, Inc., Company) for calculating payments to the licensed provider. Insurers must update their source at least monthly.

(6) The worker may select the pharmacy, except for claims enrolled in a managed care organization (MCO) where pharmacy service providers are specified by the MCO contract.

(7) Except for sections 2, 3, 4 and 6 of this rule, this rule does not apply to a worker's direct purchase of prescription medications, and does not limit a worker's right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(8) The insurer shall pay the retail-based fee for over-the-counter medications.

(9) Drugs dispensed by a hospital (inpatient or outpatient) shall be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06

436-009-0100
Sanctions and Civil Penalties

The director may impose sanctions upon a medical provider or insurer for violation of OAR 436-009 in accordance with OAR 436-010-0340.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.245, 656.254 & 656.745
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00

DIVISION 10

MEDICAL SERVICES

436-010-0001
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.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656
Hist.: WCB 1-1972, f. & ef. 1-14-72; WCB 4-1976, f. 10-20-76, ef. 11-1-76; WCD 7-1978(Admin), f. & ef. 6-5-78; WCD 2-1980(Admin), f. 1-28-80, ef. 2-1-80; WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0003, 5-1-85; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02

436-010-0002
Purpose

The purpose of these rules is to establish uniform guidelines for administering the payment for medical services to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.325, 656.327 & 656.794(3)
Hist.: WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90

436-010-0003
Applicability of Rules

(1) These rules shall be applicable 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 pursuant to ORS Chapter 656.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

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
Hist.: WCD 7-1978(Admin), f. & ef. 6-5-78; WCD 2-1980(Admin), f. 1-28-80, ef. 2-1-80; WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0004, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 3-1990(Temp), f. 1-24-90, cert. ef. 2-1-90; WCD 4-1990(Temp), f. 4-20-90, cert. ef. 5-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 15-1990, f. & cert. ef. 8-7-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f.

12-20-94, cert. ef. 2-1-95; WCD 18-1995(Temp), f. & cert. ef. 12-4-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-010-0005
Definitions

For the purpose of these rules, OAR 436-009, and 436-015, unless the context otherwise requires:

(1) "Administrative Review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(2) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

(a) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Oregon Medical Board or an oral surgeon licensed by the Oregon Board of Dentistry;

(b) A medical doctor, doctor of osteopathy, or oral surgeon practicing in and licensed under the laws of another state;

(c) For the purpose of these rules:

(A) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A); and

(B) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B); or,

(d) Any medical service provider authorized to be an attending physician in accordance with a managed care organization contract.

(3) "Authorized nurse practitioner" means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and has been assigned an authorized nurse practitioner number by the director.

(4) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(5) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(6) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied.

(7) "Current Procedural Terminology" or "CPT"® means the Current Procedural Terminology codes and terminology most recently published by the American Medical Association unless otherwise specified in these rules.

(8) "Customary Fee" means a fee that falls within the range of fees normally charged for a given service.

(9) "Days" means calendar days.

(10) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

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

(12) "Eligible" means an injured worker who has filed a claim and is employed by an employer who is located in an MCO's authorized geographical service area, covered by an insurer who has a contract with that MCO. "Eligible" also includes a worker with an accepted claim having a date of injury prior to contract when that worker's employer later becomes covered by an MCO contract.

(13) "Enrolled" means an eligible injured worker has received notification from the insurer that the worker is being required to treat under the auspices of the MCO. However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

(14) "Health Care Practitioner or Health Care Provider" has the same meaning as a "medical service provider."

(15) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

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

(17) "Home Health Care" means medically necessary medical and medically related services provided in the injured worker's home environment. These services might include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

(18) "Hospital" means an institution licensed by the State of Oregon as a hospital.

(19) "Initial Claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(20) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

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

(22) "Interim Medical Benefits" means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer's notice of the claim.

(23) "Mailed or Mailing Date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(24) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(25) "Medical Evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, x-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material utilized, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(26) "Medical Service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(27) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(28) "Medical Provider" means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(29) "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(30) "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also considered outpatient services.

(31) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(32) "Physical Capacity Evaluation" means an objective, directly observed, measurement of a worker's ability to perform a variety of

physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, and Functional Capacity Assessment will be considered to have the same meaning as Physical Capacity Evaluation.

(33) "Physical Restorative Services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia, a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the highest functional ability consistent with the worker's condition. Physical restorative services are not services to replace medical services usually prescribed during the course of recovery.

(34) "Report" means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(35) "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

(36) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensable injury.

(37) "Usual Fee" means the medical provider's fee charged the general public for a given service.

(38) "Work Capacity Evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening will be considered to have the same meaning as Work Capacity Evaluation.

(39) "Work Hardening" means an individualized, medically prescribed and monitored, work oriented treatment process. The process involves the worker participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the worker to a specific job.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.000 et seq. & 656.005
Hist.: WCB 4-1976, f. 10-20-76, ef. 11-1-76; WCD 7-1978(Admin), f. & ef. 6-5-78; WCD 2-1980(Admin), f. 1-28-80, ef. 2-1-80; WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0005, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 4-1986(Admin), f. 6-26-86, ef. 7-1-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 14-1990(Temp), f. & cert. ef. 7-20-91; WCD 16-1990(Temp), f. & cert. ef. 8-17-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0006
Administration of Rules

Any orders issued by the division in carrying out the director's authority to administer, regulate, and enforce ORS Chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726
Hist.: WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02

436-010-0008
Administrative Review

(1) Administrative review before the director:

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services disputes arising under ORS 656.245, 656.247, 656.260, 656.325 and 656.327.

(b) A party need not be represented to participate in the administrative review before the director.

(c) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement must be in writing and be approved by the director. Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the claimant or claimant's attorney. If the dispute does not resolve through mediation or alternative dispute resolution, a director's order will be issued.

(2) Administrative review and hearing processes for change of attending physician or authorized nurse practitioner issues are in OAR 436-010-0220; additional independent medical examination (IMEs) matters are in OAR 436-010-0265; and fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

(3) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

(4) All issues pertaining to disagreement about medical services within a Managed Care Organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the injured worker, are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter by the director.

(5) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all disputes subject to dispute resolution within a Managed Care Organization, upon completion of the MCO process, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision. If a party has been denied access to an MCO internal dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving the particular type of dispute, the insurer must advise the medical provider or worker that they may request review by the director.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, which ever occurs last. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438 chapter, division 005.

(c) Disputes regarding elective surgery must be processed in accordance with OAR 436-010-0250.

(d) The director may, on the director's own motion, initiate a medical services or medical treatment review at any time.

(e) Medical provider bills for treatment or services which are subject to director's review will not be deemed payable pending the outcome of the review.

(6) Parties must submit requests for administrative review to the director in the form and format provided in Bulletins 293 or 253. When an insurer or the worker's representative submits a request without the required information, the director may dismiss the request or hold ini-

tiation of the administrative review until the information is submitted. Unrepresented workers may seek help from the director to meet the filing requirements. The requesting party must notify at the same time all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker's name, date of injury, insurer, and claim number;

(b) Specify what issues are in dispute and specify with particularity the relief sought;

(c) Provide the specific dates of the unpaid disputed treatment or services.

(7) In addition to medical evidence relating to the medical dispute, all parties may submit other relevant information, including but not limited to, written factual information, sworn affidavits, and legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute.

(8) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer must provide a record packet, without cost, to the director and all other parties or their representatives as follows:

(a) Except for disputes regarding interim medical benefits, the packet must include certification that there is no issue of compensability of the underlying claim or condition. If there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document ten must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

As required by OAR 436-010-0008, we hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(c) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request in the form and format described in this rule.

(e) If the insurer fails to submit the record in the time and format specified in this rule, the director may penalize or sanction the insurer under OAR 436-010-0340.

(9) If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(c) When such an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. The physician or panel must not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted to the director for screening as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination may include, but is not limited to:

(A) A review of all medical records and diagnostic tests submitted,

(B) An examination of the worker, and

(C) Any necessary and reasonable medical tests.

(10) The director will review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

(a) A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the dispute.

(b) If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(c) If the director issues an administrative order resolving a bona fide dispute:

(A) For disputes arising under ORS 656.245, 656.260, or 656.327, a party may file a request for hearing within 30 days of the mailing date of the order.

(B) For disputes arising under ORS 656.247, a party may file a request for hearing within 60 days of the mailing date of the order.

(C) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed before the administrative order becomes final.

(D) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this subsection and may respond to such evidence submitted by others.

(E) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(11) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.

(12) In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director will award an attorney fee to be paid by the insurer or self-insured employer, as provided in ORS 656.385. The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration will be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed $2000, nor fall outside the ranges for fees as provided in the following matrix: [Matrix not included. See ED. NOTE.]

(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the issue before the director if greater than two hours. In the absence of such a statement, the director will assume the time spent was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to, the following:

(A) The fee allowed by the fee schedule provided in OAR 436-009;

(B) The overall cost of the medical treatment or service; or

(C) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above $2000, they may submit a written or faxed statement of the extraordinary circumstances to the director. Extraordinary circumstances are not established by merely exceeding eight hours or exceeding a benefit of $6000.

(d) An assessed attorney fee must be paid within 30 days of the date the order authorizing the fee becomes final.

(13) Any party who disagrees with an action or administrative order under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of an order under ORS 656.245, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(a) In the review of orders issued under ORS 656.327(2), 656.260(14) and (16), and 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(b) For claims not enrolled in an MCO, disputes about whether a medical service after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c) and whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review by the director. If appealed, review at hearing is subject to the "no new medical evidence or issues rule" in subsection (13)(a) of this rule. However, if the disputed medical service or medical treatment is determined compensable under ORS 656.245(1)(c) or 656.245(3) all disputes and assertions about whether the compensable medical services are excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services are subject to the substantial evidence rule at hearing.

(14) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the board as follows:

(a) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.

(c) The division will forward the request and other pertinent information to the board.

(15) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (14) of this rule, under these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (13) of this rule.

[ED. NOTE: Matrices referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331 & 656.704

Hist.: WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 18-1995(Temp), f. & cert. ef. 12-4-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-010-0200
Advisory Committee on Medical Care

The Advisory Committee on Medical Care will be appointed by the director. The committee will include one representative of insurers, one representative of employers, one representative of workers, one representative of managed care organizations, a diverse group of health care providers representative of those providing medical care to injured workers, and other persons as the director may determine are necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. The selection of health care providers will consider the perspective of specialty care, primary care, and ancillary care providers, and the ability of members to represent the interests of the community at large.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.794

Hist.: WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0095; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-990; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-010-0210
Who May Provide Medical Services and Authorize Timeloss

(1)Type A and B attending physicians may authorize time loss and manage medical services subject to the limitations of ORS chapter 656. (See "Matrix for health care provider types" Appendix A)

(2) Emergency room physicians may authorize time loss for not more than 14 days when they refer the worker to a primary care physician. However an emergency room physician also in private practice, apart from the duties of an emergency room physician, may qualify as a type A attending physician. For the purpose of this rule, private practice means a physician who treats individuals on an established patient basis.

(3) Authorized primary care physicians and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO. An MCO may allow greater latitude for the provider types to treat a worker enrolled under ORS 656.260.

(4) Attending physicians and authorized nurse practitioners may prescribe treatment or services to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment or services to be carried out by persons not licensed to provide a medical service or treat independently only when such services or treatment is rendered under the physician's direct control and supervision. Reimbursement to a worker for home health care provided by a worker's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(5) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(4)(a), nor under the direct control and supervision of the attending physician.

(6) Effective October 1, 2004, in order to provide any compensable medical service under ORS chapter 656, a nurse practitioner licensed under ORS 678.375 to 678.390 must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request and must have been assigned an authorized nurse practitioner number by the director. An authorized nurse practitioner may:

(a) Provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without authorization of an attending physician; and

(b) Authorize temporary disability benefits for a period of up to 60 days from the date of the first nurse practitioner visit on the initial claim.

(7) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's

knowledge of the worker's request to treat with an out-of-state physician, the insurer must give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

(a) If the insurer does not approve the worker's out-of-state physician, notice to the worker must clearly state the reason(s) for the denial, which may include, but are not limited to, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010, and identify at least two other physicians of the same healing art and specialty whom it would approve. The notice must also inform the worker that if the worker disagrees with the denial, the worker may refer the matter to the director for review under the provisions of OAR 436-010-0220.

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

(A) The Oregon fee schedule requirements;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon injured workers; and

(C) Billings for compensable services in excess of the maximum allowed under the fee schedule may not be paid by the insurer.

(8) After giving prior approval, if the out-of-state physician does not comply with these rules, the insurer may object to the worker's choice of physician and must notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by that physician after notification will not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

(9) If the worker is aggrieved by an insurer decision to object to an out-of-state attending physician, the worker or the worker's representative may refer the matter to the director for review under the provisions of OAR 436-010-0220.

Stat. Auth.:ORS 656.726(4)

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

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 5-1984(Admin), f. & ef. 8-20-84; Renumbered from 436-069-0301, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0050; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-000; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0220
Choosing and Changing Medical Providers

(1) A newly selected attending physician, authorized nurse practitioner, or a specialist physician who becomes primarily responsible for the worker's care, must notify the insurer not later than five days after the date of change or first treatment, using Form 827. An attending physician or authorized nurse practitioner:

(a) Is primarily responsible for the worker's care;

(b) Authorizes time loss;

(c) Monitors ancillary care and specialized care; and

(d) Is determined by the facts of the case and the actions of the physician, not whether a Form 827 is filed.

(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers must be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable. When the attending physician or authorized nurse practitioner refers the worker to a specialist physician, the referral must be written. An attending physician must specify any limitations regarding the referral within such document. Unless the documented referral limits the referral to consultation only, the referral is deemed to include attending physician authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate. Nothing in this rule diminishes the attending physician's responsibility to fulfill all their duties under ORS chapter 656, including authorizing temporary disability. Fees for services by more than one physician at the same time are payable only when the service is sufficiently different that separate medical skills are needed for proper care.

(3) The worker is allowed to change his or her attending physician or authorized nurse practitioner by choice two times after the initial choice. Referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, initiated by the worker, will count in this calculation. The limitations of the worker's right to choose physicians or authorized nurse practitioners under this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes by choice of the worker:

(a) Emergency services by a physician;

(b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner;

(d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change medical service providers to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:

(A) When the physician terminates practice or leaves the area;

(B) When a physician is no longer willing to treat an injured worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the physician;

(D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired; (See "Matrix for health care provider types" Appendix A);

(E) When the nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure; and

(F) When a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A Worker Requested Medical Examination;

(h) Whether a worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines; or

(i) When a worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence.

(4) When a worker has made an initial choice of attending physician or authorized nurse practitioner and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer must inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable services rendered prior to notice to the worker. If an attending physician or authorized nurse practitioner begins treatment without being informed that the worker has been given the required notification, the insurer must pay for appropriate services rendered prior to the time the insurer notifies the medical service provider that further payment will not be made and informs the worker of the right to seek approval of the director.

(5)(a) If a worker not enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of medical service provider or a Form 827 indicating the worker is choosing to change his or her attending physician or authorized nurse practitioner, the insurer must notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer must advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the request, the insurer must notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer must provide the reasons and give notification that the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician or authorized nurse practitioner issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of Form 2332.

(6) Upon receipt of a worker's request for an additional change of attending physician or authorized nurse practitioner, the director may notify the parties and request additional information. Upon receipt of a written request from the director for additional information, the parties will have 14 days to respond in writing.

(7) After receipt and review, the director will issue an order advising whether the change is approved. The change of attending physician or authorized nurse practitioner will be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

(a) Whether there is medical justification for a change, including whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(b) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(c) Whether such a change will cause unnecessary travel costs or lost time from work.

(8) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.276(4)

Stats. Implemented: ORS 656.245, 656.252 & 656.260

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0401, 5-1-85; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0060; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0230
Medical Services and Treatment Guidelines

(1) Medical services provided to the injured worker must not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) An employer or insurer representative may not attend a worker's medical appointment without written consent of the worker. The worker has the right to refuse such attendance.

(a) The consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present.

(b) The consent form must be written in a way that allows the worker to understand it and to overcome language or cultural differences.

(c) The insurer must retain a copy of a signed consent form in the claim file.

(3) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services.

(4)(a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician will not be reimbursed unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A).

(b) The attending physician, authorized nurse practitioner, or specialist physician must sign a copy of the treatment plan within 30 days of the commencement of treatment and send it to the insurer. Failure of the physician or nurse practitioner to sign or mail the treatment plan may subject the attending physician or authorized nurse practitioner to sanctions under OAR 436-010-0340, but shall not affect payment to the ancillary medical service provider.

(c) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a chiropractor, naturopath, acupuncturist, or podiatrist will be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

(d) Unless otherwise provided for within utilization and treatment standards under an MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days, and 4 visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment or services. The attending physician or authorized nurse practitioner must document the need for medical services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

(5) The attending physician or authorized nurse practitioner, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, must complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner must notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker will be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090.

(7) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker or they are provided in accordance with a utilization and treatment standard adopted by the director. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(8) X-ray films must be of diagnostic quality and accompanied by a report. 14" x 36" lateral views are not reimbursable.

(9) Upon request of either the director or the insurer, original diagnostic studies, including but not limited to actual films, must be forwarded to the director, the insurer, or the insurer's designee, within 14 days of receipt of a written request.

(a) Diagnostic studies, including films must be returned to the medical provider within a reasonable time.

(b) The insurer must pay for a reasonable charge made by the provider for the costs of delivery of diagnostic studies, including films.

(c) If a medical provider does not forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

(10) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(11) Physical restorative services may include but are not limited to a regular exercise program or swim therapy. Such services are not compensable unless the nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social and/or functional activity. The attending physician or authorized nurse practitioner must justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

(12) The cost of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury is a compensable medical expense, including when the worker received no physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eyeglasses.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248 & 656.252

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 5-1984(Admin), f. & ef. 8-20-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0201, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 2-1989, f. 8-21-89, cert. ef. 9-1-89; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0040; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-1999(Temp), f. & cert. ef. 2-11-99 thru 8-10-99; WCD 7-1999, f. & cert. ef. 4-28-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0240

Reporting Requirements for Medical Providers

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records under ORS 656.252 and diagnostic records required under ORS 656.325. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, this authorization does not authorize the release of information regarding:

(a) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation; or

(b) The release of HIV related information otherwise protected by ORS 433.045(3). HIV related information should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition(s).

(2) Any physician, hospital, clinic, or other medical service provider, must provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, or 2476 (Release of Information). "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the director, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule will prevent a medical provider from requiring a signed authorized Release of Information.

(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim must complete the first medical report (Form 827) in every detail, to include the worker's name, address, and social security number (SSN), and information required by ORS 656.252 and 656.254. The medical service provider must mail it to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period).

(a) Diagnoses stated on Form 827 and all subsequent reports must conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(b) The worker's SSN will be used by the director to carry out its duties under ORS chapter 656. The worker may voluntarily authorize additional use of the worker's SSN by various government agencies to carry out their statutory duties.

(4) All medical service providers must notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. The worker must also be notified that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the worker's chart notes.

(5) Attending physicians or authorized nurse practitioners must, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return to work form, the insurer must use Form 3245.

(6) Medical providers must maintain records necessary to document the extent of medical services provided to injured workers.

(7) Progress reports are essential. When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports must be in accordance with OAR 436-009-0015(11), 436-009-0070(2) or (3), whichever applies

(8) Reports may be handwritten and include all relevant or requested information.

(9) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(10) The medical provider must respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, original diagnostic studies, including, but not limited to, actual films, and any or all necessary records needed to review the efficacy of medical treatment or medical services, frequency, and necessity of care. The medical provider must be reimbursed for copying documents in accordance with OAR 436-009-0070(1). If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

(11) The attending physician or authorized nurse practitioner must inform the insurer and the worker of the anticipated date of release to work, the anticipated date the worker will become medically stationary, the next appointment date, and the worker's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report. The insurer must not consider the anticipated date of becoming medically stationary as a release to return to work.

(12) The attending physician or authorized nurse practitioner must notify the worker, insurer, and all other health care providers involved in the worker's treatment when the worker is determined medically stationary. The medically stationary date must be the date of the exam, and not a projected date. The notice must provide:

(a) The medically stationary date; and

(b) Whether the worker is released to any kind of work.

(13) The attending physician or authorized nurse practitioner must advise the worker, and within five days provide the insurer with written notice, of the date the injured worker is released to return to regular or modified work. The physician or nurse must not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

(14) When an injured worker files a claim for aggravation, the claim must be filed on Form 827 and must be signed by the worker or the worker's representative and the attending physician. The attending physician, on the worker's behalf, must submit the aggravation form to the insurer within five days of the examination where aggravation is identified. When an insurer or self-insured employer receives a completed aggravation form, it must process the claim. Within 14

days of the examination the attending physician must also send a written report to the insurer that includes objective findings that document:

(a) Whether the worker is unable to work as a result of the compensable worsening; and

(b) Whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273.

(15) The attending physician, authorized nurse practitioner, or the MCO may request consultation regarding conditions related to an accepted claim. The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for consultation. This requirement does not apply to diagnostic studies performed by radiologists and pathologists. The attending physician, authorized nurse practitioner, or MCO must provide the consultant with all relevant clinical information. The consultant must submit a copy of the consultation report to the attending physician, authorized nurse practitioner, the MCO, and the insurer within 10 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report. MCO requested consultations that are initiated by the insurer, which include examination of the worker, must be considered independent medical examinations subject to the provisions of OAR 436-010-0265.

(16) A medical service provider must not unreasonably interfere with the right of the insurer, under OAR 436-010-0265(1), to obtain a medical examination of the worker by a physician of the insurer's choice.

(17) Any time an injured worker changes his or her attending physician or authorized nurse practitioner:

(a) The new provider is responsible for:

(A) Submitting Form 827 to the insurer not later than five days after the change or the date of first treatment; and

(B) Requesting all available medical information, including information concerning previous temporary disability periods, from the previous attending physician, authorized nurse practitioner, or from the insurer.

(b) The requirements of paragraphs (A) and (B) also apply anytime a worker is referred to a new physician qualified to be an attending physician or to a new authorized nurse practitioner primarily responsible for the worker's care.

(c) Anyone failing to forward requested information within 14 days to the new physician or nurse will be subject to penalties under OAR 436-010-0340.

(18) Injured workers, or their representatives, are entitled to copies of all protected health information in the medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers under the following conditions:

(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0070(1), but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.

(b) For the purpose of this rule, "protected health information in the medical record" means any oral or written information in any form or medium that is created or received and relates to:

(A) The past, present, or future physical or mental health of the patient;

(B) The provision of health care to the patient; and

(C) The past, present, or future payment for the provision of health care to the patient.

(c) A worker or the worker's representative may request all or part of the record. A summary may substitute for the actual record only if the patient agrees to the substitution. Upon request, the entire health information record in the possession of the medical provider will be provided to the worker or the worker's representative. This includes records from other healthcare providers, except that the following may be withheld:

(A) Information which was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information;

(B) Psychotherapy notes;

(C) Information compiled for use in a civil, criminal, or administrative action or proceeding; and

(D) Other reasons specified by federal regulation.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.276(4)

Stats. Implemented: ORS 656.245, 656.252, 656.254 & 656.273

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0101, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 14-1990(Temp), f. & cert. ef. 7-20-91; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0030; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0250
Elective Surgery

(1) "Elective Surgery" is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

(2) Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician or authorized nurse practitioner, believes elective surgery is needed to treat a compensable injury or illness, the attending physician, authorized nurse practitioner, or the surgeon must give the insurer notice at least seven days prior to the date of the proposed surgery. Notification must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.

(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice.

(a) The insurer must notify the recommending physician, the worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired.

(A) The insurer's notice must either communicate approval to the physician; or

(B) If approval is not given, the insurer must submit a completed **Form 440-3228** (Elective Surgery Notification) to the recommending physician.

(b) If the form is not completed or insurer approval is not communicated to the physician, the physician is not required to respond.

(c) When requested, the consultation must be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer must notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer should endeavor to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, may obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

(c) When the recommending physician determines that agreement cannot be reached and that further attempts to resolve the matter would be futile, the recommending physician must notify the insurer, the worker and the worker's representative of such by signing **Form 440-3228** or providing other written notification.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or is in violation of these medical rules and cannot resolve the dispute with the recommending physician, the insurer must request an administrative review by the director within 21 days of the notice provided in subsection (4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request either by communicating the insurer's approval of the surgery or by submitting a completed **Form 440-3228**, or to timely request administrative review under this rule shall bar the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.

(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification

requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(8) Surgery which must be performed before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases the attending physician or authorized nurse practitioner should endeavor to notify the insurer of the need for emergency surgery.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260 & 656.327

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0501, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0070; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-010-0260
Monitoring and Auditing Medical Providers

(1) The department will monitor and conduct periodic audits of medical providers to ensure compliance with ORS Chapter 656 and these rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252

Hist.: WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0101; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-010-0265
Insurer Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by medical service providers of its choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. Effective July 1, 2006, the insurer must choose a provider to perform the independent medical examination from the director's list described in section (13) of this rule. A claim for aggravation, Board's Own Motion, or reopening of a claim where the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "independent medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician or authorized nurse practitioner. The examination may be conducted by one or more providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer must first notify and request authorization from the director. Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty. The process for requesting such authorization will be as follows:

(a) The insurer must submit a request for such authorization to the director in a form and format as prescribed by the director in Bulletin 252 including, but not limited to, the reasons for an additional IME, the conditions to be evaluated, dates, times, places, and purposes of previous examinations, copies of previous IME notification letters to the worker, and any other information requested by the director. A copy of the request must be provided to the worker and the worker's attorney; and

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. Upon receipt of a written request for additional information from the director, the parties have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

(3) In determining whether to approve or deny the request for an additional IME, the director may give consideration, but is not limited, to the following:

(a) Whether an IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(b) Whether there has been a significant change in the worker's condition.

(c) Whether there is a new condition or compensable aspect introduced to the claim.

(d) Whether there is a conflict of medical opinion about a worker's medical treatment or medical services, impairment, stationary status, or other issue critical to claim processing/benefits.

(e) Whether the IME is requested to establish a preponderance for medically stationary status.

(f) Whether the IME is medically harmful to the worker.

(g) Whether the IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(4) Any party aggrieved by the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the board under ORS 656.283 and OAR chapter 438.

(5) For purposes of determining the number of IMEs, any examinations scheduled but not completed are not counted as a statutory IME. The following examinations are not considered IMEs and do not require approval as outlined in section (2) of this rule:

(a) An examination conducted by or at the request or direction of the worker's attending physician or authorized nurse practitioner;

(b) An examination obtained at the request of the director;

(c) An elective surgery consultation obtained in accordance with OAR 436-010-0250(3);

(d) An examination of a permanently totally disabled worker required under ORS 656.206(5);

(e) A closing examination by a consulting physician that has been arranged by the insurer, the worker's attending physician or authorized nurse practitioner in accordance with OAR 436-010-0280;

(f) A consultation requested by the Managed Care Organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under its contract.

(6) Examinations must be at times and intervals reasonably convenient to the worker and must not delay or interrupt proper treatment of the worker.

(7) When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(8) A medical provider who unreasonably fails to timely provide diagnostic records required for an IME in accordance with OAR 436-010-0230(9) and 436-010-0240(10) may be assessed a penalty under ORS 656.325.

(9) When a worker objects to the location of an IME, the worker may request review by the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, facsimile, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if there is substantial evidence to support a finding that the travel is medically contraindicated, or unreasonable based on a showing of good cause.

(A) For the purposes of this rule, "medically contraindicated" means that the travel required to attend the IME exceeds the travel or other limitations imposed by the attending physician, authorized nurse practitioner or other persuasive medical evidence, and alternative methods of travel will not overcome the limitations.

(B) For the purposes of this rule, "good cause" means the travel would impose a hardship for the worker that outweighs the right of the insurer or self-insured employer to select an IME location of its choice.

(10) If a worker fails to attend an IME without notifying the insurer or self-insured employer before the date of the examination or without sufficient reason for not attending, the director may impose

a monetary penalty against the worker for such failure under OAR 436-010-0340.

(11) When scheduling an IME, the insurer must ensure the medical service provider has:

(a) An Invasive Medical Procedure Authorization (Form 440-3227), if applicable; and

(b) A Worker IME Survey (Form 440-0858), with instructions to give the form(s) to the worker at the time of the IME.

(12) If a medical service provider intends to perform an invasive procedure as part of an IME, the provider must explain the risks involved in the procedure to the worker and the worker's right to refuse the procedure. The worker then must check the applicable box on Form 440-3227 either agreeing to the procedure or declining the procedure, and sign the form. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

(13) Any medical service provider wishing to perform an IME or a Worker Requested Medical Exam (WRME) under ORS 656.325(1)(e) and OAR 436-060-0147 for a workers' compensation claim must meet the director's criteria and be included on the list of authorized providers maintained by the Director of the Department of Consumer and Business Services under ORS 656.328.

(a) To be on the director's list to perform IMEs or WRMEs, a medical service provider must:

(A) Hold a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon Medical Board.

(B) Complete a director-approved three-hour initial training course regarding IMEs. The training curriculum must include, at a minimum, all topics listed in Appendix B.

(i) Any party may request the director to place a provider on the director's list with less than the three-hour training. At the director's discretion, providers may be placed on the director's list to perform IMEs with less than the three-hour required training when extraordinary circumstances exist in a given case or if the worker and the insurer agree that a certain provider may perform the examination. Providers placed on the director's list in this circumstance are limited to being on the director's list only for the time required for the examination at issue.

(ii) When determining if extraordinary circumstances exist in a given case, the director may consider, but is not limited to, such factors as: medical specialty needed; number of IMEs the provider has performed in a calendar year; where the worker lives; and factors that would make the three-hour training unreasonable in a given case.

(C) Submit the Application for Independent Medical Exam Medical Service Provider Authorization (Form 440-3930) to the director. On the application, the provider must supply his or her license number, the name of the training vendor, and the date the provider completed a director-approved initial training course regarding IMEs. By signing and submitting the application form, the provider agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board, or the independent medical examination standards published in Appendix C, which apply if the provider's regulatory board does not adopt standards of conduct for IMEs. Providers on the director's list of authorized IME providers as of June 7, 2007, remain authorized to perform IMEs and do not need to reapply; and

(ii) All relevant workers' compensation laws and rules.

(b) Any party may make a written request to the director to add a provider to the director's list according to subsection (a).

(c) A provider may be sanctioned or excluded from the director's list of providers authorized to perform IMEs after a finding by the director that the provider:

(A) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C, whichever applies;

(B) Failed to comply with the requirements of this rule, as determined by the director;

(C) Has a current restriction on their license or is under a current disciplinary action from their professional regulatory board;

(D) Has entered into a voluntary agreement with his or her regulatory board which the director determines is detrimental to performing IMEs;

(E) Violated workers' compensation laws or rules; or

(F) Has failed to attend training required by the director.

(d) Within 60 days of the director's decision to exclude a provider from the director's list, the provider may appeal the decision under ORS 656.704(2) and OAR 436-001-0019.

(14) The medical service provider conducting the examination will determine the conditions under which the examination will be conducted. Subject to the provider's approval, the worker may use a video camera or tape recorder to record the examination.

(15) If there is a finding by the director, an administrative law judge, the Workers' Compensation Board, or the court, that the IME was performed by a provider who was not on the director's list of authorized IME providers at the time of the examination, the insurer shall not use the IME report nor shall the report be used in any subsequent proceeding.

(16) Except as provided in subsection (a) of this section, a worker may elect to have an observer present during the IME.

(a) An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must submit a signed observer form (440-3923A) to the examining provider acknowledging that the worker understands the worker may be asked sensitive questions during the examination in the presence of the observer. If the worker does not sign form 440-3923A, the provider may exclude the observer.

(c) An observer cannot participate in or obstruct the examination.

(d) The worker's attorney or any representative of the worker's attorney shall not be an observer. Only a person who does not receive compensation in any way for attending the examination can be an injured worker's observer.

(e) The IME provider must verify that the injured worker and any observer have been notified of the requirement in sub-section (b).

(17) Upon completion of the examination, the examining medical service provider must:

(a) Give the worker a copy of the IME Survey (Form 440-0858) on the day of the examination; and

(b) Send the insurer a copy of the report and, if applicable, the observer form (440-3923A) or the invasive procedure form (440-3227), or both.

(c) Sign a statement at the end of the report verifying who performed the examination and dictated the report, the accuracy of the content of the report, and acknowledging that any false statements may result in sanction by the director.

(18) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

(19) A complaint about an IME may be sent to the director for investigation. The director will determine the appropriate action to take in a given case, which may include consultation with or referral to the appropriate regulatory board.

(20) Training must be approved by the director before it is given. Any party may submit medical service provider IME training curriculum to the director for approval. The curriculum must include training outline, goals, objectives, specify the method of training and the number of training hours, and must include all topics addressed in Appendix B.

(21) Within 21 days of the IME training, the training supplier must send the director the date of the training and a list of all medical providers who completed the training, including names, license numbers, and addresses.

(22) Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist.: WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-1999(Temp), f. & cert. ef. 2-11-99 thru 8-10-99; WCD 7-1999, f. & cert. ef. 4-28-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 4-2007(Temp), f. & cert. ef. 6-7-07 thru 12-3-07; WCD 9-2007, f. 11-1-07, cert. ef. 12-4-07; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0270
Insurer's Rights and Duties

(1) Insurers must notify the injured worker in writing, immediately following receipt of notice or knowledge of a claim, of the manner in which they may receive medical services for compensable injuries.

(2) Insurers may obtain relevant medical records, using a computer-generated equivalent of **Form 2476** (Release of Information), with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(3) The insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim. In claims which have been denied, the insurer shall notify the medical service provider and MCO, if any, within ten days of any change of status of the claim.

(4) Upon request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner within 14 days.

(5) In disabling and non-disabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers must notify the injured worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245(1)(c).

(6) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer will be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician or authorized nurse practitioner.

(7) Insurers must reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(e), 656.325, and 656.327.

(a) Reimbursement by the insurer to the worker for transportation costs to visit his or her attending physician may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician of the same specialty who is in a geographically closer medical community in relationship to the worker's home. If a worker seeks medical services from an authorized nurse practitioner, reimbursement by the insurer to the worker for transportation costs to visit his or her authorized nurse practitioner may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate nurse practitioner of the same specialty who is in a geographically closer medical community in relationship to the worker's home. All medical practitioners within a metropolitan area are considered part of the same medical community and therefore are not considered geographically closer than any other physician in that metropolitan medical community for purposes of travel reimbursement.

(b) A worker who relocates within the State of Oregon may continue treating with the established attending physician or authorized nurse practitioner and be reimbursed transportation costs.

(c) Prior to limiting reimbursement under subsection (7)(a) of this rule, the insurer must provide the worker a written explanation and a list of providers who can timely provide similar medical services within a reasonable traveling distance for the worker. The insurer must inform the worker that medical services may continue with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited as described.

(d) When the director decides travel reimbursement disputes the determination will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0801, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0100; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-000; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-010-0275
Insurer's Duties Under MCO Contracts

(1) Insurers who enter into an MCO contract in accordance with OAR 436-015, must notify the affected insured employers of the following:

(a) The names and addresses of the complete panel of MCO medical providers within the employer's geographical service area(s);

(b) The manner in which injured workers can receive compensable medical services within the MCO;

(c) The manner in which injured workers can receive compensable medical services by medical providers outside the MCO; and

(d) The geographical service area governed by the MCO.

(2) Insurers under contract with an MCO must notify all newly insured employers in accordance with section (1) of this rule, prior to or on the effective date of coverage.

(3) At least 30 days prior to any significant changes to an MCO contract affecting injured worker benefits, the insurer must notify in accordance with OAR 436-015-0035 all affected insured employers and injured workers of the manner in which injured workers will receive medical services.

(4) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO of enrollment. The notice must:

(a) Notify the worker of the eligible attending physicians within the relevant MCO geographic service area and describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(b) Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;

(c) Describe how the worker can receive compensable medical treatment from a primary care physician or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician or authorized nurse practitioner;

(d) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(6);

(e) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

(f) Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and

(g) Notify the MCO of any request by the worker for qualification of a primary care physician or authorized nurse practitioner.

(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance must inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever occurs first.

(6) Insurers enrolling a worker who is not yet medically stationary and is required to change medical providers, must notify the worker of the right to request review by the MCO if the worker believes the change would be medically detrimental.

(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician or authorized nurse practitioner, the insurer must notify the worker and medical service provider regarding provision of care under the MCO contract, including the provisions for continuity of care.

(8) When an insurer under contract with an MCO receives a dispute regarding a matter that is to be resolved through the MCO dispute resolution process and that dispute has not been simultaneously provided to the MCO, the insurer must within 14 days:

(a) Send a copy of the dispute to the MCO; or

(b) If the MCO does not have a dispute resolution process for that issue, the insurer must notify the parties in writing to seek administrative review before the director.

(9) The insurer must also notify the MCO of:

(a) The name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, any changes in this information; and

(b) Any requests for medical services received from the worker or the worker's medical provider.

(10) Insurers under contract with MCOs must maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

(11) When the insurer is dis-enrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The notice must be mailed no later than seven days prior to the date the worker is no longer subject to the contract. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer enrolled.

(12) When a managed care contract expires or terminates without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO, that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days prior to the date of the contract's expiration or termination. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer subject.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist.: WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0280
Determination of Impairment

(1) On disabling claims, when the worker 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. For workers under the care of a type B attending physician or an authorized nurse practitioner, the provider must refer the worker to a type A attending physician to do a closing exam if there is a likelihood the worker has permanent impairment. The closing exam must be completed under OAR 436-030 and 436-035.

(2) The attending physician or authorized nurse practitioner has 14 days from the medically stationary date to send the closing report to the insurer. Within eight days of the medically stationary date, the attending physician may arrange a closing exam with a consulting physician. This exam does not count as an IME or a change of attending physician.

(3) When an attending physician 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 for the concurrence or objections of the attending physician. The attending physician must also state, in writing, whether they agree or disagree with all or part of the findings of the exam. Within seven days of receiving the report, the attending physician must make any comments in writing and send the report to the insurer. (See "Matrix for Health Care Provider types" Appendix A)

(4) The attending physician must specify the worker's residual functional capacity or refer the worker for completion of a second level physical capacities exam or work capacities exam (as described in OAR 436-009-0070(4)) pursuant to the following:

(a) A physical capacities exam when the worker has not been released to return to regular work, has not returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A work capacities exam when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(5) If the insurer issues a major contributing cause denial on the accepted claim and the worker is not medically stationary, the health care provider must do a closing exam, or in the case of a type B attending physician or authorized nurse practitioner, refer the worker to a type A attending physician for a closing exam. (See "Matrix for Health Care Provider types" Appendix A)

(6) The closing report must address the accepted conditions and must include:

(a) Objective findings of permanent impairment; and

(b) A statement of the validity of the impairment findings.

(7) The director may prescribe by bulletin what comprises a complete closing report, including, but not limited to, those specific clinical findings related to the specific body part or system affected. The bulletin may also include the impairment reporting format or form to be used as a supplement to the narrative report.

Stat. Auth.: ORS 656.726(4) & 656.245(2)(b)(B)

Stats. Implemented: ORS 656.245 & 656.252

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0601, 5-1-85; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0080; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-010-0290
Medical Care After Medically Stationary

(1) Palliative care means medical services rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when it is prescribed by the attending physician and is necessary to enable the worker to continue current employment or a vocational training program. When the worker's attending physician believes that palliative care is appropriate to enable the worker to continue current employment or a current vocational training program, the attending physician must first submit a written request for approval to the insurer.

(a) The request must:

(A) Describe any objective findings;

(B) Identify by ICD-9-CM diagnosis, the medical condition for which palliative care is requested;

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

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

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

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

(A) Palliative care may begin following submission of the request to the insurer. If approved, services are payable from the date the approved medical service begins. If the requested care is ultimately disapproved, the insurer is not liable for payment of the medical service.

(B) If the insurer disapproves the requested care, the insurer must explain, in writing:

(i) Any disagreement with the medical condition for which the care is requested;

(ii) Why the requested care is not acceptable; and/or

(iii) Why the requested care will not enable the worker to continue current employment or a current vocational training program.

(c) If the insurer fails to respond in writing within 30 days, the attending physician or injured worker may request approval from the

director within 120 days from the date the request was first submitted to the insurer. If the request is from a physician, it must include a copy of the original request and may include any other supporting information.

(d) When the attending physician or the injured worker disagrees with the insurer's disapproval, the attending physician or the injured worker may request administrative review by the director in accordance with OAR 436-010-0008, within 90 days from the date of insurer's notice of disapproval. In addition to information required by OAR 436-010-0008(6), if the request is from a physician, it must include:

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

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

(e) When the worker, insurer, or director believes palliative care, compensable under ORS 656.245(1)(c)(J), is excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services, the dispute will be resolved in accordance with ORS 656.327 and OAR 436-010-0008.

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

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

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

(A) Describe any objective findings.

(B) Identify by ICD-9-CM diagnosis, the medical condition for which the care is requested.

(C) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition.

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

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

(3) In addition to sections (1) and (2) of this rule, medical services after a worker's condition is medically stationary are compensable when they are:

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

(b) Prescription medications.

(c) Services necessary to administer or monitor administration of prescription medications.

(d) Prosthetic devices, braces, and supports.

(e) Services to monitor the status, replacement or repair of prosthetic devices, braces, and supports.

(f) Services provided under an accepted claim for aggravation.

(g) Services provided under Board's Own Motion.

(h) Services necessary to diagnose the worker's condition.

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

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.245

Hist.: WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 16-1990(Temp), f. & cert. ef. 8-17-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0041; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-010-0300
Process for Requesting Exclusion of Medical Treatment from Compensability

(1) If an injured worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process.

(2) The investigation will include a request for advice from the licensing boards of practitioners who might be affected and the Medical Advisory Committee.

(3) The director will issue an order and may adopt a rule declaring the treatment to be non-compensable. The decision of the director is appealable under ORS 656.704.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245

Hist.: WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0045; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-010-0330
Medical Arbiters and Panels of Physicians

(1) In consultation with the Workers' Compensation Management-Labor Advisory Committee under ORS 656.790, the director will establish and maintain a list of physicians to be used as follows:

(a) To appoint a medical arbiter or a panel of medical arbiters in accordance with ORS 656.268 and to select a physician in accordance with ORS 656.325(1)(b).

(b) To appoint an appropriate physician or a panel of physicians to review medical treatment or medical services disputes under ORS 656.245 and 656.327.

(2) Arbiters, panels of arbiters, physicians, and panels of physicians will be selected by the director.

(3) When a worker is required to attend an examination under this rule the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location and purpose of the examination. Such examinations will be at a place reasonably convenient to the worker, if possible.

(4) The arbiters, the panels of arbiters, the physicians and the panels of physicians selected under this rule must be paid by the insurer in accordance with OAR 436-009-0070(9) to (11).

(5) The insurer must pay the worker for all necessary related services in accordance with ORS 656.325(1).

Stat. Auth.: ORS 656.736(4)

Stats. Implemented: ORS 656.268, 656.325 & 656.327

Hist.: WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0047; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-010-0340
Sanctions and Civil Penalties

(1) If the director finds any medical service provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), and 656.325, and OAR 436-009 and 436-010, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Non-payment, reduction or recovery of fees in part, or whole, for medical services rendered;

(c) Referral to the appropriate licensing board; or

(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations.

(e) A penalty of $100 for each violation of ORS 656.325(1)(c)(C).

(2) The director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence on any health care practitioner who, under ORS 656.254, and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(b) Provide medical services that are excessive, inappropriate or ineffectual; or

(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(3) If the conduct as described in section (2) is found to be repeated and willful, the director may declare the medical service provider ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(4) A medical service provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

(5) If a financial penalty is imposed on the attending physician or authorized nurse practitioner for violation of these rules, no recovery of penalty fees may be sought from the worker.

(6) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are not appropriate, either may submit a complaint in writing to the director.

(7) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical service providers for services rendered until the insurer complies with the notification requirement. Any penalty will be limited to the amounts listed in section (8) of this rule.

(8) If the director finds any insurer in violation of statute, OAR 436-009 or 436-010, or an order of the director, the insurer may be subject to penalties under ORS 656.745 of not more than $2000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separate violation.

(9) The director may subject a worker who fails to meet the requirements in OAR 436-010-0265(10) to a $100 penalty per occurrence under ORS 656.325, to be deducted from future benefits.

Stat. Auth.: ORS 656726(4)
Stats. Implemented: ORS 656.245, 656.254 & 656.745
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0901, 5-1-85 WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90, Renumbered from 436-010-0110(3)(4) & (7); WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90;WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0130; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-990; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

DIVISION 15

MANAGED CARE ORGANIZATIONS

436-015-0001
Authority for Rules

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0002
Purpose

The purpose of these rules is to establish and provide policies, procedures, and requirements for the administration, evaluation, and enforcement of the statutes relating to the delivery of medical services by managed care organizations (MCOs) to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0003
Applicability of Rules

(1) These rules shall be applicable on or after the effective date to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794, and govern all MCOs and insurers contracting with an MCO.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99

436-015-0005
Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.

(1) "GSA" means a geographic service area.

(2) "Health Care Provider" means an entity or group of entities, organized to provide health care services or organized to provide administrative support services to those entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.

(3) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with these rules.

(4) "Primary Care Physician" means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260, OL 2007 Ch. 423
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 4-1991, f. & cert. ef. 6-14-91; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 4-2006(Temp), f. 5-11-06, cert. ef. 6-1-06 thru 11-27-06; WCD 7-2006, f. 10-19-06, cert. ef. 11-28-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-015-0006
Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS Chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260,
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0008
Administrative Review

(1) Any party may request that the director provide voluntary mediation after a request for administrative review or hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, administrative review shall continue.

(2) Administrative review before the director: The process for administrative review of such matters shall be as follows:

(a) Any party that disagrees with an action taken by an MCO pursuant to these rules must first use the dispute resolution process of the MCO. If the party does not appeal the MCO's decision, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision.

(b) The aggrieved party shall file a written request for administrative review with the administrator of the Workers' Compensation Division within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process. If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party may request administrative review within 60 days of the failure of the MCO to issue a decision. The request must specify the grounds upon which the action is contested.

(c) The director shall create a documentary record sufficient for judicial review. The director may require and allow the parties to submit such input and information appropriate to complete the review.

(d) The director shall review the relevant information and issue an order. The order shall specify that it will become final and not subject to further review unless a written request for hearing is filed with the administrator within 30 days of the mailing date of the order.

(3) Hearings before an administrative law judge: Any party who disagrees with an order under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing. In the review of orders issued pursuant to ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be remanded to the MCO for further evidence taking, correction, or other necessary action if the administrative law judge or director determines the record has been improperly, incompletely, or otherwise insufficiently developed.

(4) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) The party shall file a written request for a hearing with the administrator of the Workers' Compensation Division within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(5) Hearings on the suspension or revocation of an MCO's certification:

(a) At a hearing on a notice of intent to suspend issued pursuant to OAR 436-015-0080(2), the MCO must show cause why it should be permitted to continue to provide services under these rules.

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings pursuant to OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director shall issue an order withdrawing the notice.

(B) If the MCO disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(C) OAR 436-001 applies to the hearing.

(b) A revocation issued pursuant to OAR 436-015-0080(5) shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for hearing with the administrator of the Workers' Compensation Division.

(A) If the MCO appeals, the administrator shall set a date for a hearing and shall give the MCO at least ten days notice of the time and place of the hearing. At hearing, the MCO shall show cause why it should be permitted to continue to provide services under these rules.

(B) Within thirty days after the hearing, the director shall issue an order affirming or withdrawing the revocation.

(C) If the MCO disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(c) An emergency revocation issued pursuant to OAR 436-015-0080(7) is effective immediately. The MCO must file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 183.310 - 183.550 & 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; Administrative correction 6-13-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-015-0009
Formed/Owned/Operated

(1) No MCO formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider will be certified as an MCO.

(2) For purposes of this rule, factors which may be considered in determining that an MCO is or will be formed by an insurer or other non-qualifying employer may include, but are not limited to, the following:

(a) When an insurer or other non-qualifying employer or any member of its staff directly participates in the formation, certification, or incorporation of the MCO;

(b) When an insurer or other non-qualifying employer or any member of its staff selects, nominates, assumes a position as, or acts in the role of, a director, officer, agent, or employee of the MCO; or

(c) When an insurer or other non-qualifying employer, or any member of its staff, arranges for, lends, guarantees, or otherwise provides financing for any of the organizational costs of the MCO.

(3) For the purposes of this rule, factors which must exist for the director to conclude that an MCO is or will be owned by an insurer or other non-qualifying employer may include but are not limited to the following:

(a) When any insurer or other non-qualifying employer or any member of its staff or immediate family members thereof arranges for, lends, guarantees, or otherwise provides financial support to the MCO. For purposes of this rule, financial support does not include contracted fees for services rendered by an MCO; or

(b) When any insurer or other non-qualifying employer or any member of its staff or immediate family members thereof has any ownership or similar financial interest in or right to payment from the MCO.

(4) For purposes of this rule, factors which must exist for the director to conclude that an MCO is or will be operated by an insurer or other non-qualifying employer may include, but are not limited to, the following:

(a) When any insurer or other non-qualifying employer or any member of its staff makes or exercises any control over business, operational, or policy decisions of the MCO;

(b) When any insurer or other non-qualifying employer or any member of its staff possesses or controls the ownership of voting securities of the MCO. Possession or control shall be presumed to exist if any person, directly or indirectly, holds the power to vote or holds proxies of any other person representing ten percent or more of the voting securities of the MCO;

(c) When any insurer or other non-qualifying employer or any member of its staff provides MCO services other than as allowed by section (6) of this rule;

(d) When an MCO contracts predominately with a single insurer to provide it with business. An MCO will have up to one year from the effective date of its first contract to meet the requirement of having contracts with more than one insurer;

(e) When any insurer or other non-qualifying employer, or any member of its staff, enters into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or

(f) When any insurer or other non-qualifying employer, or any member of its staff, directs or interferes with the MCO's delivery of medical and health care services.

(5) For purposes of this rule, "staff" is any individual who is a regular employee of an insurer or other non-qualified employer or who is a regular employee of any parent or subsidiary entity of an insurer or non-qualified employer.

(6) Notwithstanding the provisions of sections (2), (3), and (4) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be in accordance with protocols and standards established by the certified MCO program and approved by the director. For purposes of this rule, the insurer cannot provide or participate in provision of managed

care services related to dispute resolution, service utilization review, or physician peer review.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0010
Notice of Intent to Form

(1) Any health care provider or group of medical service providers initiating an MCO pursuant to ORS 656.260, shall submit a "Notice of Intent to Form" to the division, by certified mail, in a form prescribed by the director. The notice shall include but is not limited to:

(a) Identity of the person or persons who participate in discussions intended to result in the formation of an MCO. If the person is a member of a closely held corporation, the notice should include the identity of the shareholders.

(b) The name, address, and telephone number of a contact person.

(c) A synopsis of the information which will be shared in discussions preceding the application for MCO certification.

(2) The application for certification must be submitted within 120 days of the filing of the Notice of Intent to Form.

Stat. Auth.: ORS 656.726(34)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0020
Qualifying

(1) Any health care provider or group of medical service providers as defined in these rules must qualify as an MCO prior to submission of an application for certification. To qualify, the applicant must:

(a) Submit a proposed plan for the MCO, along with 4 copies, to the administrator of the Workers' Compensation Division in which the applicant outlines the manner in which the proposed MCO will meet the requirements of ORS 656.260 and OAR 436-015-0030;

(b) Identify in the plan the specific persons to be directors of the proposed MCO, the person to be the president of the proposed MCO, the title and name of the person to be the day-to-day administrator of the MCO, and the title and name of the person to be the administrator of the financial affairs of the proposed MCO; and

(c) Provide affidavits signed by each person identified in subsection (1)(b) above which certifies that the individual has no interest in an insurance company pursuant to OAR 436-015-0009.

(2) If the proposed plan for the MCO is approved by the director, the applicant shall be authorized to proceed to acquire the necessary services to meet the certification requirements.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 4-1991, f. & cert. ef. 6-14-91; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0030
Applying for Certification

(1) A health care provider or group of medical service providers applying for certification as an MCO must submit to the director, within 120 days of the filing of the Notice of Intent to Form, the following:

(a) Four copies of an application which includes specific information indicating the manner in which the MCO will be able to meet the provisions of these rules;

(b) The MCO certification of incorporation and a copy of the MCO by-laws;

(c) A non-refundable fee of $1,500 which will be deposited in the Department of Consumer and Business Services Fund; and

(d) The approved MCO plan.

(2) The MCO shall provide a description of the initial GSA. The GSA shall be designated by a listing of the postal zip codes in the service area.

(3) The MCO plan shall provide a description of the times, places, and manner of providing services under the plan adequate to ensure that workers governed by the MCO shall be able to:

(a) Access an MCO provider panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;

(b) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner within 24 hours of the MCO's knowledge of the need or a request for treatment;

(c) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner in the MCO within 5 working days, subsequent to treatment by a physician outside the MCO;

(d) Receive treatment by an MCO physician in cases requiring emergency in-patient hospitalization;

(e) Receive information on a 24-hour basis regarding medical services available within the MCO which shall include the worker's right to receive emergency or urgent care, and the hours of regular MCO operation if assistance is needed to select an attending physician or answer other questions;

(f) Seek treatment from any category of medical service provider as defined in subsection (6)(a) of this rule and have a choice of at least 3 medical service providers within each category. The worker shall also have at least 3 choices, as needed, of ancillary service providers including, but not limited to, physical therapists and psychologists. Treatment by all medical service providers including attending physicians will be governed by the MCO treatment standards and protocols;

(g) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;

(h) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographical service area. Such workers may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category and if they agree to the terms and conditions of the MCO;

(i) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker; and

(j) Receive specialized medical services the MCO is not otherwise able to provide. The application must include a description of the times, places, and manner of providing such specialized medical services.

(4) The MCO plan must provide a procedure which allows for workers to receive compensable medical treatment from a primary care physician or authorized nurse practitioner who is not a member of the MCO. The procedure must identify the criteria the MCO will use for approval or disapproval of such treatment, and provide written notice of the MCO physician qualification procedures to the worker.

(5) The MCO shall provide:

(a) Copies of contract agreement(s) or other documents signed by the MCO and each participating medical service provider/health care provider representative which verify membership; and

(b) A list of the names, addresses, and specialties of the individuals who will provide services under the managed care plan together with appropriate evidence of any licensing, registration or certification requirements for that individual to practice. This list shall indicate which medical service providers will act as attending physicians in each GSA within the MCO.

(6) The MCO plan shall provide:

(a) An adequate number of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractor, dentist, naturopath, optometrist, osteopath, physician, and podiatrist, as listed in ORS 676.110. The requirements of this section must be met unless the MCO shows evidence that the minimum number is not available within a GSA.

(b) A process that allows workers to select a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010. If the MCO has fewer than three authorized nurse practitioners from which workers can choose within a GSA, the MCO must allow workers to seek treatment outside the MCO from authorized nurse practitioners, consistent with the MCO's treatment and utilization standards. Treatment must also be consistent with ORS 656.245(2)(b)(C), which limits the authorization of treat-

ment of the worker by a nurse practitioner to 90 days and authorization of payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the initial claim. Such authorized nurse practitioners are not themselves bound by the MCO's treatment and utilization standards; however, workers are subject to those standards.

(c) A program which specifies the criteria for selection and deselection of physicians and the process for peer review. The processes for terminating a physician and peer review shall provide for adequate notice and hearing rights for any physician.

(7) The MCO plan must provide adequate methods for monitoring and reviewing contract matters between its providers and the MCO to ensure appropriate treatment or to prevent inappropriate or excessive treatment including but not limited to:

(a) A program of peer review and utilization review to prevent inappropriate or excessive treatment including, but not limited to, the following:

(A) A pre-admission review program of elective admissions to the hospital and of elective surgeries.

(B) Individual case management programs, which identify ways to provide appropriate care for less money for cases which are likely to prove very costly, such as physical rehabilitation or psychiatric care.

(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, time loss of claimant, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile shall not be released to anyone outside the MCO without the physician's specific written consent except that the physician's profile shall be released to the director without the necessity of obtaining such consent.

(D) Concurrent review programs, which periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary.

(E) Retrospective review programs, which examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate.

(F) Second surgical opinion programs which allow workers to obtain the opinion of a second physician when elective surgery is recommended. Second surgical opinions must be required prior to repeat surgeries.

(b) A quality assurance program which includes, but is not limited to:

(A) A system for resolution and monitoring of problems and complaints which includes, but is not limited to, the problems and complaints of workers and medical service providers;

(B) Physician peer review which shall be conducted by a group designated by the MCO or the director and which must include, but is not limited to, members of the same healing art in which the physician practices;

(C) A standardized claimant medical record keeping system designed to facilitate entry of information into computerized databases for purposes of quality assurance.

(c) A program for monitoring and reviewing other contract matters that meets the requirements of ORS 656.260(4) and which are not covered under peer review, service utilization review, dispute resolution, and quality assurance.

(8) The MCO plan must include a procedure for internal dispute resolution to resolve complaints by enrolled injured workers, medical providers, and insurers in accordance with OAR 436-015-0110. The internal dispute resolution procedure shall include a provision allowing the waiver of the time period to appeal a decision to the MCO upon a showing of good cause.

(9) The MCO plan must include a summary of the process used by the MCO to develop and review treatment standards, protocols, and guidelines. This summary must include, but is not limited to:

(a) A description of the medical expertise or specialties of the clinicians involved;

(b) A description regarding what the protocols and guidelines are based on;

(c) The criteria used by the MCO in selecting the conditions for which the MCO implements treatment protocols and guidelines;

(d) A description of the criteria used by the MCO to determine when it needs to review or revise its treatment standards, protocols, and guidelines;

(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes;

(f) Sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning; and

(g) A description of how the MCO will ensure the worker continues to receive appropriate care in a timely, effective and convenient manner throughout the dispute resolution process.

(10) The MCO plan shall provide other programs that meet the requirements of ORS 656.260(4) including:

(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled injured workers; and

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program shall include:

(A) Identification of how the MCO will promote such services.

(B) A method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer.

(C) A method by which an MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001.

(D) A provision that all notifications to the insurer from the MCO shall be considered as a request to the insurer for services as detailed in OAR 437-001.

(E) A provision that the MCO shall maintain complete files of all notifications for a period of 3 years following the date that notification was given by the MCO.

(11) The MCO shall establish one place of business in this state where the organization administers the plan, keeps membership records and other records as required by OAR 436-015-0050.

(12) The MCO plan must include a procedure for timely and accurate reporting to the director necessary information regarding medical and health care service costs and utilization in accordance with OAR 436-015-0040 and OAR 436-009.

(13) The MCO shall designate an in-state communication liaison for the department and the insurers at the MCO's established in-state location. The responsibilities of the liaison shall include, but not be limited to:

(a) Coordinating and channeling all outgoing correspondence and medical bills;

(b) Unless otherwise provided by the MCO contract, providing centralized receipt and distribution of all reimbursements back to the MCO members and primary care physicians; and

(c) Serving as a member on the quality assurance committee.

(14) The MCO must provide satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.

(15) The MCO plan shall describe the reimbursement procedures for all services provided in accordance with the MCO plan. The members must comply with the following billing and report processing procedures:

(a) Submit all bills in accordance with the MCO contract with the insurer.

(b) Submit all reports and related correspondence to the insurer's authorized claims processing location with copies to the MCO in-state communication liaison or as otherwise provided by the contract.

(16) The MCO plan shall provide a procedure within the MCO plan to provide financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(17) The MCO plan must describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers within the plan and how workers can access those providers.

(18) Within 45 days of receipt of all information required for certification, the director shall notify the applicant of the effective date of the certification and the initial geographical service area of the MCO. If the certification is denied, the applicant will be provided with the reason therefore.

(19) The application for certification for an MCO shall not be approved if the MCO fails to meet the requirements of these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260, OL 2007 Ch. 423
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 4-2006(Temp), f. 5-11-06 thru 11-27-06, cert. ef. 6-1-06; WCD 7-2006, f. 10-19-06, cert. ef. 11-28-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-015-0035
Coverage Responsibility of an MCO

(1) An MCO shall provide comprehensive medical services in accordance with its certification to all enrolled injured workers covered by the insurer/MCO contract.

(2) The director shall designate an MCO's initial GSA and approve any expansions to the MCO's service area. Injured workers shall not be governed by an MCO until the director has approved the geographical service area. GSAs shall be established by postal zip code. The MCO may only provide contract services to those GSAs approved by the director.

(3) Any expansion of an MCO's GSA must be approved by the director. The request for expansion must identify the postal zip code areas of the proposed expansion and include evidence that the MCO has an adequate provider panel in the new areas which meet the minimum requirements as set forth in OAR 436-015-0030. An MCO may be authorized by the director to expand the GSA without the minimum categories of medical service providers when the MCO establishes that there are not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards. Such providers, unlike primary care physicians, cannot be required to comply with the terms and conditions regarding services performed by the MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards.

(4) An MCO may contract only with an insurer as defined in OAR 436-010-0005. When an MCO contracts with an insurer to provide services, the contract shall specify those employers governed by the contract. The MCO/insurer contract must include the following terms and conditions:

(a) The contract must specify who is governed by the contract;

(b) The insured's place of employment must be within the authorized geographical service area;

(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location shall be governed by the same MCO(s). When insurers contract with multiple MCOs each worker shall have initial choice at time of injury to select which MCO will manage their care except when the employer provides a coordinated health care insurance program as defined in OAR 436-010-0005.

(d) Workers enrolled in an MCO shall receive medical services in the manner prescribed by the terms and conditions of the contract; and

(e) To ensure continuity of care, the contract shall specify the manner in which injured workers will receive medical services on open claims including but not be limited to the following:

(A) Upon enrollment, allowing the worker to continue to treat with a non-qualified medical service provider for at least seven days after the mailing date of the notice of enrollment; and

(B) Upon termination or expiration of the MCO/insurer contract, allows the workers to continue treatment in accordance with ORS 656.245(4)(a).

(5) Notwithstanding the requirements of this rule, failure of the MCO to provide such medical services does not relieve the insurers of their responsibility to ensure benefits are provided injured workers under ORS Chapter 656.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245 & 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 7-1992(Temp), f. & cert. ef. 4-15-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; Administrative correction 6-13-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0040
Reporting Requirements for an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO shall provide the director with a copy of the entire text of any MCO/insurer contract agreement, signed by the insurer and the MCO, within 30 days of execution of such contracts. Amendments, addendums, and cancellations, together with the entire text of the underlying contracts, shall be submitted to the director within 30 days of execution.

(2) Notwithstanding section (1), when an MCO/insurer contract agreement contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination, or workers will no longer be subject to the contract after it expires or terminates without renewal pursuant to ORS 656.245(4)(a).

(3) Any amendment to the approved MCO plan must be submitted to the director for approval. The MCO shall not take any action based on the amendment until the amended plan is approved.

(4) Within 45 days of the end of each calendar quarter, each MCO shall provide the following information, current on the last day of the quarter, in a form and format as prescribed by the director: specify quarter being reported, MCO certification number, membership listings by category of medical service provider (in coded form), including provider names, specialty (in coded form), Tax ID number, Oregon license number, business address and phone number. (All fields are required unless specifically excepted by bulletin.) When a medical provider has multiple offices, only one office location in each geographical service area needs to be reported. In addition, the updated membership listing shall include the names and addresses of all health care providers participating in the MCO.

(5) By April 30 of each year, each MCO shall provide the director with the following information for the previous calendar year:

(a) A summary of any sanctions or punitive actions taken by the MCO against its members;

(b) A summary of actions taken by the MCO's peer review committee; and

(c) An affidavit that the approved MCO plan is consistent with the MCO's business practices, and that any amendments to the plan have been approved by the director.

(6) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.

(7) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260, OL 2007 Ch. 423
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 13-1992, f. & cert. ef. 9-21-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 4-2006(Temp), f. 5-11-06, cert. ef. 6-1-06 thru 11-27-06; WCD 7-2006, f. 10-19-06, cert. ef. 11-28-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-015-0050
Notice of Place of Business in State; Records MCO Must Keep in Oregon

(1) Every MCO shall give the division notice of one in-state location and mailing address where the MCO keeps records of the following:

(a) Updated membership listings of all MCO members;

(b) Records of any sanctions or punitive actions taken by the MCO against its members;

(c) Records of actions taken by the MCO's peer review committee;

(d) Records of utilization reviews performed in accordance with the requirements of utilization and treatment standards pursuant to ORS 656.260 showing cases reviewed, the issues involved, and the action taken;

(e) A profile analysis of each provider in the MCO listed by the International Classifications of Disease-9-Clinical Manifestations (ICD-9-CM) diagnosis;

(f) A record of those enrolled injured workers receiving treatment by non-panel primary care physicians or authorized nurse practitioners authorized to treat pursuant to OAR 436-015-0070; and

(g) All other records as necessary to ensure compliance with the certification requirements in accordance with OAR 436-015-0030.

(2) Records retained as required by section (1) of this rule must be maintained at the authorized in-state location for 3 full calendar years.

(3) If the MCO/insurer contract is canceled for any reason, all MCO records, as identified in section (1), relating to treatment provided to workers within the MCO must be forwarded to the insurer upon request. The records included in subsections (1)(b), (c), (d), and (e) of this rule are confidential in accordance with ORS 656.260(6) through (10).

(4) Individual MCO providers must maintain claimant medical records as provided by OAR 436-010-0240.

(5) Nothing in this section is intended to otherwise limit the number of locations the MCO may maintain to carry out the provisions of these rules.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.260

Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04

436-015-0060
Commencement/Termination of Members

(1) Prospective new members of an MCO shall submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership pursuant to the membership requirements of the MCO. The MCO shall verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee shall be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by primary care physicians or authorized nurse practitioners who provide services under OAR 436-015-0070.

(2) Individual members may elect to terminate their participation in the MCO or be subject to cancellation by the MCO pursuant to the membership requirements of the MCO plan. Upon termination of a member, the MCO shall:

(a) Make alternate arrangements to provide continuing medical services for any affected injured workers under the plan.

(b) Replace any terminated member when necessary to maintain an adequate number of each category of medical service provider.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.260

Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04

436-015-0070
Primary Care Physicians and Authorized Nurse Practitioners Who Are Not MCO Members

(1) The MCO shall authorize a nurse practitioner or physician who is not a member of the MCO to provide medical services to an enrolled worker if:

(a) The nurse practitioner qualifies as an authorized nurse practitioner under ORS 656.245 and OAR 436-010-0005 or the physician qualifies as a primary care physician under ORS 656.260(4)(g);

(b) The nurse practitioner or physician agrees to comply with all terms and conditions regarding services governed by the MCO. For purposes of this section, the phrase "all terms and conditions regarding services governed by the MCO" means MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services in accordance with OAR 436-015-0090. However, the MCO's terms and conditions may not place limits on the length of services unless such limits are stated in ORS Chapter 656; and

(c) The nurse practitioner or physician agrees to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require.

(2) The MCO cannot deny authorization of a primary care physician or authorized nurse practitioner based on past practices.

(3) The primary care physician or authorized nurse practitioner who is not a member of the MCO will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if an injured worker has selected a primary care physician or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.

(4) Notwithstanding section (1), for those workers receiving their medical services from a facility which maintains a single medical record on the worker, but provides treatment by multiple primary care physicians or authorized nurse practitioners who are not MCO members, the requirements of sections (1) and (3) will be deemed to be met. In this situation, the worker shall select one physician or authorized nurse practitioner to treat the compensable injury as the primary care physician or authorized nurse practitioner.

(5) Any questions or disputes relating to the worker's selection of a primary care physician or authorized nurse practitioner who is not an MCO member shall be resolved pursuant to OAR 436-015-0110.

(6) Any disputes relating to a worker's non-MCO primary care physician's, non-MCO authorized nurse practitioner's, or other non-MCO physician's compliance with MCO standards and protocols shall be resolved pursuant to OAR 436-015-0110.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.260

Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-015-0080
Suspension; Revocation

(1) Pursuant to ORS 656.260, the certification of a managed care organization issued by the director may be suspended or revoked if:

(a) The director finds a serious danger to the public health or safety;

(b) The MCO is providing services not in accordance with the terms of the certified MCO plan;

(c) There is a change in legal entity of the MCO which does not conform to the requirements of these rules;

(d) The MCO fails to comply with ORS Chapter 656, OAR 436-009, 436-010, 436-015, or orders of the director.

(e) The MCO or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or 656.745;

(f) Any false or misleading information is submitted by the MCO or any member of the organization;

(g) The MCO continues to utilize the services of a health care practitioner whose license has been suspended or revoked by the licensing board; or

(h) The director determines that the MCO was or is formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider as defined in these rules.

(2) The director shall provide the MCO written notice of an intent to suspend the MCO's certification.

(a) The notice shall:

(A) Describe generally the acts of the MCO and the circumstances that would be grounds for suspension;

(B) Advise the MCO of their right to participate in a show cause hearing and the date, time, and place of the hearing.

(b) The notice shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served at least 30 days prior to the scheduled date of the hearing.

(3) The show cause hearing on the suspension shall be conducted as provided in OAR 436-015-0008(5).

(4) An order of suspension shall suspend the MCO's authority to enter into new contracts with insurers for a specified period of time up to a maximum of one year. During the suspension, the MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension.

(a) A suspension may be set aside prior to the end of the suspension period if the director is satisfied of the MCO's current compliance, ability, and commitment to comply with ORS Chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan.

(b) Prior to the end of the suspension period the division shall determine if the MCO is in compliance with ORS Chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan. If the MCO is in compliance the suspension will terminate on its designated date. If the MCO is not in compliance the suspension may be extended beyond one year without further hearing or revocation proceedings may be initiated.

(5) The process for revocation of a MCO shall be as follows:

(a) The director shall provide the MCO with notice of an order of revocation. The order shall:

(A) Describe generally the acts of the MCO and the circumstances that are grounds for revocation; and

(B) Advise the MCO that the revocation shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for the revocation to the satisfaction of the director or files an appeal as provided in OAR 436-015-0008(5).

(b) The order shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served.

(c) A show cause hearing on the revocation shall be conducted as provided in OAR 436-015-0008(5).

(d) If revocation is affirmed, the revocation is effective ten days after service of the order upon the MCO unless the MCO appeals.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for 3 years or longer, it may petition the director to restore its authority by making application as provided in these rules.

(7) Notwithstanding section (5) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show-cause hearing. Such order shall be final, unless the MCO requests a hearing. The process for review shall be as provided in OAR 436-015-0008(5).

(8) Insurer contractual obligations to allow a managed care organization to provide medical services for injured workers are null and void upon revocation of the MCO certification by the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 4-1991, f. & cert. ef. 6-14-91; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-015-0090
Charges and Fees

(1) Billings for medical services under an MCO shall be submitted in the form and format as prescribed in OAR 436-009. The payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to OAR 436-009.

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by primary care physicians who qualify under ORS 656.260(4)(g) or authorized nurse practitioners who qualify under ORS 656.245(6) shall not be less than fees paid to MCO providers for similar medical services. Fees paid to medical providers who are not under contract with the MCO, shall be subject to the provisions of OAR 436-009.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245 & 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 6-2004, f. 6-14-04, cert. ef. 6-29-04

436-015-0095
Insurer's Rights and Duties

Insurers shall also comply with OAR 436-010 and 436-009 when carrying out their duties under these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02

436-015-0100
Monitoring/Auditing

(1) The division shall monitor and conduct periodic audits of an MCO as necessary to ensure the compliance with the MCO certification and performance requirements.

(2) All records of an MCO and their individual members shall be disclosed upon request of the director. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99

436-015-0110
Dispute Resolution/Complaints of Rule Violation

(1) Disputes which arise between any party and an MCO shall first be processed through the dispute resolution process of the MCO.

(2) The MCO shall promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary shall include at least the following:

(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;

(b) The types of issues the MCO will consider in its dispute resolution process;

(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and

(d) Advise that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) Notification must be provided to the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute pursuant to this rule; or

(b) Issues any decision pursuant to this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO shall send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.

(5) If an MCO receives a complaint or dispute which is not included in the MCO dispute resolution process, the MCO shall, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director pursuant to OAR 436-015-0008. The notice shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter which we handle. To pursue this issue, you must request administrative review of the issue by the director of the Department of Consumer and Business Services (DCBS). Send written requests for review to: DCBS, Workers' Compensation Division, Medical Review Unit, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days of your receipt of this notice, you will lose all rights to appeal the decision. For assistance, injured workers may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant. All others, or those who are calling from outside Oregon, should call 1-503-947-7585 (TTY 503-947-7993).

(6) The time frame for resolution of the dispute by the MCO shall not exceed 60 days from the date of receipt of the dispute by the MCO until issuance of the final decision by the MCO. After the MCO resolves a dispute pursuant to ORS 656.260(14), the MCO shall notify all parties to the dispute in writing, including the worker's attorney where written notification has been provided by the attorney with an explanation of the reasons for the decision. This notice shall inform the parties of the next step in the process, including the right of an aggrieved party to seek administrative review by the director pursuant to OAR 436-015-0008. The notice shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days of your receipt of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Review Unit, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. If you have questions, call a Workers' Compensation Division Benefit Consultant at (503) 947-7585 (TTY 503-947-7993) or (toll-free in Oregon) 1-800-452-0288.

(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO shall notify the parties of the next step in the process, including the right of an aggrieved party to seek administrative review by the director pursuant to OAR 436-015-0008 including the appeal rights provided in (6) above.

(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further the dispute resolution process. Any of the parties also may request in writing that the director assist in resolution if the dispute cannot be resolved by the MCO.

(9) Complaints pertaining to violations of these rules shall be directed in writing to the Compliance Section of the division. The division may return the complaint to the originating party for completion if the complaint does not satisfy the requirements of this rule. The complaints must:

(a) State the grounds for alleging rule violation;

(b) Include the specific contention of error;

(c) State the complainant's request for correction and relief; and

(d) Include sufficient documentation to support the complaint.

(10) The division may investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330.

(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-015-0120
Sanctions and Civil Penalties

(1) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against any MCO:

(a) Reprimand by the director;

(b) Civil penalty as provided under ORS 656.745(2) and (3). All penalties collected under this section shall be paid into the Department of Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker, insurer, or medical provider;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violation.

(c) Suspension or revocation of the MCO's certification pursuant to OAR 436-015-0080.

(2) If the director determines that an insurer has entered into a contract with an MCO which violates OAR 436-015 or the MCO's certified plan, the insurer shall be subject to civil penalties as provided in ORS 656.745.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260, OL 2007 Ch. 423
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 4-1991, f. & cert. ef. 6-14-91; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

DIVISION 30

CLAIM CLOSURE AND RECONSIDERATION

436-030-0001
Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4) and 656.268.

Stat. Auth.: ORS 656.268, 656.726, 1995 OL Ch. 332 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCB 5-1975, f. 2-6-75, ef. 2-25-75; WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0000, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01

436-030-0002
Purpose of Rules

The purpose of these rules is to provide standards, conditions, procedures, and reporting requirements for:

(1) Requests for closure by the worker;

(2) Claim closure under ORS 656.268(1);

(3) Determining medically stationary status;

(4) Determining temporary disability benefits;

(5) Awards of permanent partial disability;

(6) Review and determination of the disabling or nondisabling status of a claim;

(7) Determining permanent total disability awards;

(8) Review for reduction of permanent total disability awards;

(9) Review of prior permanent partial disability awards consistent with OAR 436-030-0003; and

(10) Reconsideration of notices of closure.

Stat. Auth.: ORS 656.268, 656.726, 1995 OL Ch. 332 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.262 & 1999 OL 313
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0002, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

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 requests for reconsideration received by the department on or after the effective date of these rules.

(2) All orders issued by the division to carry out the statute and these rules are considered an order of the director.

(3) These rules take the place of the rules adopted on January 1, 2005, by Workers' Compensation Division Administrative Order 04-062, and carry out ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.277, 656.278, and 656.325.

(a) For claims in which the worker became medically stationary prior to 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.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.262, 656.268, 656.277, 656.325, 656.726, OL Ch. 332 1995 & Ch. 313 1999, 1999 OL 313, 349, 350, 377, 865, OL 2001
Hist.: WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0003, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1991(Temp), f. 8-20-91, cert. ef. 9-1-91; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 12-2000(Temp), f. 12-22-00, cert. ef. 1-1-01 thru 6-29-01; Administrative correction 11-20-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 1-2002(Temp), f. & cert. ef.

1-15-02 thru 7-13-02; WCD 4-2002, f. 4-5-02, cert ef. 4-8-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0005
Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrator" means the administrator of the Workers' Compensation Division, Department of Consumer and Business Services, or the administrator's delegate for the matter.

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

(3) "Day(s)" means calendar day(s) unless otherwise specified (e.g., "working day(s)").

(4) "Director" means the director of the Department of Consumer and Business Services, or the director's delegate for the matter.

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

(6) "Instant Fatality" means a compensable claim for death benefits where the worker dies within 24 hours of the injury.

(7) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer, or a self-insured employer group.

(8) "Mailed or Mailing Date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by electronic transmission (by facsimile or "fax") will be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(9) "Notice of Closure" means a notice to the worker issued by the insurer to

(a) Close an accepted disabling claim, including fatal claims;

(b) Correct, rescind, or rescind and reissue a Notice of Closure previously issued; or

(c) Reduce permanent total disability to permanent partial disability.

(10) "Notice of Refusal to Reclassify" means the insurer's written response, to a worker's request, which notifies the worker of the insurer's decision regarding the nondisabling status of a claim.

(11) "Reconsideration" means review by the director of an insurer's Notice of Closure.

(12) "Statutory closure date" means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).

(13) "Statutory appeal period" means the time frame for appealing a Notice of Closure or Order on Reconsideration.

(14) "Work disability", for purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

(15) "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.005, 656.268, 656.726 & OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), 12-30-81, ef. 1-1-82; Renumbered from 436-065-0004, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0007
Administrative Review

(1) The following matters are subject to dispute resolution before the director:

(a) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through 436-030-0185, except Notices of Closure under section (2)(b) of this rule.

(b) The director may abate, withdraw, or amend the Order on Reconsideration during the 30-day appeal period for the Order on Reconsideration.

(c) Notices of Refusal to Reclassify issued by insurers are appealable by the worker to the director under ORS 656.273 and 656.277 and OAR 436-060-0018.

(2) The following matters are brought before the Hearings Division of the Workers' Compensation Board:

(a) Director's Review orders and Orders on Reconsideration issued under OAR 436-060-0018 and these rules within the timeframes in OAR 436-060-0018 and 436-030-0145, respectively.

(b) Notices of Closure that rescind permanent total disability under ORS 656.206.

(c) Any other action taken under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS Chapter 656.

(3) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

(a) The party must send the request for hearing in writing to the director within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The Workers' Compensation Division will forward the request and other pertinent information to the Hearings Division.

(c) An Administrative Law Judge from the Hearings Division, acting on behalf of the director, will conduct the hearing in accordance with ORS 656.740 and Chapter 183.

(4) Director's Administrative Review of other actions: Except as covered under sections (1) through (3) of this rule, any party seeking an action or decision by the director or aggrieved by an action taken by any other party under these rules, may request administrative review by the director as follows:

(a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is disputed.

(b) The director may require and allow such evidence as is deemed appropriate to complete the review.

(c) The director may, unless otherwise obligated by statute, at the director's discretion, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999, (§9, Ch. 170, OL 2003)
Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 199, 350, OL 2001
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0009
Appeals of Notices of Closure

(1) Except as provided in section (2) of this rule, a worker or insurer must first request reconsideration of a Notice of Closure when:

(a) The worker was determined medically stationary after July 1, 1990; or

(b) The worker is not determined medically stationary, and the claim is closed under ORS 656.268(1)(b) or (c).

(2) If a worker disagrees with a Notice of Closure rescinding permanent total disability benefits under ORS 656.206, the worker must request a hearing before the Hearings Division.

(3) If a worker was determined medically stationary on or before July 1, 1990, Workers' Compensation Division Administrative Order 13-1987 rules apply.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 & 1999 OL Ch. 313, 429, OL 2003
Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 & 1999 OL Ch. 313, 429, OL 2003
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; Renumbered from 436-030-0020(3), WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0015
Insurer Responsibility

(1) When an insurer issues a Notice of Closure (Form 440-1644, 1644c, 1644r), the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the worksheet (Form 440-2807) upon which the Notice is based, a completed "Insurer Notice of Closure Summary" (Form 440-1503) and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and

(c) Issuing the Updated Notice of Acceptance at Closure on the same date as the Notice of Closure.

(d) The Updated Notice of Acceptance at Closure must contain the following title, information, and language:

(A) Title: "Updated Notice of Acceptance at Closure";

(B) Information: A list of all compensable conditions that have been accepted, even if a condition was denied, ordered accepted by litigation, and is under appeal. Any conditions under appeal and those which were the basis for this claim opening must be specifically identified;

(C) Language, in bold print:

"Notice to Worker: This notice restates and includes all prior acceptances. The conditions that were the basis of this claim opening are the only conditions considered at the time of claim closure. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal, unless and until the condition is found to be compensable after all litigation is complete. Appeal of any denied conditions or objections to this notice will not delay claim closure. Any condition found compensable after the Notice of Closure is issued will require the insurer to reopen the claim for processing of that condition. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(e) In the case of an instant fatality, the Updated Notice of Acceptance may be combined with the Notice of Closure if the following is included:

(A) Title: "Updated Notice of Acceptance and Closure";

(B) Information: Names of all known beneficiaries, the beneficiaries' right to and the extent of fatal benefits due under ORS 656.204, and the medically stationary date.

(C) Language, in bold print:

"Notice to Worker's Beneficiary or Estate: This notice restates any prior acceptances. The insurer is required to determine the appropriate benefits to be paid to any beneficiaries and begin those payments within 30 days of the mailing date of this notice. If you disagree with the notice of acceptance, you may appeal the decision to the Workers' Compensation Board, (insert current address for Workers' Compensation Board) within 30 days of the mailing date. If you disagree with the claim closure, you may appeal the decision to the Workers' Compensation Division, Appellate Review Unit, (insert current address for Workers' Compensation Division) within 60 days of the mailing date of this notice. If you have questions about this notice, you may contact the Ombudsman for Injured Workers, the Workers' Compensation Division, or consult with an attorney."

(f) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(g) In the event an omission or error requires a corrected Updated Notice of Acceptance at Closure, the word "CORRECTED" must appear in capital letters adjacent to the word "Updated".

(h) In the event that the "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.

(2) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(3) In claims with a date of injury on or after January 1, 2005 where the worker has not returned to regular work and ORS 656.726(4)(f) does not apply, or in claims with a date of injury on or after January 1, 2006 when the worker has not been released to regular work and ORS 656.726(4)(f) does not apply, the insurer must consider:

(a) The worker's age at the time the notice is issued;

(b) Adaptability to return to employment;

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the notice of closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements. If the insurer cannot obtain five years of work history despite all reasonable efforts, the insurer must document its efforts and provide as much work history as it can obtain.

(4) In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, ORS 656.726(4)(f) does not apply, and the claim involves injury to, or disease of, unscheduled body parts, areas, or systems, the insurer must consider:

(a) The worker's age at time the notice is issued;

(b) Adaptability to return to employment:

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the notice of closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements.

(5) The insurer must consider any other records or information pertinent to claim determination prior to issuing a notice of closure.

(6) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of his or her impending claim closure and that any time loss disability payments will end soon.

(7) The insurer must, within 14 days of closing the claim, provide the worker's attorney the same documents relied upon for claim closure.

(8) The insurer must not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

(9) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.

(10) Denials issued under ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

(11) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.331, 656.726, 656.745, OL Ch. 332 1995, Ch. 313 1999 & OL 2001 Ch. 377
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95, Renumbered from 436-030-0020 & 436-030-0040; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0017
Requests for Claim Closure by the Worker

(1) A worker may request closure from the insurer. The insurer must issue a Notice of Closure or Notice of Refusal to Close within 10 days of receipt of a written request.

(2) If an insurer issues a notice of refusal to close the claim, the notice must be identified in capital letters as a "NOTICE OF REFUSAL TO CLOSE" and must include the following information and appeal language:

(a) Name of the worker;

(b) Date of injury;

(c) Insurer's claim number;

(d) Mailing date of the notice;

(e) The accepted and denied conditions;

(f) Rationale for the insurer's decision; and

(g) The following language, in bold print:

"If you disagree with this Notice of Refusal to Close your claim, you must file a letter of disagreement with the Workers' Compensation Board within sixty (60) days from the date of this notice. Your letter must state that you want a hearing, note your address and the date of your accident, if you know the date. You must mail your letter of disagreement to the Workers' Compensation Board, [INSURER: Insert current address of Workers' Compensation Board here]. If your claim qualifies and you request it, you may receive an expedited hearing (within 30 days). Your request cannot, by law, affect your employment. If you do not file your letter of disagreement within sixty (60) days from the date of this notice, your hearing will be denied as the appeal time has passed. You may be represented by an attorney if you so choose."

(3) If the worker disagrees with the Notice of Refusal to Close, the worker may request a hearing from the Workers' Compensation Board.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.319, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0020
Requirements for Claim Closure

(1) Provided the worker is not 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 there is sufficient information to determine the extent of permanent disability under ORS 656.245(2)(b)(B), and indicates the worker's compensable condition is medically stationary;

(b) The accepted injury/condition 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; or

(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 action(s) in accordance with these rules.

(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) For purposes of determining the extent of disability, "sufficient information" requires the following:

(a) An authorized nurse practitioner's, podiatrist's, chiropractor's, naturopathic physician's, physician assistant's or attending physician's written statement that clearly indicates there is no permanent impairment, residuals, or limitations attributable to the accepted condition(s), and there is no reasonable expectation, based on evidence in the record, of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s). If the physician, nurse practitioner, podiatrist, chiropractor, naturopathic physician, or physician assistant indicates there is no impairment, but the record reveals otherwise, a closing examination and reports specified under (b) of this section are required; or

(b) A closing medical examination and report when there is a reasonable expectation of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s) based on evidence in the record or the physician's opinion. The closing medical examination report must describe in detail all measurements and findings regarding any permanent impairment, residuals, or limitations attributable to the accepted condition(s) under OAR 436-010-0280 and 436-035; and, if there is not clear and convincing evidence that the worker has been released to regular work (for dates of injury on or after January 1, 2006) or returned to regular work at the job held at the time of injury and ORS 656.726(4)(f) does not apply, all of the following:

(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(3)(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 a summary worksheet, "Notice of Closure Worksheet", Form 440-2807 (Form 2807), as described by bulletin of the director.

(5) The "Notice of Closure", Form 440-1644 (Form 1644), is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, 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 worker's appeal rights;

(k) The right of the worker 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 is to be shown on the Notice of Closure;

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

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

(7) The Notice of Closure (Form 440-1644) 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) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

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

(11) 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.

(12) 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.

(13) If after claim closure, the worker became enrolled and actively engaged in an approved training program under OAR 436-120, a new Notice of Closure must be issued consistent with the following:

(a) In claims with dates of injury on or after January 1, 2005, the insurer must redetermine work disability when:

(A) The worker has ended training; and either

(B) The worker's condition is medically stationary; or

(C) The claim otherwise qualifies for closure in accordance with these rules.

(b) For claims with dates of injury before January 1, 2005, permanent disability must be redetermined by the insurer when:

(A) The worker has ended training; and either

(B) The worker's condition is medically stationary; or

(C) The claim otherwise qualifies for closure in accordance with these rules., except

(D) When the worker became medically stationary after June 7, 1995 for a scheduled disability. Then the scheduled disability must remain unchanged from the last award of compensation in that claim unless the condition did not remain medically stationary through training.

(c) For claims with dates of injury before January 1, 2005, if the worker has remained medically stationary throughout training and the closing examination is six months old or older, a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's accepted condition since the previous closing examination.

(14) 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 440-1502 consistent with the instructions of the director and disperse it within 14 days of the change.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995, Ch. 313 1999

Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.268 & 656.270, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999, §1, ch. 252, OL 2007

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0006, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1991, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0023

Correcting and Rescinding Notices of Closure

(1) An insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that Notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure.

(2) The form, format, and completion of the Correcting and Rescinding Notices of Closure are the same as those of the Notice of Closure except that, to correct a Notice of Closure, a **Form 440-1644c** (**Form 1644c**) must be used and, to rescind a Notice of Closure, a **Form 440-1644r** (**Form 1644r**) must be used. An insurer may rescind and reissue a Notice of Closure by using a **Form 440-1644** (**Form 1644**) when such actions can be accomplished at the same time, the claim remains closed, and other provisions of these rules are met.

(3) The "Date of closure (mailing date)" on the Correcting or Rescinding Notice of Closure must be the date the correction or rescission is mailed. The mailing date of the Notice of Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(8) and (9).

(5) Rescinding Notices of Closure, **Form 1644r**, are used to rescind the Notice of Closure and return the claim to open status. Examples of appropriate uses of Rescinding Notices of Closure include, but are not limited to:

(a) The worker was not medically stationary at the time the Notice of Closure was issued;

(b) The closure was otherwise premature;

(c) Grant PPD when the Notice of Closure being rescinded granted TTD only.

(6) The Rescinding Notice of Closure must:

(a) Advise the worker that the claim remains open and no aggravation rights end date has been established, if it is rescinding the first closure of the claim;

(b) Initiate a 60-day appeal period during which any request for reconsideration must be received by the director;

(c) Explain the reason for the action being taken; and

(d) Be distributed and mailed to the parties consistent with these rules.

(7) When a Notice of Closure granting only timeloss has been issued, if the insurer determines the worker's medically stationary status is unchanged and the worker is entitled to an award of permanent disability, the insurer must use a Notice of Closure, **Form 1644**, to rescind and reissue the closure. In such cases, the Notice of Closure must:

(a) Contain all required information consistent with these rules;

(b) Bear the heading "Rescind and Reissue;

(c) Explain the reason the action is being taken;

(d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;

(e) Establish a new 60-day appeal period;

(f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and

(g) Be distributed and mailed to the parties consistent with these rules.

(8) Correcting Notices of Closure, **Form 1644c**, are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure must not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability. Examples of appropriate uses of Correcting Notices of Closure include, but are not limited to:

(a) Permanent disability award computation errors (dollars, degrees, percentages);

(b) An incorrect "mailing date";

(c) Return-to-work status errors or omissions;

(d) Incorrect or incomplete statement of temporary disability.

(9) A Correcting Notice of Closure must:

(a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);

(b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;

(c) State in the body of the correcting notice only the information being corrected on the Notice of Closure and the basis for the correction;

(d) Not change the appeal period for the Notice of Closure being corrected; and

(e) Initiate a new 60-day appeal period during which any request for reconsideration must be received, but only for those items being corrected.

[Forms: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.268 & 656.270, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999

Hist.: WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0034
Claim Closure When the Worker Is Not Medically Stationary

(1) The insurer must close a claim if a worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner. In order to close a claim under this rule, the insurer must:

(a) After waiting the period of thirty days for the worker to treat, send the worker written notification of the following by certified mail:

(A) It is the worker's responsibility to seek medical treatment in a timely manner,

(B) Informing the worker of the consequences for failing to seek treatment in a timely manner, including but not limited to claim closure and possible loss or reduction of a disability award, if any,

(C) That the claim will be closed unless the worker establishes within 14 days that:

(i) Treatment has resumed by attending an existing appointment or scheduling a new appointment, or

(ii) The reasons for not treating were outside the worker's control.

(b) Wait the 14 day period given in the notification letter to allow the worker to provide evidence that the absence of treatment was either authorized by the physician or beyond the worker's control.

(c) Determine whether claim closure is appropriate based on the information provided by the worker or absence thereof.

(d) Rate any permanent disability apparent in the record (e.g., irreversible findings) at the time claim closure is appropriate, regardless of receiving a response from the worker.

(2) The date the claim qualifies for closure, when a worker fails to seek treatment for a period in excess of 30 days, is the latest (most chronologically recent) of the following which occurs prior to the closure:

(a) 30 days from the last treatment provided or authorized by the attending physician or authorized nurse practitioner;

(b) The date the worker failed to attend a follow-up visit that was recommended by the attending physician or authorized nurse practitioner for reasons within the worker's control;

(c) The date the worker returns to or is released to regular work if it is after the last examination date; or

(d) If the worker responds within the 14 day period established by the notification letter and the worker's response fails to establish that the worker has resumed treatment or that the reasons for not treating were outside the worker's control, the date of the worker's response.

(3) A claim must be closed when the worker is not medically stationary, and the worker fails to attend a mandatory closing examination for reasons within the worker's control, and the insurer has notified the worker, by certified letter, at least 10 days prior to the mandatory examination, that claim closure will result for failure to attend a mandatory closing examination. The notification letter must inform the worker of the worker's responsibility to attend the mandatory closing examination and of the consequences for failing to do so, including but not limited to claim closure and the possible loss or reduction of a disability award.

(a) Workers have 7 days from the date of exam to demonstrate good cause for failing to attend, before any further action is taken by the insurer toward claim closure.

(b) Where the worker fails to attend a mandatory closing examination for reasons within the worker's control, the date the claim qualifies for closure is the date of the failed mandatory closing examination.

(c) Where a closing exam has been scheduled between a worker and attending physician directly, insurers may close under (1) of this section.

(4) A claim may be closed when the worker is not medically stationary and a major contributing cause denial has been issued on an accepted combined condition.

(a) The major contributing cause denial must inform the worker that claim closure may result from the issuance of the denial and provide all other information required by these rules.

(b) When a major contributing cause denial has been issued following the acceptance of a combined condition, the date the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability under OAR 436-035-0007(5) and 436-030-0020(2) or the date of the denial, whichever is later.

(5) When any two of the above occur concurrently, the earliest date the claim qualifies for closure is used to close the claim and noted on the notice.

(6) The attending physician or authorized nurse practitioner must be copied on all notification and denial letters applicable to this rule.

(7) When the director has issued a suspension order, under OAR 436-060-0095 or 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.

(8) When a worker fails to seek treatment with an authorized attending physician as defined by ORS 656.005 or authorized nurse practitioner as defined in ORS 656.245, the claim must be closed under section (1) of this rule. Section (2) of this rule must be used to determine the effective date of the closure. All notification letters issued under this section of the rule must clearly identify that the reason for the impending closure is because of the worker's failure to treat with an authorized attending physician or nurse practitioner.

Stat. Auth.: ORS 656.262, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Hist.: WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0035
Determining Medically Stationary Status

(1) A worker's compensable condition is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether or not a worker's compensable condition 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's compensable condition 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 condition.

(4) When there is a conflict as to the date upon which a worker's compensable condition 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.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0036
Determining Temporary Disability

(1) Temporary disability must be determined under ORS Chapter 656, OAR 436-060 and this rule, less time worked. Beginning and ending dates of each authorized period of temporary total disability and temporary partial disability must be noted on the Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law."

(2) Except as provided in section (3) of this rule and ORS 656.268(9), a worker is not entitled to any award for temporary disability for any period of time in which the worker is medically stationary.

(3) Awards of temporary disability must include the day the worker is medically stationary or the date the claim otherwise qualifies for closure, unless temporary disability is not authorized for another reason at that time.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.005, 656.160, 656.210, 656.212, 656.236, 656.245, 656.262, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-030-0038
Permanent Partial Disability

The standards developed under ORS 656.726(4) and contained in OAR 436-035 must be applied when evaluating a worker's permanent partial disability.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.214, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0055
Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule and OAR 436-030-0065:

(a) "Incapacitated from regularly performing work" means that the worker does not have the necessary physical and mental capacity and the work skills to perform the essential functions of the job. Employment in a sheltered workshop is not considered regular employment unless this was the worker's job at the time of injury.

(b) "Suitable occupation" means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

(c) "Gainful occupation" means those types of general occupations that provide wages that:

(A) Meet the requirements in ORS 656.206(11)(a) for workers with a date of injury prior to January 1, 2006; or

(B) Meet the requirements in ORS 656.206(11)(b) for workers with a date of injury on or after January 1, 2006.

(d) "Work skills" means those skills acquired through experience or training that are necessary to gain and adequately perform skilled, semi-skilled or unskilled occupations. Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

(e) A "reasonable geographic distance" means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 50-mile radius of the worker's place of residence at the time of:

(i) The original injury;

(ii) The worker's last gainful employment;

(iii) Insurer's determination; or

(iv) Reconsideration by the director.

(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills, and financial obligations as the worker does at the time of his rating of disability, would go to seek work.

(f) "Types of general occupations" means groups of jobs which actually exist in a normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening may exist in the future.

(g) "Normal labor market" means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity, or technology trends in the long-term labor market.

(h) "Withdrawn from the workforce" means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. The receipt of retirement benefits does not establish a worker has withdrawn from the workforce.

(2) All disability which existed before the injury must be included in determining permanent total disability.

(3) In order for a worker to be determined permanently and totally disabled, a worker must:

(a) Prove permanent and total disability;

(b) Be willing to seek regular and gainful employment;

(c) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and

(d) Not have withdrawn from the workforce during the period for which benefits are being sought.

(4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:

(a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) Inability to regularly perform work at a gainful and suitable occupation; and

(c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.

(5) Notices of Closure and Orders on Reconsideration which grant permanent total disability must notify the worker that:

(a) The claim must be reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker must make the statement on a form provided by the insurer in accordance with the requirements under section (6) of this rule.

(6) If asked to provide a statement under subsection (5)(b) of this rule, the worker is allowed 30 days to respond. Such statements are subject to the following:

(a) If the worker fails to provide the requested statement, the director may suspend the worker's permanent total disability benefits. Benefits must be resumed when the statement is provided. Benefits not paid for the period the statement was withheld must be recoverable for no more than one year from the date of suspension.

(b) If the worker provides a report which is false, incomplete, or inaccurate, the insurer must investigate. The investigation may result in suspension of permanent total disability benefits.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.268, 656.726, OL Ch. 332 1995, Ch. 313 1999
Hist.: WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0065
Review of Permanent Total Disability Awards

(1) The insurer must reexamine each permanent total disability claim at least once every two years or when requested to do so by the director to determine if the worker has materially improved, either medically or vocationally, and is capable of regularly performing work at a suitable and gainful occupation. The insurer must notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's permanent total disability status. Workers who fail to cooperate with the reexamination may have benefits suspended under OAR 436-060-0095.

(2) A worker receiving permanent total disability benefits must submit to a vocational evaluation, if requested by the director, insurer, or self-insured employer under ORS 656.206(8).

(3) Any decision by the insurer to reduce permanent total disability must be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation must include: medical reports, including sufficient information necessary to determine the extent of permanent partial disability, vocational and investigation reports (including visual records, if available) which demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence.

(4) An award of permanent total disability for scheduled injuries before July 1, 1975, must be considered for reduction only when the insurer has evidence that the medical condition has improved.

(5) Except for section (4) of this rule, an award of permanent total disability may be reduced only when the insurer has a preponderance of evidence that the worker has materially improved, either medically or vocationally, and is regularly performing work at a suitable and gainful occupation or is currently capable of doing so. Preexisting disability must be included in redetermination of the worker's permanent total disability status.

(6) When the insurer reduces a permanent total disability claim, the insurer must, based upon sufficient information to determine the extent of permanent partial disability, issue a Notice of Closure which reduces the permanent total disability and awards permanent partial disability, if any.

(7) Any party to the claim who does not agree with the Notice of Closure may, within the statutory period, appeal the order under OAR 436-030-0007(1)(a). Appeal is to the Hearings Division for workers that were:

(a) Medically stationary on or before July 1, 1990; or

(b) Receiving permanent total disability benefits and a Notice of Closure dated on or after January 1, 2006 rescinded those benefits.

(8) A worker who incurs a compensable injury while receiving permanent total disability benefits is entitled to additional benefits for the new condition, but benefits are limited to medical and impairment benefits under ORS 656.206(9).

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.214, 656.268, 656.283, 656.319, 656.325, 656.331, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0066
Review of Prior Permanent Partial Disability Awards

For claims having a date of injury prior to January 1, 2005 which involve unscheduled body parts, areas, or systems as defined by OAR 436-035-0005, and all claims with dates of injury on or after January 1, 2005, an award of permanent partial disability is subject to periodic examination and adjustment under ORS 656.268 and 656.325 and in accordance with the following conditions:

(1) Requests for review and adjustment must be made in writing to the Workers' Compensation Division.

(2) The party requesting review of permanent disability must send a copy of the request to all involved parties at the time the request is made. The worker may submit any information in rebuttal.

(3) All pertinent medical, vocational, and other applicable evidence must be submitted with the request, including sufficient information to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the director will make any necessary adjustments allowed under OAR 436-035.

(4) The basis for the request for adjustment in the permanent disability award must be asserted to be failure of the worker to make a reasonable effort to reduce the disability.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.325, 656.331, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-030-0115
Reconsideration of Notices of Closure

(1) A worker or insurer may request reconsideration of a Notice of Closure by mailing or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005 and 436-030-0145(1). The reconsideration proceeding begins as described in OAR 436-030-0145(2).

(2) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician or authorized nurse practitioner at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed because the worker's condition is not medically stationary under OAR 436-030-0165(10), medical evidence submitted may address the worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

(3) All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record under ORS 656.268(6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments, written statements, and sworn affidavits from the parties.

(4) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:

(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.

(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but must not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.

(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter and the costs for the original transcript and its copies. An original transcript

of the deposition must be sent to the department and each party must be sent a copy of the transcript.

(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.

(5) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will review those issues raised by the parties and the requirements under ORS 656.268(1). Once the reconsideration proceeding is initiated, issues must be raised and further evidence submitted within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed under ORS 656.268(6).

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313, Sec. 12 (6)(a)(A), 865, OL 2001
Stats. Implemented: ORS 656.268 & 1999 OL Ch. 313 Sec. 12 (6)(a)(A), 865, OL 2001
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 11-1995(Temp), f. & cert. ef. 8-23-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0125
Reconsideration Form and Format

A request for reconsideration may be in the form and format the director provides by bulletin. A reconsideration request should include at least the following:

(1) Worker's name;
(2) Date of injury;
(3) Date of the closure being appealed;
(4) Any specific issues regarding the Notice of Closure;
(5) The name of the worker's attorney;
(6) The name of the insurer's attorney;
(7) Any special language needs;
(8) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;
(9) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and
(10) Any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at, before, or pertaining to claim closure.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0135
Reconsideration Procedure

(1) Within 14 days from the start date of the reconsideration proceeding, the insurer must provide the director and the worker or the worker's attorney, in chronological order by document date, all documents pertaining to the claim which include, but are not limited to the complete medical record and all official action and notices on the claim.

(2) The request for reconsideration and all other information submitted to the director by any party during the reconsideration process must be copied to all interested parties. Failure to comply with this requirement may result in the information not being included as part of the record on reconsideration.

(3) The director will issue an order rescinding a Notice of Closure when the director finds, upon reconsideration:

(a) The claim was closed prematurely because the worker's accepted condition(s) was not medically stationary and the claim did not qualify for closure under ORS 656.268(1)(a); or

(b) The claim was not closed according to the requirements of these rules and ORS 656.268(1)(b) or (c).

(4) 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.

(5) When a new condition is accepted after a prior claim closure, and the newly accepted condition is subsequently closed, the director and the parties may mutually agree to consolidate requests for review of the closures into one reconsideration proceeding, provided the director has jurisdiction and neither of the closures have become final by operation of law.

(6) The reconsideration order may affirm, reduce, or increase the compensation awarded by the Notice of Closure.

(7) After the reconsideration order has been issued and before the end of the 30-day appeal period for the order on reconsideration, if a party discovers that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268(6) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0145
Reconsideration Time Frames and Postponements

(1) Statutory time frames for appealing a Notice of Closure are:

(a) For claims with a medically stationary date prior to June 7, 1995, the appeal period is 180 days from the claim closure. The time required to complete the reconsideration proceeding pursuant to this rule must not be included in the 180 days from the mailing date of the Notice of Closure to request a hearing.

(A) The 180-day time limit will be tolled upon receipt of the request for reconsideration from the mailing date of the request for reconsideration until the reconsideration request is either dismissed or an Order on Reconsideration is issued.

(B) The 180-day time limit will not be tolled when a request for reconsideration is withdrawn under OAR 436-030-0185.

(b) For claims with a medically stationary date, or date the claim statutorily qualifies for closure, on or after June 7, 1995, a request for reconsideration must be mailed within 60 days of the mailing date of the Notice of Closure. A request for hearing must be made within 30 days of the mailing date of the Order on Reconsideration.

(c) For claims closed on or after January 1, 2004, the insurer's request for reconsideration is limited to the findings used to rate impairment and must be mailed within seven days of the mailing date of the Notice of Closure.

(2) The reconsideration proceeding begins upon:

(a) The director's receipt of the worker's request for reconsideration, if the insurer has not previously requested reconsideration consistent with subsection (1)(c) of this rule; or

(b) The 61st day after the closure of the claim, if the insurer has requested reconsideration consistent with subsection (1)(c) of this rule; unless the director receives, within the appeal time frames in section (1) of this rule, a request for reconsideration or a statement by the worker instructing the director to start the reconsideration proceeding.

(3) Fourteen days after the date the reconsideration proceeding begins, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding.

(a) Evidence received or issues raised subsequent to the 14 day deadline will be considered in the reconsideration proceeding to the extent practicable.

(b) Upon review of the record the director may request, in accordance with ORS 656.268(6), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(c) Except as provided in section (5) and (6) of this rule, the director will either mail an Order on Reconsideration within 18 working days from the date the reconsideration proceeding begins or notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days in accordance with the provisions of ORS 656.268(6).

(4) Medical arbiter panel requests must be received by the department within the 14 day time frame beginning on the date the reconsideration proceeding starts.

(5) When the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits under ORS 656.268(7), the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(6) The reconsideration proceeding may be stayed for one of the following reasons:

(a) The parties consent to deferring the reconsideration proceeding, under ORS 656.268(7)(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

(b) When a Claim Disposition Agreement (CDA) is filed, the reconsideration proceeding is stayed until the CDA is either approved or set aside.

(7) If the director fails to mail an Order on Reconsideration or a Notice of Postponement under the time frames specified in ORS 656.268, the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the director had issued an Order on Reconsideration affirming the Notice of Closure. Under section (1) of this rule, the counting of the 180-day time limit for requesting a hearing under former ORS 656.268(6)(b) will resume on the date after the director should have issued an Order on Reconsideration.

(8) Notwithstanding any other provision regarding the reconsideration proceeding, the director may extend nonstatutory time frames to allow the parties sufficient time to present evidence and address their issues and concerns.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented:ORS 656.268, ch. 429, OL 2003, 656.726, §7, ch. 252, OL 2007 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0155
Reconsideration Record

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding.

(a) The record is maintained in the Workers' Compensation Division's claim file and consists of all documents and material received and date stamped by the director prior to the issuance of the Order on Reconsideration, unless the document(s) is an exact duplicate of what is in the file then the director is not required to retain the duplicate document(s).

(b) The insurer or self-insured employer must not send billing information and duplicate documents to the department, unless specifically requested by the director.

(2) Except as noted in this section, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.

(3) The director will send non-medical information, nursing notes, or physical therapy treatment notes to the arbiter if:

(a) A party requests the director to submit those specific materials;

(b) The party identifies and provides the director with specific dates of those materials requested to be submitted; and

(c) The materials otherwise meet the requirements of this rule.

(4) When any surveillance video obtained prior to closure has been submitted to physician(s) involved in the evaluation or treatment of the worker, it must be provided for arbiter review.

(a) Surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker.

(b) All written materials previously forwarded to physician(s) along with the surveillance video, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted.

(c) Surveillance video must be labeled according to the date(s) and total time of the recording(s).

(5) When reconsideration is requested, the insurer is required to provide the director and the other parties with a copy of all documents contained in the record at claim closure. For cases involving a medical service provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the medical service provider's authority to act as an attending physician. Responses of the parties to the medical arbiter report will be included in the record if received prior to completion of the reconsideration proceeding.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268(6) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0165
Medical Arbiter Examination Process

(1) The director will select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(7)(d).

(a) Any party that objects to a physician on the basis that the physician is not qualified under ORS 656.005(12)(b) must notify the director prior to the examination of the specific objection. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician. All costs related to the completion of the medical arbiter process in this rule must be paid by the insurer.

(b) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(7).

(c) Arbiters or panel members will not include any medical service providers whose examination or treatment is the subject of the review.

(2) When the director has determined a claim qualifies for medical arbiter deselection, a list of appropriate physicians will be faxed or sent by overnight mail to the parties.

(a) Each party may eliminate one physician from the list by crossing out the physician's name.

(b) The parties may agree to one physician from the list by responding in writing. The parties must also deselect one physician from the list in case the agreed upon physician is unavailable.

(c) All responses must be signed and received by the director within three business days. No further opportunity will be given for the parties to provide input regarding the arbiter deselection process once the three business day period has expired. No further attempts at deselection will be made when continuing the arbiter deselection process is not practical.

(3) The worker's failure to attend the medical arbiter examination or to cooperate with the medical arbiter will result in suspension of all disability benefits effective on the date of the examination unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The worker must call the director within 24 hours after failing to attend the examination to provide any "good cause" reason for missing the exam.

(a) Notice of the examination will be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney if the worker is represented.

(b) For the purposes of this rule, non-cooperation includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the physician reports the findings as medically invalid.

(c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause."

(4) If a worker misses the medical arbiter examination, the director will determine whether or not there was a "good cause" reason for missing the examination.

(5) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with

the arbiter, the worker's disability benefits will be suspended and the reconsideration proceeding postponed for up to an additional 60 days.

(6) The suspension will be lifted if any of the following occurred during the additional 60-day postponement period:

(a) The worker established a "good cause" reason for missing or failing to cooperate with the examination;

(b) The request for reconsideration was withdrawn by the worker; or

(c) The worker attended and cooperated with a rescheduled arbiter examination.

(7) If none of the events which end the suspension under section (6) of this rule occurred prior to the expiration of the 60-day additional postponement, the suspension of benefits will remain in effect.

(8) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(a) The parties must submit to the director any issues they wish the medical arbiter or panel of medical arbiters to address within 14 days after the date the reconsideration proceeding begins. The parties must not submit issues directly to the medical arbiter or panel of medical arbiters. The medical arbiter or panel of medical arbiters will only consider issues appropriate to the reconsideration proceeding.

(b) The report of the medical arbiter or panel of medical arbiters must address all questions raised by the director.

(c) The medical arbiter will provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer(s) within five working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0070 and must be paid by the insurer.

(9) When the worker's medical condition is not stationary on reconsideration which may result in difficulties in obtaining findings of impairment by the arbiter, the director will, where appropriate, send a letter to the parties requesting consent to defer the reconsideration proceeding.

(a) If the parties agree to the deferral, the reconsideration proceeding will be deferred until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the impairment due to the compensable condition(s) may be submitted at the time the parties notify the director that the medical arbiter exam can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (7).

(b) If deferral is not appropriate, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).

(10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be paid under OAR 436-009-0015, 436-009-0040, and 436-009-0070.

(11) When requested by the Hearings Division, the director may schedule a medical arbiter examination for a worker who has appealed a Notice of Closure rescinding permanent total disability benefits under ORS 656.206.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268 & 1999 OL Ch. 313, Ch. 349, OL 2001
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 11-1995(Temp), f. & cert. ef. 8-23-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0175
Fees and Penalties Within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155 and 436-030-0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155, and 436-030-0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. Penalties will not be assessed if an increase in compensation results from one of the following:

(a) An order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted under ORS 656.726(4)(f);

(b) New information is obtained through a medical arbiter examination, for claims with medically stationary dates or statutory closure dates on or after June 7, 1995; or

(c) Information that the insurer or self-insured employer demonstrates they could not reasonably have known at the time of claim closure.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, will be found to be at least 20 percent disabled.

For example: A worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, will be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the director. The insurer must pay the attorney 10 percent out of any additional compensation awarded. "Additional compensation" includes an increase in a permanent or temporary disability award.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268, §7, ch. 252, OL 2007
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 11-1995(Temp), f. & cert. ef. 8-23-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 2-1999(Temp), f. 1-14-99, cert. ef. 2-1-99 thru 7-30-99; WCD 8-1999, f. & cert. ef. 4-28-99; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0185
Reconsideration: Settlements and Withdrawals

(1) Contested matters arising out of a claim closure may be resolved by mutual agreement of the parties at any time after the claim has been closed under ORS 656.268 but before that claim closure has become final by operation of law. If the parties have reached such an agreement prior to the completion of the reconsideration proceeding, the parties must submit the stipulation agreement to the director for approval as part of the reconsideration proceeding. The stipulation submitted for review at the reconsideration proceeding must:

(a) Address only issues that pertain to a claim closure and cannot include any issues of compensability;

(b) List the body part(s) for which any award is made and recite all disability awarded in both degrees and percent of loss as appropriate based on date of injury when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement for claims with dates of injury prior to January 1, 2005, the stated percent of loss will control.

(2) The director will review the stipulation and issue an order approving or denying the stipulation within 18 working days from the director's receipt of the stipulation. Stipulations approved by the director can not be appealed.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the stipulation, as well as a substantial determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

(4) If the stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) Address the disapproval; or

(b) Request that the director issue an Order on Reconsideration addressing the substantive issues.

(5) When the parties desire to enter into a stipulated agreement to resolve disputed issues relating to the claim closure but are unable to reach an agreement, the parties may request the assistance of the director to mediate an agreement.

(6) When the parties desire to enter into a stipulated agreement that addresses all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the director of their resolution and request the director enter an Order on Reconsideration affirming the Notice of Closure. The request for an affirming order must be made prior to the date an Order on Reconsideration is issued and in accordance with the following procedure.

(a) A written request for an affirming reconsideration order must:

(A) Be made by certified mail;

(B) Be signed by both parties or their representatives;

(C) State that the parties waive their right to an arbiter review and that all matters subject to the mandatory reconsideration process have been resolved; and

(D) Be accompanied by a copy of the proposed stipulated agreement.

(b) After the affirming Order on Reconsideration has been issued, the parties will submit their stipulation to a referee of the Hearings Division, Workers' Compensation Board, for approval in accordance with the provisions of ORS 656.289 and the Board's rules of practice and procedure.

(c) An Order on Reconsideration issued under this rule is final and is subject to review under ORS 656.283.

(d) This provision does not apply to Claims Disposition Agreements filed under ORS 656.236.

(7) A worker requesting a reconsideration may withdraw the request for reconsideration without agreement of the other parties only if:

(a) No additional information has been submitted by the other parties;

(b) No medical arbiter exam has occurred; and

(c) The insurer has not requested reconsideration under OAR 436-030-0145.

(8) Notwithstanding (7) above, if additional information has been submitted by the other party(ies), a medical arbiter exam has occurred or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless all parties agree to the withdrawal.

(9) If the insurer has requested reconsideration, either the worker or the insurer may initiate the withdrawal request but both must agree to the withdrawal.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268(6) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 11-2007, f. 11-1-07, cert. ef. 1-2-08

436-030-0575
Audits

(1) Notices of Closure issued by insurers and supporting documentation including, but not limited to, the worksheet upon which the Notice of Closure is based, will be subject to periodic audit by the director. Supporting documentation and records must be maintained in accordance with OAR 436-050.

(2) The director reserves the right to visit the worksite to determine compliance with these rules.

(3) The insurer or self-insured employer is required to provide the director, within seven days of the director's request, any data the director identifies as necessary to determine the impact of legislative changes on permanent partial disability awards.

Stat. Auth.: ORS 656.268, 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268, 656.455, 656.726, 656.750 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-030-0580
Penalties and Sanctions

(1) Under ORS 656.745, the director or designee may assess a civil penalty against an employer or insurer who fails to comply with the statutes, rules, or orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(2) An insurer or medical service provider failing to meet the requirements set forth in these rules may be assessed a civil penalty.

(3) Under OAR 436-010-0340, the director may impose sanctions for any medical service provider where the insurer can provide sufficient documentation to substantiate lack of cooperation. The medical service provider will be sent a warning letter about the reporting requirements and possible penalties. Failure by the medical service provider to submit the requested information within the specified period may result in civil penalties.

(4) Sufficient documentation to substantiate lack of cooperation by the medical service provider includes:

(a) Copies of letters to the medical service provider;

(b) Memos to the claim file of follow-up phone calls or the lack of response;

(c) Letters from the medical service provider indicating a lack of cooperation; or

(d) Medical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

(5) In arriving at the amount of penalty, the director or designee may assess a penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations in any three-month period.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 13-1987, f. 12-17-87, ef. 1-1-88; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert.ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

DIVISION 35

DISABILITY RATING STANDARDS

436-035-0001
Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726(4).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03

436-035-0002
Purpose of Rules

These rules establish standards for rating permanent disability under the Workers' Compensation Act. These standards are written to reflect the criteria for rating outlined in ORS Chapter 656 and assign values for disabilities that are applied consistently at all levels of the Workers' Compensation award and appeal process.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.005, 656.007, 656.012, 656.210, 656.212, 656.214, 656.245, 656.262, 656.268, 656. 273, 656.726, 656.790 & 656.225
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 18-1990 (Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0003
Applicability of Rules

(1) These rules apply to the rating of permanent disability under 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. Except for provisions in 1995 Or. Law, Chapter 332, for workers medically stationary prior to June 7, 1995, but on or after July 1, 1990, Administrative Order 93-056 applies to the rating of permanent disability. Except for provisions in 1995 Or. Law, Chapter 332, for workers medically stationary prior to July 1, 1990, Administrative Order 6-1988 applies to the rating of permanent disability.

(2) Except for provisions in 1995 Or. Law, Chapter 332, for workers medically stationary after July 1, 1990 and a request for reconsideration has been made under ORS 656.268, disability rating standards in effect on the date of issuance of the Determination Order or

Notice of Closure and any relevant temporary rules adopted under ORS 656.726(4)(f)(D) apply.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 1-1989(Temp), f. & cert. ef. 1-24-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 20-1990(Temp), f. & cert. ef. 11-20-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1991(Temp), f. 9-13-91, cert. ef. 10-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 10-1992(Temp), f. & cert. ef. 6-1-92; WCD 15-1992, f. 11-20-92, cert. ef. 11-27-92; WCD 3-1993(Temp), f. & cert. ef. 6-17-93; WCD 13-1995(Temp), f. & cert. ef. 9-21-95; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 19-1996(Temp), f. & cert. ef. 8-19-1996; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0005
Definitions

As used in OAR 436-035-0001 through 436-035-0500, unless the context requires otherwise:

(1) "Activities of Daily Living (ADL)" include, but are not limited to, the following personal activities required by an individual for continued well-being: eating/nutrition; self-care and personal hygiene; communication and cognitive functions; and physical activity, e.g., standing, walking, kneeling, hand functions, etc.

(2) "Ankylosis" means a bony fusion, fibrous union or arthrodesis of a joint. Ankylosis does not include pseudarthrosis or articular arthropathies.

(3) "Combined condition" means a preexisting condition and a compensable condition contribute to the worker's overall disability or need for treatment.

(4) "Date of Issuance", for purposes of these rules, means the mailing date of a Notice of Closure, Determination Order or Order on Reconsideration under ORS 656.268 and 656.283(7).

(5) "Dictionary of Occupational Titles" or (DOT) means the publication of the same name by the U.S. Department of Labor, Fourth Edition Revised 1991.

(6) "Direct medical sequela" means a condition which originates or stems from an accepted condition that is clearly established medically. Disability from direct medical sequelae is rated under these rules and ORS 656.268(14). For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to radiculopathy. The weakness is considered a "direct medical sequela" of the herniated disc.

(7) "Earning Capacity" means impairment as modified by age, education and adaptability.

(8) "Impairment" means a compensable, permanent loss of use or function of a body part/system related to the compensable condition, determined under these rules, OAR 436-010-0280 and ORS 656.726(4)(f).

(9) "Irreversible findings" for the purposes of these rules are:

ARM
Arm angulation
Radial head resection
Shortening
EYE
Enucleation
Lens implant
Lensectomy
GONADAL
Loss of gonads resulting in absence of, or an abnormally high, hormone level
HAND
Carpal bone fusion
Carpal bone removal
KIDNEY
Nephrectomy
LEG
Knee angulation
Length discrepancy
Meniscectomy
Patellectomy
LUNG
Lobectomy
SHOULDER
Acrominonectomy
Clavicle resection
SPINE
Compression fractures
Diskectomy
Laminectomy
SPLEEN
Splenectomy
URINARY TRACT DIVERSION
Cutaneous ureterostomy without intubation
Nephrostomy or intubated uresterostomy
Uretero-Intestinal
OTHER
Amputations/resections
Ankylosed/fused joints
Displaced pelvic fracture ("healed" with displacement)
Loss of opposition
Organ transplants (heart, lung, liver, kidney)
Prosthetic joint replacements

(10) "Medical arbiter" means a physician(s) under ORS 656.005(12)(b)(A) appointed by the Director under OAR 436-010-0330.

(11) "Offset" means to reduce a current permanent partial disability award, or portions thereof, by a prior Oregon workers' compensation permanent partial disability award from a different claim.

(12) "Physician's release" means written notification, provided by the attending physician to the worker and the worker's employer or insurer, releasing the worker to work and describing any limitations the worker has.

(13) "Preponderance of medical evidence" or "opinion" does not necessarily mean the opinion supported by the greater number of documents or greater number of concurrences; rather it means the more probative and more reliable medical opinion based upon factors including, but not limited to, one or more of the following:

(a) The most accurate history;
(b) The most objective findings;
(c) Sound medical principles; or
(d) Clear and concise reasoning.

(14) "Redetermination" means a reevaluation of disability under ORS 656.267, 656.268(9), 656.273 and 656.325.

(15) "Regular work" means the job the worker held at the time of injury.

(16) "Scheduled disability" means a compensable permanent loss of use or function which results from injuries to those body parts listed in ORS 656.214(3)(a) through (5).

(17) "Social-vocational factors" means age, education and adaptability factors under ORS 656.726(4)(f).

(18) "Superimposed condition" means a condition that arises after the compensable injury or disease which contributes to the worker's overall disability or need for treatment but is not the result of the original injury or disease. Disability from a superimposed condition is not rated. For example: The accepted condition is a low back strain. Two months after the injury, the worker becomes pregnant (non-work related). The pregnancy is considered a "superimposed condition."

(19) "Unscheduled disability" means a compensable condition that results in a permanent loss of earning capacity as described in these rules and arising from those losses under OAR 436-035-0330 through 436-035-0450.

(20) "Work Disability", for the purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 20-1990(Temp), f. & cert. ef. 11-20-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-035-0007
General Principles

(1) Except for OAR 436-035-0014, a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted compensable condition and direct medical sequela. Unrelated or noncompensable impairment findings are excluded and are not valued under these rules. Permanent total disability is determined under OAR 436-030-0055.

(2) Permanent disability is rated on the permanent loss of use or function of a body part, area, or system due to a compensable, consequential or combined condition and any direct medical sequela, and may be modified by the factors of age, education, and adaptability. Except impairment determined under ORS 656.726(4)(f), the losses, as defined and used in these standards, shall be the sole criteria for the rating of permanent disability under these rules.

(3) When newly accepted or omitted conditions have been added to the accepted conditions since the last arrangement of compensation, the extent of permanent disability is to be redetermined. Impairment values for conditions which are not actually worsened, unchanged, or improved are not redetermined and retain the same impairment values established at the last arrangement of compensation.

(4) Where a worker has a prior award of permanent disability under Oregon workers' compensation law, disability is determined under OAR 436-035-0015 (offset), rather than OAR 436-035-0013, for purposes of determining disability only as it pertains to multiple Oregon workers' compensation claims.

(5) Impairment is established based on objective findings of the attending physician under ORS 656.245(2)(b)(B) and OAR 436-010-0280. On reconsideration, where a medical arbiter is used, impairment is established based on objective findings of the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should be used.

(6) Objective findings made by a consulting physician or other medical providers (e.g. occupational or physical therapists) at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings as prescribed in OAR 436-010-0280.

(7) If there is no measurable impairment under these rules, no award of permanent partial disability is allowed.

(8) Pain is considered in the impairment values in these rules to the extent that it results in measurable impairment. If there is no measurable impairment, no award of permanent disability is allowed for pain. To the extent that pain results in disability greater than that evidenced by the measurable impairment, including the disability due to expected waxing and waning of the worker's condition, this loss of earning capacity is considered and valued under OAR 436-035-0012 and is included in the adaptability factor.

(9) When a joint is ankylosed in more than one direction or plane, the largest ankylosis value is used for rating the loss or only one of the values is used if they are identical. This value is granted in lieu of all other range of motion or ankylosis values for that joint.

(10) Except as otherwise required by these rules, methods used by the examiner for making findings of impairment are the methods described in the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev. 1990*, and are reported by the physician in the form and format required by these rules.

(11) Range of motion is measured using the goniometer as described in the AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised), 1990, except when measuring spinal range of motion; then an inclinometer must be used.

(12) Validity is established for findings of impairment according to the criteria noted in the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990*, unless the validity criteria for a particular finding is not addressed in this reference, is not pertinent to these rules, or is determined by physician opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment which are determined to be ratable under these rules are rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid. When findings are determined invalid, the findings receive a value of zero. If the validity criteria are not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid. For purposes of this rule, the straight leg raising validity test (SLR) is not the sole criterion used to invalidate lumbar range of motion findings.

(13) Except for contralateral comparison determinations under OAR 436-035-0011(3), loss of opposition determination under OAR 436-035-0040, averaging muscle values under OAR 436-035-0011(8), and impairment determined under ORS 656.726(4)(f), only impairment values listed in these rules are to be used in determining impairment. Prorating or interpolating between the listed values is not allowed. For findings that fall between the listed impairment values, the next higher appropriate value is used for rating.

(14) Values found in these rules consider the loss of use, function, or earning capacity directly associated with the compensable condition. When a worker's impairment findings do not meet the threshold (minimum) findings established in these rules, no value is granted.

(a) Not all surgical procedures result in loss of use, function, or earning capacity. Some surgical procedures improve the use and function of body parts, areas or systems or ultimately may contribute to an increase in earning capacity. Accordingly, not all surgical procedures receive a value under these rules.

(b) Not all medical conditions or diagnoses result in loss of use, function, or earning capacity. Accordingly, not all medical conditions or diagnoses receive a value under these rules.

(15) Waxing and waning of signs or symptoms related to a worker's compensable medical condition is already contemplated in the values provided in these rules. There is no additional value granted for the varying extent of waxing and waning of the condition. Waxing and waning means there is not an actual worsening of the condition under ORS 656.273.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 5-1975, f. 2-6-75, ef. 2-25-75; WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0005, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; Renumbered from 436-030-0120; WCD 5-1988, f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 20-1990(Temp), f. & cert. ef. 11-20-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 6-1999, f. & cert. ef. 4-26-99; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0008
Calculating Disability Benefits (Dates of Injury prior to 1/1/2005)

(1) Scheduled disability is rated on the permanent loss of use or function of a body part due to an accepted compensable, consequential or combined condition, or any direct medical sequelae. Except impairment determined under ORS 656.726(4)(f), the losses, as defined and used in these standards, are the sole criteria for the rating of permanent scheduled disability. To calculate the scheduled impairment benefit use the following steps.

(a) Determine the percent of scheduled impairment using the impairment values found in OAR 436-035-0019 through 436-035-0260, and the applicable procedures within these rules.

(b) Multiply the result in (a) by the maximum degrees, under ORS 656.214, for the injured body part.

(c) Multiply the result from (b) by the statutory dollar rate under ORS 656.214 and illustrated in Bulletin 111.

(d) The result from (c) is the scheduled impairment benefit. If there are multiple extremities with impairment then each is determined and awarded separately, including hearing and vision loss. Example: Scheduled Impairment Benefit. [Example not included. See ED. NOTE.]

(2) Unscheduled disability is rated on the permanent loss of use or function of a body part, area, or system and due to an accepted compensable, consequential or combined condition, and any direct medical sequelae, as modified by the factors of age, education, and adaptability. Except for impairment determined under ORS 656.726(4)(f), the losses, as defined and used in these standards, are the sole criteria for the rating of permanent unscheduled disability.

(a) To calculate the unscheduled impairment benefit when the worker returns or is released to regular work according to OAR 436-035-0009(3), use the following steps.

(A) Determine the percent of unscheduled impairment using the impairment values found in OAR 436-035-0019 and 436-035-0330 through 436-035-0450, and the applicable procedures within these rules.

(B) Multiply the result in (A) by the maximum degrees for unscheduled impairment.

(C) Multiply the result in (B) by the statutory dollar rate under ORS 656.214 and illustrated in Bulletin 111.

(D) The result in (C) is the unscheduled impairment benefit. Example: Unscheduled Impairment Benefit (worker returns/is released to regular work). [Example not included. See ED. NOTE.]

(b) To calculate the unscheduled disability benefit when the worker does not return or is not released to regular work according to OAR 436-035-0009(3), use the following steps.

(A) Determine the percent of unscheduled impairment using the impairment values found in OAR 436-035-0019 and 436-035-0330

through 436-035-0450, and the applicable procedures within these rules.

(B) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (A).

(C) Multiply the result from (B) by the maximum degrees for unscheduled impairment.

(D) Multiply the result from (C) by the statutory dollar rate for unscheduled impairment under ORS 656.214.

(E) The result from (D) is the unscheduled impairment benefit Example: Unscheduled Impairment Benefit (worker does not return/released to regular work); [Example not included. See ED. NOTE.]

[ED. NOTE: Examples referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726(4)
Hist.: WCD 5-1975, f. 2-6-75, ef. 2-25-75; WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0005, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; Renumbered from 436-030-0120; WCD 5-1988, f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 20-1990(Temp), f. & cert. ef. 11-20-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 6-1999, f. & cert. ef. 4-26-99; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0009
Calculating Disability Benefits (Date of Injury on or after 1/1/2005)

(1) Permanent impairment is expressed as a percent of the whole person and the impairment value will not exceed 100% of the whole person.

(2) If the impairment results from injury to more than one extremity, area, or system, the whole person values for each are combined (not added) to arrive at a final impairment value.

(3) Only permanent impairment is rated for those workers with a date of injury prior to January 1, 2006 and who:

(a) Return to and are working at their regular work on the date of issuance; or

(b) The attending physician or authorized nurse practitioner releases to regular work and the work is available, but the worker fails or refuses to return to that job; or

(c) The attending physician or authorized nurse practitioner releases to regular work, but the worker's employment is terminated for cause unrelated to the injury.

(4) Only permanent impairment is rated for those workers with a date of injury on or after January 1, 2006, and who have been released or returned to regular work by the attending physician or authorized nurse practitioner.

(5) To calculate the impairment benefit due the worker use the following steps:

(a) Determine the percent of impairment according to these rules.

(b) Multiply the percent of impairment determined in (a) by 100 per ORS 656.214.

(c) Multiply the result from (b) by the state's average weekly wage at the time of injury as defined by ORS 656.005 and illustrated in Bulletin 111.

(d) The result in (c) is the total impairment benefit, which is paid regardless of the worker's return to work status. In the absence of social-vocational factoring as a result of the worker's return to work status, this is also the permanent partial disability award. Example: Impairment Benefit (paid regardless of return to work status) [Example not included. See ED. NOTE.]

(6) If the worker has not met the return or release to regular work criteria in section (3) or (4) of this rule, the worker receives both an impairment and work disability benefit, and the total permanent partial disability award is calculated as follows.

(a) Determine the percent of impairment as a whole person (WP) value according to these rules.

(b) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (a).

(c) Multiply the result from (b) by 150 per ORS 656.214.

(d) Multiply the result from (c) by worker's average weekly wage as calculated under ORS 656.210(2). The worker's average weekly wage can be no less than 50% and no more than 133% of the state's average weekly wage at the time of injury when determining work disability benefits.

(e) Add the result from (d) to the impairment benefit value, which would be calculated using the method in section (4) of this rule.

(f) The result from (e) is the permanent partial disability award that would be due the worker. Example: Work Disability Benefit and PPD Award (no return to work) [Example not included. See ED. NOTE.]

[ED. NOTE: Examples referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0011
Determining Percent of Impairment

(1) The total impairment rating for a body part cannot be more than 100% of the body part.

(2) When rating disability the movement in a joint is measured in active degrees of motion. Impairment findings describing lost ranges of motion are converted to retained ranges of motion by subtracting the measured loss from the normal of full ranges established in these rules.

(a) Range of motion values for each direction in a single joint are first added, then combined with other impairment findings. [Example not included. See ED. NOTE.]

(b) Range of motion values for multiple joints in a single body part (e.g. of a finger) are determined by finding the range of motion values for each joint (e.g. MCP, PIP, DIP) and combining those values for an overall loss of range of motion value for that body part. This value is then combined with other impairment values.

(3) The range of motion or laxity (instability) of an injured joint is compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease or when either joint's range of motion is zero degrees or is ankylosed. The strength of an injured extremity, shoulder, or hip is compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease. [Example not included. See ED. NOTE.]

(a) If the motion of the injured or contralateral joint exceeds the values for ranges of motion established under these rules, the values established under these rules are maximums used to establish impairment.

(b) When the contralateral joint has a history of injury or disease, the findings of the injured joint are valued based upon the values established under these rules.

(4) Specific impairment findings (e.g., weakness, reduced range of motion, etc.) are awarded in whole number increments. This may require rounding non-whole number percentages and contralateral comparison degrees of motion for given impairment findings before combining with any other applicable impairment value.

(a) Except for subsection (b) of this section, before combining, the sum of the impairment values is rounded to the nearest whole number. For the decimal portion of the number, point 5 and above is rounded up, below point 5 is rounded down. [Example not included. See ED. NOTE.]

(b) When the sum of impairment values is greater than zero and less than 0.5, a value of 1% will be granted. [Example not included. See ED. NOTE.]

(5) If there are impairment findings in two or more body parts in an extremity, the total impairment findings in the distal body part are converted to a value in the most proximal body part under the applicable conversion chart in these rules. This conversion is done prior to combining impairment values for the most proximal body part. [Example not included. See ED. NOTE.]

(6) Except as otherwise noted in these rules, impairment values to a given body part, area, or system are combined according to the method outlined on pages 254-256 by the AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. (Revised), 1990, as follows:

(a) The combined value is obtained by inserting the values for A and B into the formula A + B*(1.0 - A). The larger of the two numbers is A and the smaller is B. The whole number percentages of impairment are converted to their decimal equivalents (e.g. 12% converts to .12; 3% converts to .03). The resulting percentage is rounded to a whole number as determined in section (1) of this rule. Upon combin-

ing the largest two percentages, the resulting percentage is combined with any lesser percentage(s) in descending order using the same formula until all percentages have been combined prior to performing further computations. After the calculations are completed, the decimal result is then converted back to a percentage equivalent. [Example not included. See ED. NOTE.]

(b) Impairment values for a given body part, area, or system must be combined before combining with other impairment values. If the given body part is an upper or lower extremity, ear(s), or eye(s) then the impairment value is to be converted to a whole person value before combining with other impairment values, except when the date of injury for the claim is prior to January 1, 2005. [Example not included. See ED. NOTE.]

(7) To determine impairment due to loss of strength, the 0 to 5 international grading system and 0 to 5 method as noted in the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. Revised, 1990* are used. The grade of strength is reported by the physician and assigned a percentage value from the table in subsection (a) of this section. The impairment value of the involved nerve is multiplied by this value. Grades identified as "++" or "--" are considered either a "+" or "-", respectively.

(a) The grading is valued as follows: [Example not included. See ED. NOTE.]

(b) When a physician reports a loss of strength with muscle action (e.g. flexion, extension, etc.) or when only the affected muscle(s) is identified, current anatomy texts or the *AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. (Revised), 1990*, the *4th Ed., 1993, or the 5th Ed., 2001*, may be referenced to identify the specific muscle(s), peripheral nerve(s) or spinal nerve root(s) involved.

(8) For muscles supplied (innervated) by the same nerve, the loss of strength is determined by averaging the percentages of impairment for each involved muscle to arrive at a single percentage of impairment for the involved nerve. [Example not included. See ED. NOTE.]

(9) When multiple nerves have impairment findings found under these rules, these impairment values are first combined for an overall loss of strength value for the body part before combining with other impairment values.

[Publications: Publications referenced are available from the agency.]
[ED. NOTE: Examples referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0012
Social-Vocational Factors (Age/Education/Adaptability)

(1) When a worker does not meet the return/release to regular work requirements under ORS 656.726(4), the factors of age, education, and adaptability are determined under this rule and the final result is the social-vocational factor which is used in the calculation of permanent disability benefits. When the date of injury is prior to January 1, 2005, the worker must have ratable unscheduled impairment under OAR 436-035-0019 or 436-035-0330 through 436-035-0450.

(2) The age factor is based on the worker's age at the date of issuance and has a value of 0 or +1.

(a) Workers age 40 and above receive a value of + 1.

(b) Workers less than 40 years old receive a value of 0.

(3) The education factor is based on the worker's formal education and Specific Vocational Preparation (SVP) time at the date of issuance. These two values are determined by sections (4) and (5) of this rule, and are added to give a value from 0 to +5.

(4) A value of a worker's formal education is given as follows:

(a) Workers who have earned or acquired a high school diploma or general equivalency diploma (GED) are given a neutral value of 0. For purposes of this section, a GED is a certificate issued by any certifying authority or its equivalent.

(b) Workers who have not earned or acquired a high school diploma or a GED certificate are given a value of +1.

(5) A value for a worker's Specific Vocational Preparation (SVP) time is given based on the job(s) successfully performed by the worker in the five (5) years prior to the date of issuance. The SVP value is determined by identifying these jobs and locating their SVP in the Dictionary of Occupational Titles (DOT) or a specific job analysis. The job with the highest SVP the worker has met is used to assign a value according to the following table: [Table not included. See ED. NOTE.]

(a) For the purposes of this rule, SVP is defined as the amount of time required by a typical worker to acquire the knowledge, skills and abilities needed to perform a specific job.

(b) When a job is most accurately described by a combination of DOT codes, use all applicable DOT codes. If a preponderance of evidence establishes that the requirements of a specific job differ from the DOT description(s), a specific job analysis which includes the SVP time requirement may be substituted for the DOT description(s) if it more accurately describes the job.

(c) A worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the time period specified in the table.

(d) A worker meets the SVP for a job after successfully completing an authorized training program, on-the-job training, vocational training, or apprentice training for that job classification. College training organized around a specific vocational objective is considered specific vocational training.

(e) For those workers who have not met the specific vocational preparation training time for any job, a value of +4 is granted.

(6) The values obtained in sections (4) and (5) of this rule are added to arrive at a final value for the education factor.

(7) The adaptability factor is a comparison of the worker's Base Functional Capacity (BFC) to their maximum Residual Functional Capacity (RFC). The adaptability factor is determined by subsections (8) to (12) of this section, and has a value from +1 to +7.

(8) For purposes of determining adaptability the following definitions apply:

(a) "Base Functional Capacity" (BFC) means an individual's demonstrated physical capacity before the date of injury or disease.

(b) "Residual Functional Capacity" (RFC) means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition.

(c) "Sedentary restricted" means the worker only has the ability to carry or lift dockets, ledgers, small tools and other items weighing less than 10 pounds. A worker is also sedentary restricted if the worker can perform the full range of sedentary activities, but with restrictions.

(d) "Sedentary (S)" means the worker has the ability to occasionally lift or carry dockets, ledgers, small tools and other items weighing 10 pounds.

(e) "Sedentary/Light (S/L)" means the worker has the ability to do more than sedentary activities, but less than the full range of light activities. A worker is also sedentary/light if the worker can perform the full range of light activities, but with restrictions.

(f) "Light (L)" means the worker has the ability to occasionally lift 20 pounds and can frequently lift or carry objects weighing up to 10 pounds.

(g) "Medium/Light (M/L)" means the worker has the ability to do more than light activities, but less than the full range of medium activities. A worker is also medium/light if the worker can perform the full range of medium activities, but with restrictions.

(h) "Medium (M)" means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently.

(i) "Medium/Heavy (M/H)" means the worker has the ability to do more than medium activities, but less than the full range of heavy activities. A worker is also medium/heavy if the worker can perform the full range of heavy activities, but with restrictions.

(j) "Heavy (H)" means the worker has the ability to occasionally lift 100 pounds and the ability to frequently lift or carry objects weighing 50 pounds.

(k) "Very Heavy (V/H)" means the worker has the ability to occasionally lift in excess of 100 pounds and the ability to frequently lift or carry objects weighing more than 50 pounds.

(l) "Restrictions" means that, by a preponderance of medical opinion, the worker is permanently limited by:

(A) Sitting, standing, or walking less than two hours at a time; or

(B) Precluded from working the same number of hours as were worked at the time of injury or eight hours per day, whichever is less; or

(C) From frequently performing at least one of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling.

(m) "Occasionally" means the activity or condition exists up to 1/3 of the time.

(n) "Frequently" means the activity or condition exists up to 2/3 of the time.

(o) "Constantly" means the activity or condition exists 2/3 or more of the time.

(9) Base Functional Capacity (BFC) is established by utilizing the following classifications: sedentary (S), light (L), medium (M), heavy (H), and very heavy (VH) as defined in section (8) of this rule. Base Functional Capacity is the most current of:

(a) The highest strength category of the job(s) successfully performed by the worker in the five (5) years prior to the date of injury. The strength categories are found in the Dictionary of Occupational Titles (DOT). When a job is most accurately described by a combination of DOT codes, use all applicable DOT codes. If a preponderance of evidence establishes that the requirements of a specific job differ from the DOT descriptions, a specific job analysis which includes the strength requirements may be substituted for the DOT description(s) if it most accurately describes the job. If a job analysis determines that the strength requirements are in between strength categories then use the higher strength category; or

(b) A second-level physical capacity evaluation as defined in OAR 436-010-0005 and 436-009-0070(4)(b) performed prior to the date of the on-the-job injury; or

(c) For those workers who do not meet the requirements under section (5) of this rule, and who have not had a second-level physical capacity evaluation performed prior to the on-the-job injury or disease, their prior strength is based on the worker's job at the time of injury.

(d) Where a worker's highest prior strength has been reduced as a result of an injury or condition which is not an accepted Oregon workers' compensation claim the Base Functional Capacity is the highest of:

(A) The job at injury; or

(B) A second-level physical capacities evaluation as defined in OAR 436-010-0005 and 436-009-0070(4)(b) performed after the injury or condition which was not an accepted Oregon workers' compensation claim but before the current work related injury.

(10) Residual functional capacity (RFC) is established by utilizing the following classifications: restricted sedentary (RS), sedentary (S), sedentary/light (S/L), light (L), medium/light (M/L), medium (M), medium/heavy (M/H), heavy (H), and very heavy (VH) and restrictions as defined in section (8) of this rule.

(a) Residual functional capacity is evidenced by the attending physician's release unless a preponderance of medical opinion describes a different RFC.

(b) For the purposes of this rule, the other medical opinion must include at least a second-level physical capacity evaluation (PCE) or work capacity evaluation (WCE) as defined in OAR 436-010-0005 and 436-009-0070(4) or a medical evaluation which addresses the worker's capability for lifting, carrying, pushing/pulling, standing, walking, sitting, climbing, balancing, stooping, kneeling, crouching, crawling and reaching. If multiple levels of lifting and carrying are measured, an overall analysis of the worker's lifting and carrying abilities should be provided in order to allow an accurate determination of these abilities. Where a worker fails to cooperate or use maximal effort in the evaluation, the medical opinion of the evaluator may establish the worker's likely RFC had the worker cooperated and used maximal effort.

(11) In comparing the worker's Base Functional Capacity (BFC) to the Residual Functional Capacity (RFC), the values for adaptability to perform a given job are as follows: [Table not included. See ED. NOTE.]

(12) For those workers determined by these rules to have an RFC established between two categories and also have restrictions, the next lower classification is used. (For example, if a worker's RFC is established at S/L but also has restrictions, use S).

(13) When the date of injury is on or after January 1, 2005, adaptability is determined by applying the worker's extent of total impairment to the following adaptability scale and comparing the value from the residual functional capacity scale in section (11) of this rule and using the higher of the two values for adaptability. [Table not included. See ED. NOTE.]

(14) When the date of injury is prior to January 1, 2005, for those workers who have ratable unscheduled impairment found in rules OAR 436-035-0019 or 436-035-0330 through 436-035-0450, adaptability is determined by applying the extent of total unscheduled impairment to the adaptability scale in section (13) of this rule and the residual functional capacity scale in section (11) of this rule and using the higher of the two values for adaptability.

(15) To determine the social-vocational factor value, which represents the total calculation of age, education, and adaptability complete the following steps.

(a) Determine the appropriate value for the age factor using section (2) of this rule.

(b) Determine the appropriate value for the education factor using sections (4) and (5) of this rule.

(c) Add age and education values together.

(d) Determine the appropriate value for the adaptability factor using sections (7) through (14) of this rule.

(e) Multiply the result from step (c) by the value from step (d) for the social-vocational factor value.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0013
Apportionment

Except as provided in section (4) of this section, where a worker has a superimposed or unrelated condition, only disability due to the compensable condition is rated, provided the compensable condition is medically stationary. Then, apportionment is appropriate. Disability is determined as follows:

(1) The physician describes the current total overall findings of impairment. The physician describes the portion of those findings that are due to the compensable condition. Only the portion of those impairment findings that are due to the compensable condition receive a value. [Example not included. See ED. NOTE.]

(2) In claims where a worker's adaptability factor is determined under OAR 436-035-0012 and is affected by the compensable condition, the physician describes any loss of residual functional capacity due only to the compensable condition and only that portion receives a value.

(3) For conditions other than those noted in section (2) of this rule, adaptability is determined under OAR 436-035-0012 based on the physician's description of the portion of impairment due only to the compensable condition.

(4) Workers with an irreversible finding of impairment due to the compensable condition receive the full value awarded in these rules for the irreversible finding. This value is combined with impairment noted in section (1) of this section. [Example not included. See ED. NOTE.]

[ED. NOTE: Examples referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0014
Preexisting Condition/Major Contributing Cause

(1) Where a worker has a preexisting condition, the following applies:

(a) For purposes of these rules only, a prior Oregon workers' compensation claim is not considered a preexisting condition.

(b) Under ORS 656.225, disability caused solely by a worker's preexisting condition is rated completely if work conditions or events were the major contributing cause of a pathological worsening of the preexisting physical condition or an actual worsening of the preexisting mental disorder. Apportionment of disability is not appropriate.

(c) Where a worker's compensable condition combines with a preexisting condition, under ORS 656.005(7), the current disability resulting from the total accepted combined condition is rated under these rules as long as the compensable condition remains the major contributing cause of the accepted combined condition (e.g., a major contributing cause denial has not been issued under ORS 656.262(7)(b)). Apportionment of disability is not appropriate. [Example not included. See ED. NOTE.]

(2) If the worker is not medically stationary, but otherwise qualifies for closure under ORS 656.268 (e.g., when a major contributing cause denial has been issued), the following applies:

(a) When the worker's compensable condition is not medically stationary and, upon examination, the findings of impairment related to the compensable condition would not overlap the findings of impairment related to any combined or superimposed condition, the following applies:

(A) Impairment is established based on an examination in which the physician first describes the current findings regarding impairment due to the worker's compensable condition. Then the physician estimates the likely future portion of those findings that would be present at the time the worker's condition is anticipated to become medically stationary. The value of the current findings is adjusted accordingly and only the portion of those current findings that are anticipated at the time of medically stationary status receives a value.

(B) The physician will estimate the worker's likely future residual functional capacity that would be due only to the compensable condition at the time the condition is anticipated to become medically stationary. Only the portion due to the compensable condition at the time of medically stationary status receives a value.

(C) For dates of injury prior to January 1, 2005, when the compensable condition is to the shoulder, hip, head, neck, or torso, the physician estimates the worker's likely future residual functional capacity, under OAR 436-035-0012(8)(c) through (o), that would be due only to the compensable condition at the time the condition is anticipate to become medically stationary. Only the portion due to the compensable condition at the time of medically stationary status receives a value. For other unscheduled compensable conditions, adaptability is determined under OAR 436-035-0012 based on the physician's estimate of likely impairment.

(b) When the worker's overall condition is not medically stationary and, upon examination, the findings of impairment related to the compensable condition would overlap the findings of impairment related to any combined or superimposed condition, the following applies:

(A) Impairment is established based on an examination in which the physician describes current overall findings regarding impairment considering the worker's overall condition. The physician then estimates the likely future portion of those findings that would be present at the time the worker's condition is anticipated to become medically stationary. Next, the physician estimates the portion of those findings that would be due only to the compensable condition. The current overall value of the findings of impairment is adjusted accordingly and only the portion of those impairment findings that are anticipated at the time of medically stationary status and are due to the compensable condition receive a value. [Example not included. See ED. NOTE.]

(B) The physician will estimate the worker's likely future residual functional capacity under OAR 436-035-0012(8)(c) through (o), that would be due only to the compensable condition at the time medically stationary status is anticipated. Only the portion due to the compensable condition at the time of medically stationary status will receive a value.

(C) For dates of injury prior to January 1, 2005, to estimate an adaptability factor when the compensable condition is to the shoulder, hip, head, neck, or torso, the physician estimates the worker's likely future residual functional capacity under OAR 436-035-0012(8)(c) through (o), that would be due only to the compensable condition at the time medically stationary status is anticipated. Only the portion due to the compensable condition at the time of medically stationary status receives a value. For other unscheduled compensable conditions, adaptability shall be determined under OAR 436-035-0012 based on the physician's estimated likely impairment. [Example not included. See ED. NOTE.]

(c) Workers with an irreversible finding of impairment due to the compensable condition receive the full value awarded in these rules for the irreversible finding. This value is then combined with the portion of impairment findings that are anticipated at the time of medically stationary status and due to the compensable condition which are rated under OAR 436-035-0013(4). [Example not included. See ED. NOTE.]

[ED. NOTE: Examples referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0015

Offsetting Prior Awards

If a worker has a prior award of permanent disability under Oregon Workers' Compensation Law, the award is considered in subsequent claims under ORS 656.222 and 656.214. For purposes of these rules only, a prior Oregon workers' compensation claim is not considered a preexisting condition.

(1) Before actually offsetting the prior award, a determination is made as to whether or not there is a preponderance of medical evidence or opinion establishing that disability from the prior injury or disease was still present on the date of the injury or disease of the claim being determined. If disability from the prior injury or disease was not still present, an offset is not applied.

(2) If disability from the prior injury or disease was still present, an offset is applied. A worker is not entitled to be doubly compensated for a permanent loss of use or function or loss of earning capacity for a body part which would have resulted from the current injury or disease but which has already been produced by an earlier injury or disease and had been compensated by a prior award. Therefore, only like body parts are to be offset (e.g., left leg to left leg, low back to low back, psychological to psychological, etc.). A more distal body part award may be offset against a more proximal body part award (or vice versa) if there is a combined effect of impairment (e.g., a right forearm award may be offset against a right arm award). Where appropriate, social-vocational factors may be offset for different body parts, systems, or conditions. Only that portion of such loss which was not present prior to the current injury or disease is awarded. The following factors are considered when determining the extent of the current disability award:

(a) The worker's loss of use or function or loss of earning capacity for the current disability under the standards;

(b) The conditions or findings of impairment from the prior awards which were still present just prior to the current claim;

(c) The worker's social-vocational factors which were still present just prior to the current claim, if appropriate; and

(d) The combined effect of the prior and current injuries (the overall disability to a given body part), including the extent to which the current loss of use or function or loss of earning capacity (impairment and social-vocational factors) from a prior injury or disease was still present at the time of the current injury or disease. After considering and comparing the claims, any award of compensation in the current claim for loss of use or function or loss of earning capacity caused by the current injury or disease (which did not exist at the time of the current injury or disease and for which the worker was not previously compensated) is granted. When comparing the current disability award to the prior disability award, the current award cannot exceed the amount of compensation due the current injury or disease prior to the offset consideration.

Stat. Auth.: ORS 656.726

Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0016

Reopened Claim for Aggravation/Worsening

(1) When a claim has been reopened under ORS 656.273 and then closed, the worker's compensable condition at the time of the current claim closure or reconsideration is compared with the worker's compensable condition as it existed at the time of the last award or arrangement of compensation, to determine if there is a change in the worker's overall permanent partial disability award.

(2) There is no redetermination for those compensable conditions which are not included in the accepted aggravation claim. Impairment values for those conditions not actually worsened continue to be the same impairment values that were established at the last arrangement of compensation.

(3) Except as provided by ORS 656.325 and 656.268(9), where a redetermination of permanent disability under ORS 656.273 results in an award that is less than the total of the worker's prior arrangements of compensation in the claim, the award is not reduced.

Stat. Auth.: ORS 656.726

Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0017
Authorized Training Program (ATP)

(1) When a worker ceases to be enrolled and actively engaged in training under ORS 656.268(9) and there is no accepted aggravation in the current open period, one of the following applies:

(a) When the date of injury is prior to January 1, 2005, the worker is entitled to have the amount of unscheduled permanent disability for a compensable condition reevaluated under these rules. The reevaluation includes impairment, which may increase, decrease, or affirm the worker's permanent disability award; or

(b) When the date of injury is on or after January 1, 2005, the worker is entitled to have the amount of work disability reevaluated under these rules, which does not include impairment.

(2) When a worker ceases to be enrolled and actively engaged in training under ORS 656.268(9) and there is an accepted aggravation in the same open period, permanent partial disability is redetermined under OAR 436-035-0016.

Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0018
Death

If the worker dies due to causes unrelated to the accepted compensable conditions of the claim, the following applies:

(1) When all compensable conditions are medically stationary under OAR 436-030-0035 at the time of death, the following applies:

(a) Impairment findings, reported under OAR 436-010-0280, are rated under these rules.

(b) Impairment findings not reported according to OAR 436-010-0280 are determined based on the physician's estimate of those findings regarding impairment due to the worker's compensable condition.

(c) For unscheduled disability with a date of injury prior to January 1, 2005, age, education, and adaptability are determined under OAR 436-035-0012 if the findings are documented. If findings for determining adaptability are not documented, the physician estimates the likely residual functional capacity, under OAR 436-035-0012(8)(c) through (o), due to the compensable condition, if the compensable condition is to the hip, shoulder, head, neck, or torso. If the compensable condition is other than the shoulder, hip, head, neck, or torso, adaptability is determined under OAR 436-035-0012 based on the physician's estimated likely impairment.

(d) For disability with a date of injury on or after January 1, 2005, age, education, and adaptability are determined under OAR 436-035-0012 if the findings are documented. If findings for determining adaptability are not documented, the physician estimates the likely residual functional capacity that is due to the compensable condition under OAR 436-035-0012(8)(c) through (o). Using the physician's estimated likely impairment, adaptability is determined under OAR 436-035-0012.

(2) When all compensable conditions are not medically stationary under OAR 436-030-0035 at the time of death, the following applies:

(a) Impairment is established based on the physician's estimate of those findings regarding impairment due to the worker's compensable condition that would still be present when the worker's condition would have become medically stationary. Those findings that are anticipated to have remained at the time of medically stationary status receive a value.

(b) For unscheduled disability with a date of injury prior to January 1, 2005, age, education, and adaptability factors are determined under OAR 436-035-0012. Unless the worker is released to regular work and impairment only is rated, the physician estimates the likely residual functional capacity, under OAR 436-035-0012(8)(c) through (o), due to the compensable condition, that would remain due to the compensable condition, if the compensable condition is to the shoulder, hip, head, neck, or torso. The estimated portion due to the compensable condition receives an adaptability value. If the compensable condition is other than the shoulder, hip, head, neck, or torso, adaptability is determined under OAR 436-035-0012 based on the physician's estimated likely impairment.

(3) In claims where there is a compensable condition that is medically stationary and a compensable condition that is not medically stationary, the conditions are rated according to sections (1) and (2) of this rule, respectively. The adaptability factor is determined by comparing the adaptability values from sections (1) and (2) of this rule, and using the higher of the values for adaptability.

(4) If the worker dies due to causes related to the accepted compensable conditions of the claim, death benefits are due under ORS 656.204 and 656.208.

Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0019
Chronic Condition

(1) A worker is entitled to a 5% chronic condition impairment value for each applicable body part, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following body parts:

(a) Lower leg (below knee/foot/ankle);
(b) Upper leg (knee and above);
(c) Forearm (below elbow/hand/wrist);
(d) Arm (elbow and above);
(e) Cervical;
(f) Thoracic spine;
(g) Shoulder;
(h) Low back; or
(i) Hip.

(2) Chronic condition impairments are to be combined with other impairment values, not added.

Stat. Auth.: ORS 656.726
Stats. Implemented.: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
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436-035-0020
Parts of the Upper Extremities

(1) The arm begins with the head of the humerus. It includes the elbow joint.

(2) The forearm begins distal to the elbow joint and includes the wrist (carpal bones).

(3) The hand begins at the joints between the carpals and metacarpals. It extends to the joints between the metacarpals and the phalanges.

(4) The thumb and fingers begin at the joints between the metacarpal bones and the phalanges. They extend to the tips of the thumb and fingers, respectively.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.273 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0006, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0130; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0030
Amputations in the Upper Extremities

(1) Loss of the arm at or proximal to the elbow joint is 100% loss of the arm.

(2) Loss of the forearm at or proximal to the wrist joint is 100% loss of the forearm.

(3) Loss of the hand at the carpal bones is 100% loss of the hand.

(4) Loss of all or part of a metacarpal is rated at 10% of the hand

(5) Amputation or resection (without reattachment) proximal to the head of the proximal phalanx is 100% loss of the thumb. The ratings for other amputation(s) or resection(s) (without reattachment) of the thumb are as follows:

(6) Amputation or resection (without reattachment) proximal to the head of the proximal phalanx is 100% loss of the finger. The ratings for other amputation(s) or resection(s) (without reattachment) of the finger are as follows:

(7) Oblique (angled) amputations are rated at the most proximal loss of bone.

(8) When a value is granted under sections (5) and (6) of this rule which includes a joint, no value for range of motion of this joint is granted in addition to the amputation value.

(9) Loss of length in a digit other than amputation or resection without reattachment (e.g. fractures, loss of soft tissue from infection, amputation or resection with reattachment, etc.) is rated by comparing

the remaining overall length of the digit to the applicable amputation chart under these rules and rating the overall length equivalency.

[ED NOTE: Diagrams referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCB 5-1975, f. 2-6-75, ef. 2-25-75; WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0010, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0140; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0040
Loss of Opposition in Thumb/Finger Amputations

(1) Loss of opposition is rated as a proportionate loss of use of the digits which can no longer be effectively opposed.

(a) For amputations which are not exactly at the joints, adjust the ratings in steps of 5%, increasing as the amputation gets closer to the attachment to the hand, decreasing to zero as it gets closer to the tip.

(b) When the value for loss of opposition is less than 5%, no value is granted.

(2) The following ratings apply to thumb amputations for loss of opposition:

(a) For thumb amputations at the interphalangeal level: [Rating not included. See ED. NOTE.]

(b) For thumb amputations at the metacarpophalangeal level: [Rating not included. See ED. NOTE.]

(3) The following ratings apply to finger amputations for loss of opposition. In every case, the opposing digit is the thumb: [Rating not included. See ED. NOTE.]

(4) When determining loss of opposition due to loss of length in a digit, other than amputation or resection without reattachment, the value is established by comparing the remaining overall length of the digit to the applicable amputation chart under these rules and rated according to the overall length equivalency.

(5) If the injury is to one digit only and opposition loss is awarded for a second digit, do not convert the two digits to loss in the hand. Conversion to hand can take place only when more than one digit has impairment without considering opposition.

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0150; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0050
Thumb

(1) The following ratings are for loss of flexion at the interphalangeal joint of the thumb: [Rating not included. See ED. NOTE.]

(2) The following ratings are for loss of extension at the interphalangeal joint of the thumb: [Rating not included. See ED. NOTE.]

(3) The following ratings are for ankylosis of the interphalangeal joint of the thumb: [Rating not included. See ED. NOTE.]

(4) The following ratings are for loss of flexion at the metacarpophalangeal joint of the thumb: [Rating not included. See ED. NOTE.]

(5) The following ratings are for loss of extension at the metacarpophalangeal joint of the thumb: [Rating not included. See ED. NOTE.]

(6) The following ratings are for ankylosis of the metacarpophalangeal joint of the thumb: [Rating not included. See ED. NOTE.]

(7) Rotational, lateral, dorsal, or palmar deformity of the thumb receives a value of 10% of the thumb.

(8) For losses in the carpometacarpal joint refer to OAR 436-035-0075.

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0100, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0160; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 15-1996(Temp), f. & cert. ef. 7-3-96; WCD 18-1996(Temp), f. 8-6-96, cert. ef. 8-7-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0060
Finger

(1) The following ratings are for loss of flexion at the distal interphalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(2) The following ratings are for loss of extension at the distal interphalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(3) The following ratings are for ankylosis in the distal interphalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(4) The following ratings are for loss of flexion at the proximal interphalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(5) The following ratings are for loss of extension at the proximal interphalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(6) The following ratings are for ankylosis in the proximal interphalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(7) The following ratings are for loss of flexion at the metacarpophalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(8) The following ratings are for loss of extension at the metacarpophalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(9) The following ratings are for ankylosis in the metacarpophalangeal joint of any finger: [Rating not included. See ED. NOTE.]

(10) Rotational, lateral, dorsal, or palmar deformity of a finger shall receive a value of 10% for the finger.

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0170; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0070
Conversion of Thumb/Finger Values to Hand Value

(1) Loss of use of two or more digits is converted to a value for loss in the hand if the worker will receive more money for the conversion. At least two digits must have impairment other than loss of opposition to qualify for conversion to hand.

(2) When converting impairment values of digits to hand values, the applicable hand impairment is determined by rating the total impairment value in each digit under OAR 436-035-0011(2)(b), then converting the digit values to hand values, and then adding the converted values. Digit values between zero and one are rounded to one prior to conversion.

(3) The following table shall be used to convert loss in the thumb to loss in the hand: [Table not included. See ED. NOTE.]

(4) The following table shall be used to convert loss in the index finger to loss in the hand: [Table not included. See ED. NOTE.]

(5) The following table shall be used to convert loss in the middle finger to loss in the hand: [Table not included. See ED. NOTE.]

(6) The following table shall be used to convert loss in the ring finger to loss in the hand: [Table not included. See ED. NOTE.]

(7) The following table shall be used to convert loss in the little finger to loss in the hand: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0180; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0075
Hand

(1) Pursuant to OAR 436-035-0020(3), the ratings in this section are hand values. Abduction and adduction of the carpometacarpal joint of the thumb are associated with the ability to extend and flex. This association has been taken into consideration in establishing the percentages of impairment.

(2) The following ratings are for loss of flexion (adduction) of the carpometacarpal joint of the thumb: [Rating not included. See ED. NOTE.]

(3) The following ratings are for loss of extension (abduction) of the carpometacarpal joint of the thumb: [Rating not included. See ED. NOTE.]

(4) The following ratings are for ankylosis of the carpometacarpal joint in flexion (adduction) of the thumb: [Rating not included. See ED. NOTE.]

(5) The following ratings are for ankylosis of the carpometacarpal joint in extension (abduction) of the thumb: [Rating not included. See ED. NOTE.]

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0080
Wrist

(1) The following ratings are for loss of (dorsiflexion) extension at the wrist joint: [Rating not included. See ED. NOTE.]

(2) The following ratings are for (dorsiflexion) extension ankylosis in the wrist joint: [Rating not included. See ED. NOTE.]

(3) The following ratings are for loss of (palmar) flexion in the wrist joint: [Rating not included. See ED. NOTE.]

(4) The following ratings are for (palmar) flexion ankylosis in the wrist joint: [Rating not included. See ED. NOTE.]

(5) The following ratings are for loss of radial deviation in the wrist joint: [Rating not included. See ED. NOTE.]

(6) The following ratings are for radial deviation ankylosis in the wrist joint: [Rating not included. See ED. NOTE.]

(7) The following ratings are for loss of ulnar deviation in the wrist joint: [Rating not included. See ED. NOTE.]

(8) The following ratings are for ulnar deviation ankylosis in the wrist joint: [Rating not included. See ED. NOTE.]

(9) Injuries which result in a loss of pronation or supination in the wrist joint shall be valued pursuant to OAR 436-035-0100(4).

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0520, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; Amended 12-21-88 as WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0190; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0090
Conversion of Hand/Forearm Values to Arm Value

The following table shall be used to convert a loss in the hand/forearm to a loss in the arm: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0524, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0200; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0100
Arm

(1) The following ratings are for loss of flexion in the elbow joint (150° describes the arm in full flexion): [Rating not included. See ED. NOTE.]

(2) The following ratings are for loss of extension in the elbow joint (0° describes the arm in full extension): [Rating not included. See ED. NOTE.]

(3) Ankylosis of the elbow in flexion or extension shall be rated as follows: [Rating not included. See ED. NOTE.]

(4) The following ratings are for loss of pronation or supination in the elbow joint. If there are losses in both pronation and supination, rate each separately and add the values: [Rating not included. See ED. NOTE.]

(5) Ankylosis of the elbow in pronation or supination will be rated as follows: [Rating not included. See ED. NOTE.]

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0525, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0210; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0110
Other Upper Extremity Findings

(1) Loss of palmar sensation in the hand, finger(s), or thumb is rated according to the location and quality of the loss, and is measured by the two point discrimination method, as noted by the AMA Guides, 3rd Ed. Rev., 1990.

(a) If enough sensitivity remains to distinguish two pin pricks applied at the same time (two point), the following apply: [Rating not included. See ED. NOTE.]

(b) In determining sensation findings for a digit which has been resected or amputated, the value is established by comparing the remaining overall length of the digit to the table in subsection (1)(c) of this rule and rating the length equivalency. For Example: Amputation of 1/2 the middle phalanx of the index finger with total sensory loss extending from the level of amputation to the metacarpophalangeal joint, results in a value for 1/2 the digit or 33%.

(c) Loss of sensation in the finger(s) or thumb is rated as follows: [Rating not included. See ED. NOTE.]

(d) If the level of the loss is less than 1/2 the distal phalanx or falls between the levels in subsection (c) of this section, rate at the next highest (or more proximal) level.

(e) In determining sensation impairment in a digit in which the sensation loss does not extend to the distal end of the digit, the value is established by determining the value for loss from the distal end of the digit to the proximal location of the loss, and subtracting the value for loss from the distal end of the digit to the distal location of the loss. [Rating not included. See ED. NOTE.]

(f) Any portion of palmar sensation loss is rated as follows: [Rating not included. See ED. NOTE.]

(g) Loss of sensation on the dorsal side of the hand, fingers or thumb is not considered a loss of function, so no value is allowed.

(h) Sensory loss in the forearm or arm is not considered a loss of function, therefore no value is allowed.

(i) When there are multiple losses of palmar sensation in a single body part (e.g. hand, finger(s), or thumb), the impairment values are first combined for an overall loss of sensation value for the individual digit or hand. This value is then combined with other impairment values for that digit or hand prior to conversion.

(j) Hypersensitivity resulting in a loss of use in the digits or palm, is valued utilizing the above loss of sensation tables. Mild hypersensitivity is valued at the equivalent impairment level as less than normal sensation, moderate hypersensitivity the equivalent of protective sensation loss, and severe hypersensitivity the equivalent of a total loss of sensation.

(2) When surgery or an injury results in arm length discrepancies involving the injured arm, the following values are given on the affected arm for the length discrepancy: [Values not included. See ED. NOTE.]

(3) Joint instability in the finger(s), thumb, or hand is rated according to the body part affected: [Rating not included. See ED. NOTE.]

(4) Lateral deviation or malalignment of the upper extremity is valued as follows:

(a) Increased lateral deviation at the elbow is determined as follows: [Values not included. See ED. NOTE.]

(b) Fracture resulting in angulation or malalignment, other than at the elbow, is determined as follows: [Values not included. See ED. NOTE.]

(5) Surgery on the upper extremity is valued as follows:

(a) Finger/Thumb Surgery Finger Impairment Prosthetic joint replacement 1/2 the lowest ankylosis value for the involved joint [Values not included. See ED. NOTE.]

(b) Forearm/Hand Surgery Forearm/Hand Impairment Carpometacarpal arthroplasty1/2 the lowest ankylosis value for the involved joint; [Values not included. See ED. NOTE.]

(6) Dermatological conditions, including burns, which are limited to the arm, forearm, hand, fingers, or thumb are rated according to the body part affected. The percentages indicated in the classes below are

applied to the affected body part(s), e.g. a Class 1 dermatological condition of the thumb is 3% of the thumb, or a Class 1 dermatological condition of the hand is 3% of the hand, or a Class 1 dermatological condition of the arm is 3% of the arm. Contact dermatitis of an upper extremity is rated in this section unless it is an allergic systemic reaction, which is also rated under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated under OAR 436-035-0440. Impairments may or may not show signs or symptoms of skin disorder upon examination but are rated according to the following classes:

(a) Class 1: 3% for the affected body part if treatment results in no more than minimal limitation in the performance of activities of daily living, although exposure to physical or chemical agents may temporarily increase limitations.

(b) Class 2: 15% for the affected body part if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of activities of daily living.

(c) Class 3: 38% for the affected body part if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of activities of daily living.

(d) Class 4: 68% for the affected body part if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of activities of daily living.

(e) Class 5: 90% for the affected body part if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or being permanently admitted to a care facility, and the worker has severe limitations in the performance of activities of daily living.

(7) Vascular dysfunction of the upper extremity is valued according to the affected body part, using the following classification table:

(a) Class 1: 3% for the affected body part if the worker experiences only transient edema; and on physical examination, the findings are limited to the following: loss of pulses, minimal loss of subcutaneous tissue of fingertips, calcification of arteries as detected by radiographic examination, asymptomatic dilation of arteries or veins (not requiring surgery and not resulting in curtailment of activity), or cold intolerance (e.g. Raynaud's phenomenon) which results in a loss of use or function that occurs with exposure to temperatures below freezing (0° Centigrade).

(b) Class 2: 15% for the affected body part if the worker experiences intermittent pain with repetitive exertional activity; or there is persistent moderate edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed stump of an amputated digit, with evidence of persistent vascular disease, or a healed ulcer; or cold intolerance (e.g. Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 4° Centigrade.

(c) Class 3: 35% for the affected body part if the worker experiences intermittent pain with moderate upper extremity usage; or there is marked edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed amputation of two or more digits, with evidence of persistent vascular disease, or superficial ulceration; or cold intolerance (e.g. Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 10° Centigrade.

(d) Class 4: 63% for the affected body part if the worker experiences intermittent pain upon mild upper extremity usage; or there is marked edema that cannot be controlled by elastic supports; or there are signs of vascular damage such as an amputation at or above the wrist, with evidence of persistent vascular disease, or persistent widespread or deep ulceration involving one extremity; or cold intolerance (e.g. Raynaud's phenomenon) which results in a loss of use or function that occurs on exposure to temperatures below 15° Centigrade.

(e) Class 5: 88% for the affected body part if the worker experiences constant and severe pain at rest; or there are signs of vascular damage involving more than one extremity such as amputation at or above the wrist, or amputation of all digits involving more than one extremity with evidence of persistent vascular disease, or persistent widespread deep ulceration involving more than one extremity; or cold intolerance such as Raynaud's phenomenon which results in a loss of use or function that occurs on exposure to temperatures below 20° Centigrade.

(f) If partial amputation of the affected body part occurs as a result of vascular disease, the impairment values are rated separately.

(8) Injuries to unilateral spinal nerve roots or brachial plexus with resultant loss of strength in the arm, forearm or hand are determined according to the specific nerve root which supplies (innervates) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7): [Table not included. See ED. NOTE.]

(a) SPINAL NERVE ROOT Arm Impairment: [Table not included. See ED. NOTE.]

(b) For loss of strength in bilateral extremities, each extremity is rated separately.

(9) When a spinal nerve root or brachial plexus are not injured, valid loss of strength in the arm, forearm or hand, substantiated by clinical findings, is valued based on the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength, as described in the following table and as modified under OAR 436-035-0011(7). [Table not included. See ED. NOTE.]

(a) Loss of strength due to an injury in a single finger or thumb receives a value of zero.

(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(d) When loss of strength is present in the shoulder, refer to OAR 436-035-0330 for determination of the impairment.

(10) For motor loss in any part of an arm which is due to brain or spinal cord damage, impairment is valued as follows:

(a) Severity of Motor Loss Arm Impairment: [Value not included. See ED. NOTE.]

(b) When a value is granted under subsection (a) of this section, additional impairment values are not allowed for weakness, chronic condition, or reduced range of motion in the same extremity.

(c) For bilateral extremity loss, each extremity is rated separately.

(11) Neurological dysfunction resulting in cold intolerance in the upper extremity is valued according to the affected body part utilizing the same classifications for cold intolerance due to vascular dysfunction in section (7) of this rule.

[ED. NOTE: Ratings and Values referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0530, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988, f. 8-22-88, cert. ef. 8-1-9-88; WCD 5-1988, f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0220; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-035-0115
Conversion of Upper Extremity Values to Whole Person Values

(1) The tables in this rule are used to convert losses in the upper extremity to a whole person (WP) value for claims with a date of injury on or after January 1, 2005.

(2) The following table is used to convert losses in the thumb and fingers to a whole person (WP) value.

(3) The following table is used to convert a loss in a hand/forearm to a whole person (WP) value.

(4) The following table is used to convert a loss in the arm to a whole person (WP) value.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656
Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0130
Parts of the Lower Extremities

(1) The leg begins with the femoral head and includes the knee joint.

(2) The foot begins just distal to the knee joint and extends just proximal to the metatarsophalangeal joints of the toes.

(3) The toes begin at the metatarsophalangeal joints. Disabilities in the toes are not converted to foot values, regardless of the number of toes involved, unless the foot is also impaired.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0535, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0240; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0140
Amputations in the Lower Extremities

(1) Amputation at or above the knee joint (up to and including the femoral head) is rated at 100% loss of the leg.

(2) Amputation of the foot:

(a) At or above the tibio-talar joint but below the knee joint is rated at 100% loss of the foot.

(b) At the tarsometatarsal joints is rated at 75% loss of the foot.

(c) At the mid-metatarsal area is rated at 50% of the foot.

(d) Loss of all or part of a metatarsal is rated at 10% of the foot.

(3) Amputation of the great toe:

(a) At the interphalangeal joint is rated at 50% loss of the great toe. Between the interphalangeal joint and the tip will be rated in 5% increments, starting with zero for no loss of the tip.

(b) At the metatarsophalangeal joint is rated at 100% loss of the great toe. Between the interphalangeal joint and the metatarsophalangeal joint will be rated in 5% increments, starting with 50% of the great toe for amputation at the interphalangeal joint.

(4) Amputation of the second through fifth toes:

(a) At the distal interphalangeal joint is rated at 50% loss of the toe. Between the distal interphalangeal and the tip will be rated in 5% increments, starting with zero for no loss of the tip.

(b) At the proximal interphalangeal joint is rated at 75% loss of the toe. Between the proximal interphalangeal joint and the distal interphalangeal joint will be rated in 5% increments, starting with 50% of the toe for amputation at the distal interphalangeal joint.

(c) At the metatarsophalangeal joint is rated at 100% loss of the toe. Between the proximal interphalangeal joint and the metatarsophalangeal joint will be rated in 5% increments, starting with 75% of the toe for amputation at the proximal interphalangeal joint.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0536, 5-1-85; WCD 2-1988, f. 6-3-87, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0250; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0150
Great Toe

(1) The following ratings are for loss of plantarflexion in the interphalangeal joint of the great toe: [Rating not included. See ED. NOTE.]

(2) The following ratings are for plantarflexion ankylosis of the interphalangeal joint of the great toe: [Rating not included. See ED. NOTE.]

(3) The following ratings are for loss of dorsiflexion (extension) in the metatarsophalangeal joint of the great toe: [Rating not included. See ED. NOTE.]

(4) The following ratings are for dorsiflexion (extension) ankylosis of the metatarsophalangeal joint of the great toe: [Rating not included. See ED. NOTE.]

(5) The following ratings are for loss of plantarflexion in the metatarsophalangeal joint of the great toe: [Rating not included. See ED. NOTE.]

(6) The following ratings are for plantar flexion ankylosis of the metatarsophalangeal joint of the great toe: [Rating not included. See ED. NOTE.]

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0537, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0260; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03

436-035-0160
Second through Fifth Toes

(1) No rating is given for loss of motion in the distal interphalangeal joint of the second through fifth toes (to be referred to as toes), except in the case of ankylosis.

(2) Ankylosis in the distal interphalangeal joint of the toes is rated as follows: [Rating not included. See ED. NOTE.]

(3) No rating is given for loss of motion in the proximal interphalangeal joint of the toes, except in the case of ankylosis.

(4) Ankylosis in the proximal interphalangeal joint of the toes is rated as follows: [Rating not included. See ED. NOTE.]

(5) The following ratings are for loss of dorsiflexion (extension) in the metatarsophalangeal joints of the toes: [Rating not included. See ED. NOTE.]

(6) The following ratings are for dorsiflexion (extension) ankylosis in the metatarsophalangeal joints of the toes: [Rating not included. See ED. NOTE.]

(7) The following ratings are for loss of (plantar) flexion in the metatarsophalangeal joints of the toes: [Rating not included. See ED. NOTE.]

(8) Plantarflexion ankylosis in the metatarsophalangeal joints of the toes is rated as follows: [Rating not included. See ED. NOTE.]

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0510, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0280; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0180
Conversion of Toe Values to Foot Value

(1) If the only findings are in the toes, it is not possible to convert the toe findings to a loss in the foot unless there are impairment findings in the foot. Each toe must be converted to the foot separately. After converting to the foot, each converted value is added.

(2) If there are impairment findings in the foot and impairment findings in the great toe, the following table is used to convert losses in the great toe to losses in the foot: [Table not included. See ED. NOTE.]

(3) If there are impairment findings in the foot and impairment findings in the second through the fifth toes, the following table is used to convert losses in the toes to losses in the foot: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0515, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0290; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97

436-035-0190
Foot

(1) Ankylosis at the tarsometatarsal joints receives a rating of 10% of the foot for each of the tarsometatarsal joints ankylosed.

(2) The following ratings are for loss of subtalar inversion in the foot: [Rating not included. See ED. NOTE.]

(3) The following ratings are for subtalar inversion (varus) ankylosis in the foot: [Rating not included. See ED. NOTE.]

(4) The following ratings are for loss of subtalar eversion in the foot: [Rating not included. See ED. NOTE.]

(5) The following ratings are for subtalar eversion (valgus) ankylosis in the foot: [Rating not included. See ED. NOTE.]

(6) The following ratings are for loss of dorsiflexion (extension) in the ankle joint: [Rating not included. See ED. NOTE.]

(7) The following ratings are for dorsiflexion (extension) ankylosis in the ankle joint: [Rating not included. See ED. NOTE.]

(8) The following ratings are for loss of plantar flexion in the ankle joint: [Rating not included. See ED. NOTE.]

(9) The following ratings are for plantar flexion ankylosis in the ankle joint: [Rating not included. See ED. NOTE.]

(10) The following applies when determining impairment for loss of motion or ankylosis in the ankle or subtalar joint:

(a) If there is loss of motion only (no ankylosis in either joint) in the subtalar joint or the ankle joint, the following applies:

(A) the values for loss of motion in the subtalar joint are added;

(B) the values for loss of motion in the ankle joint are added;

(C) the value for loss of motion in the subtalar joint is added to the value for loss of motion in the ankle joint.

(b) If there is ankylosis in the ankle or subtalar joint, the following applies:

(A) When there is ankylosis in one joint only with no loss of motion or ankylosis in the other joint, that ankylosis value is granted.

(B) When there is loss of motion in one joint and ankylosis in the other joint, add the ankylosis value to the value for loss of motion in the non-ankylosed joint.

(C) When the ankle joint is ankylosed in plantar flexion and dorsiflexion, use only the largest ankylosis value for rating the loss or only one of the values if they are identical. Under OAR 436-035-0007(9), this ankylosis value is granted in lieu of all other range of motion or ankylosis values for the ankle joint.

(D) When the subtalar joint is ankylosed in inversion and eversion, use only the largest ankylosis value for rating the loss or only one of the values if they are identical. Under OAR 436-035-0007(9), this ankylosis value is granted in lieu of all other range of motion or ankylosis values for the subtalar joint.

(E) When both joints are ankylosed, add the ankle joint value to the subtalar joint value.

[ED. NOTE: Ratings referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0524, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0310; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0210
Conversion of Foot Value to Leg Value

The following ratings are for converting losses in the foot to losses in the leg:

Impairment of Foot - Leg	Impairment of Foot - Leg	Impairment of Foot - Leg	Impairment of Foot - Leg
1% = 1%	27% = 24%	52% = 47%	77% = 69%
2% = 2%	28% = 25%	53% = 48%	78% = 70%
3% = 3%	29% = 26%	54% = 49%	79% = 71%
4% = 4%	30% = 27%	55–56% = 50%	80% = 72%
5–6% = 5%	31% = 28%	57% = 51%	81% = 73%
7% = 6%	32% = 29%	58% = 52%	82% = 74%
8% = 7%	33% = 30%	59% = 53%	83% = 75%
9% = 8%	34% = 31%	60% = 54%	84% = 76%
10% = 9%	35–36% = 32%	61% = 55%	85–86% = 77%
11% = 10%	37% = 33%	62% = 56%	87% = 78%
12% = 11%	38% = 34%	63% = 57%	88% = 79%
13% = 12%	39% = 35%	64% = 58%	89% = 80%
14% = 13%	40% = 36%	65–66% = 59%	90% = 81%
15–16% = 14%	41% = 37%	67 = 60%	91% = 82%
17% = 15%	42% = 38%	68% = 61%	92% = 83%
18% = 16%	43% = 39%	69% = 62%	93% = 84%
19% = 17%	44% = 40%	70% = 63%	94% = 85%
20% = 18%	45–46% = 41%	71% = 64%	95–96% = 86%
21% = 19%	47% = 42%	72% = 65%	97% = 87%
22% = 20%	48% = 43%	73% = 66%	98% = 88%
23% = 21%	49% = 44%	74% = 67%	99% = 89%
24% = 22%	50% = 45%	75–76% = 68%	100% = 90%
25–26% = 23%	51% = 46%		

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0525, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0320; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91

436-035-0220
Leg

(1) The following ratings are for loss of flexion in the knee (150° describes the knee in full flexion): [Rating not included. See ED. NOTE.]

(2) The following ratings are for loss of extension in the knee (0° describes the knee in full extension): [Rating not included. See ED. NOTE.]

(3) Ankylosis of the knee in flexion or extension shall be rated as follows: [Rating not included. See ED. NOTE.]

(4) The determination of loss of range of motion in the hip is valued in this section when there is no pelvic bone involvement. Loss associated with pelvic bone involvement is determined pursuant to OAR 436-035-0340.

(5) The following ratings are for loss of forward flexion in the hip: [Rating not included. See ED. NOTE.]

(6) The following ratings are for loss of backward extension in the hip joint: [Rating not included. See ED. NOTE.]

(7) The following ratings are for loss of abduction in the hip joint: [Rating not included. See ED. NOTE.]

(8) The following ratings are for loss of adduction in the hip joint: [Rating not included. See ED. NOTE.]

(9) The following ratings are for loss of internal rotation in the hip joint: [Rating not included. See ED. NOTE.]

(10) The following ratings are for loss of external rotation in the hip joint: [Rating not included. See ED. NOTE.]

(11) Ankylosis in the hip joint is rated under OAR 436-035-0340.

[ED. NOTE: Ratings referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0530, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0330; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0230
Other Lower Extremity Findings

(1) Loss or alteration (e.g. hypersensitivity) of sensation in the leg is not considered disabling except for the plantar surface of the foot and toes, including the great toe, where it is rated as follows: [Table not included. See ED. NOTE.]

(2) The following ratings are for length discrepancies of the injured leg. However, loss of length due to flexion/extension deformities are excluded. The rating is the same whether the length change is a result of an injury to the foot or to the upper leg: [Rates not included. See ED. NOTE.]

(3) Valid instability in the ankle or knee substantiated by clinical findings is valued based on the ligament demonstrating the laxity, as described in the following table: [Table not included. See ED. NOTE.]

(5) The following values are for surgery of the toes, foot, or leg: [Values not included. See ED. NOTE.]

(6) Dermatological conditions including burns which are limited to the leg or foot are rated according to the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g. a Class 1 dermatological condition of the foot is 3% of the foot, or a Class 1 dermatological condition of the leg is 3% of the leg. Contact dermatitis is determined under this section unless it is caused by an allergic systemic reaction which is also determined under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated under OAR 436-035-0440. Impairments may or may not show signs or symptoms of skin disorder upon examination but are rated according to the following classes:

(a) Class 1: 3% for the leg or foot if treatment results in no more than minimal limitations in the performance of the activities of daily living, although exposure to physical or chemical agents may temporarily increase limitations.

(b) Class 2: 15% for the leg or foot if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of activities of daily living.

(c) Class 3: 38% for the leg or foot if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of activities of daily living.

(d) Class 4: 68% for the leg or foot if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of activities of daily living.

(e) Class 5: 90% for the leg or foot if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or permanently admitting the worker to a care facility, and the worker has severe limitations in the performance of activities of daily living.

(f) Full thickness skin loss of the heel is valued at 10% of the foot, even when the area is successfully covered with an appropriate skin graft.

(7) The following ratings are for vascular dysfunction of the leg. The impairment values are determined according to the following classifications:

(a) Class 1: 3% for the leg. Workers belong in Class 1 when any of the following exist:

(A) Loss of pulses in the foot.

(B) Minimal loss of subcutaneous tissue.

(C) Calcification of the arteries (as revealed by x-ray).

(D) Transient edema.

(b) Class 2: 15% for the leg. Workers belong in Class 2 when they suffer from any of the following:

(A) Limping due to intermittent claudication that occurs when walking at least 100 yards.

(B) Vascular damage, as evidenced by a healed painless stump of a single amputated toe, with evidence of chronic vascular dysfunction or a healed ulcer.

(C) Persistent moderate edema which is only partially controlled by support hose.

(c) Class 3: 35% for the leg. Workers belong in Class 3 when they suffer from any of the following:

(A) Limping due to intermittent claudication when walking as little as 25 yards and no more than 100 yards.

(B) Vascular damage, as evidenced by healed amputation stumps of two or more toes on one foot, with evidence of chronic vascular dysfunction or persistent superficial ulcers on one leg.

(C) Obvious severe edema which is only partially controlled by support hose.

(d) Class 4: 63% for the leg. Workers belong in Class 4 when they suffer from any of the following:

(A) Limping due to intermittent claudication after walking less than 25 yards.

(B) Intermittent Pain in the legs due to intermittent claudication when at rest.

(C) Vascular damage, as evidenced by amputation at or above the ankle on one leg, or amputation of two or more toes on both feet, with evidence of chronic vascular dysfunction or widespread or deep ulcers on one leg.

(D) Obvious severe edema which cannot be controlled with support hose.

(e) Class 5: 88% for the leg. Workers belong in Class 5 when they suffer from either of the following:

(A) Constant severe pain due to claudication at rest.

(B) Vascular damage, as evidenced by amputations at or above the ankles of both legs, or amputation of all toes on both feet, with evidence of persistent vascular dysfunction or of persistent, widespread, or deep ulcerations on both legs.

(f) If partial amputation of the lower extremity occurs as a result of vascular dysfunction, the impairment values are rated separately. The amputation value is then combined with the impairment value for the vascular dysfunction.

(8) Injuries to unilateral spinal nerve roots with resultant loss of strength in the leg or foot is determined according to the specific nerve root supplying (innervating) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7). [Table not included. See ED. NOTE.]

(9) When a spinal nerve root or lumbosacral plexus are not injured, valid loss of strength in the leg or foot, substantiated by clinical findings, is valued based on the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength, as described in the following table and as modified under OAR 436-035-0011(7). [Table not included. See ED. NOTE.]

(a) Loss of strength due to an injury in a single toe receives a value of zero.

(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(10) For motor loss to any part of a leg which is due to brain or spinal cord damage, impairment is valued as follows: [Value not included. See ED. NOTE.]

(11) If there is a diagnosis of Grade IV chondromalacia, extensive arthritis or extensive degenerative joint disease and one or more of the following are present: secondary strength loss; chronic effusion; varus or valgus deformity less than that specified in section (4) of this rule, then one or more of the following rating values apply:

(a) 5% of the foot for the ankle joint; or

(b) 5% of the leg for the knee joint.

(12) For a diagnosis of degenerative joint disease, chondromalacia, or arthritis which does not meet the criteria noted in section (11) of this rule, the impairment is determined under the chronic condition rule (OAR 436-035-0019) if the criteria in that rule is met.

(13) Other impairment values, e.g., weakness, chronic condition, reduced range of motion, etc., are combined with the value granted in section (11) of this rule.

(14) When there is an injury to the knee/leg and objective medical evidence establishes the worker cannot walk or stand or both for a total of more than two hours in an 8-hour period, the award is 15% of the knee/leg, except for:

(a) A worker who is entitled to receive an impairment value under section (11) of this rule (degenerative joint disease, arthritis or chondromalacia) is awarded 10% of the knee/leg, in lieu of the 15%.

(b) A worker who is entitled to receive a dermatological or vascular impairment value, Class II or higher, under section (6) or (7) of this rule is not allowed an additional value under this section.

(c) When a worker qualifies to receive a value under section (15) of this rule and a value pursuant to this section, only one of the values is granted for limited standing or walking; the higher monetary value.

(15) Where the objective medical evidence indicates a severe injury to the foot/ankle has occurred (e.g. severe soft tissue crush injuries, trimalleolar fracture, calcaneal fractures, or post-traumatic avascular necrosis), the following applies:

(a) When objective medical evidence establishes the worker cannot walk or stand or both for a total of more than two hours in an 8-hour period, the award is 15% of the foot/ankle, except for (b) of this section.

(b) A worker who has a dermatological or vascular impairment value, Class II or higher, under section (6) or (7) of this rule, is not allowed an additional value under this section.

(c) When a worker qualifies to receive a value under section (14) of this rule, as well as a value under this section, only the one resulting in the higher monetary value is granted.

[ED. NOTE: Ratings & Values referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80.; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0532, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0340; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 10-1992(Temp), f. & cert. ef. 6-1-92; WCD 15-1992, f. 11-20-92, cert. ef. 11-27-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0235

Conversion of Lower Extremity Values to Whole Person Values

(1) The tables in this rule are used to convert losses in the lower extremity to a whole person (WP) value for claims with a date of injury on or after January 1, 2005.

(2) The following table is used to convert losses in the great toe to a whole person (WP) value. Impairment in any of the other toes receives a whole person value of 1% for each toe that is injured.

(3) The following table is used to convert a loss in the foot to a whole person (WP) value.

(4) The following table is used to convert a loss in the leg to a whole person (WP) value.

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0250

Hearing Loss

(1) The following information is provided by the attending physician or reviewed and commented on by the attending physician, under OAR 436-035-0007(5) and (6), to value work-related hearing loss:

(a) A written record, history, examination, diagnosis, opinion, interpretation and a statement noting if further material improvement would reasonably be expected from medical treatment or the passage

of time by a medical provider with specialty training or experience in evaluating hearing loss.

(b) The complete audiometric testing.

(2) Compensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure. Unless the conditions have combined under OAR 436-035-0014(1), hearing loss which existed before this injury or exposure will be offset against hearing loss in the claim, if adequately documented by a baseline audiogram obtained within 180 days of assignment to a high noise environment.

(a) The offset will be done at the monaural percentage of impairment level.

(b) Determine the monaural percentage of impairment for the baseline audiogram under section (4) of this rule.

(c) Subtract the baseline audiogram impairment from the current audiogram impairment to obtain the impairment value.

(3) Hearing loss is based on audiograms which must report on air conduction frequencies at 500, 1,000, 2,000, 3,000, 4,000 and 6,000 Hz.

(a) Audiograms should be based on **American National Standards Institute S3.6 (1989) standards**.

(b) Test results will be accepted only if they come from a test conducted at least 14 consecutive hours after the worker has been removed from significant exposure to noise.

(4) Impairment of hearing is calculated from the number of decibels by which the worker's hearing exceeds 150 decibels (hearing impairment threshold). Compensation for monaural hearing loss is calculated as follows:

(a) Add the audiogram findings at 500, 1,000, 2,000, 3,000, 4,000 and 6,000 Hz. Decibel readings in excess of 100 will be entered into the computations as 100 dB.

(b) Hearing loss due to presbycusis is based on the worker's age at the time of the audiogram. Consult the Presbycusis Correction Values Table below. (These values represent the total decibels of hearing loss in the six standard frequencies which normally results from aging.) Find the figure for presbycusis hearing loss. Take this presbycusis figure and subtract the hearing impairment threshold of 150 decibels. Subtract any positive value from the sum of the audiogram entries. This value represents the total decibels of hearing loss in the six standard frequencies which normally results from aging that exceed the hearing impairment threshold. (If there is no positive value there is no hearing impairment attributable to presbycusis above the hearing impairment threshold.)

(c) Consult the Monaural Hearing Loss Table below, using the figure found in subsection (b) of this section. This table will give you the percent of monaural hearing loss to be compensated.

(d) No value is allowed for db totals of 150 or less. The value for db totals of 550 or more is 100%.

(5) Binaural hearing loss is calculated as follows:

(a) Find the percent of monaural hearing loss for each ear by using the method listed in (4)(a)–(c) above.

(b) Multiply the percent of loss in the better ear by seven.

(c) Add to that result the percent of loss in the other ear.

(d) Divide this sum by eight. This is the percent of binaural hearing loss to be compensated.

(e) This method is expressed by the formula: [Formula not included. See ED. NOTE.]

(6) Use the method (monaural or binaural) which results in the greater impairment.

(7) Tinnitus and other auditory losses may be determined as losses under OAR 436-035-0390.

[ED. NOTE: Tables and Formulas referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats.Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0536, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0360; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 1-1997, f. & cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0255
Conversion of Hearing Loss Values to Whole Person Values

(1) The following table is used to convert a loss of hearing in one ear to a whole person (WP) value for claims with a date of injury on or after January 1, 2005. [Table not included. See ED. NOTE.]

(2) The following table is used to convert a loss of hearing in two ears to a whole person (WP) value for claims with a date of injury on or after January 1, 2005. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats.Implemented: ORS 656
Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0260
Visual Loss

(1) Visual loss due to a work-related illness or injury is rated for central visual acuity, integrity of the peripheral visual fields, and ocular motility. For ocular disturbances which cause visual impairment that is not reflected in visual acuity, visual fields or ocular motility refer to section (5) of this rule. For lacrimal system disturbances refer to OAR 436-035-0440.

(2) Ratings for loss in central visual acuity are calculated for each eye as follows:

(a) Reports for central visual acuity must be for distance and near acuity. Both acuities are measured with best correction, utilizing the lenses recommended by the worker's physician.

(b) The ratings for loss of distance acuity are as follows, reported in standard increments of Snellen notation for English and Metric 6: [Ratings not included. See ED. NOTE.]

(c) The ratings for loss of near acuity are as follows: reported in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation: [Ratings not included. See ED. NOTE.]

(d) Once the ratings for near and distance acuity are found, add them and divide by two. The value which results is the rating for lost central visual acuity.

(e) If a lens has been removed and a prosthetic lens implanted, an additional 25%, is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(f) If a lens has been removed and there is no prosthetic lens implanted, an additional 50% is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(g) The table below may be substituted for combining central visual acuity and the loss of a lens for a total central visual acuity. The table displays the percent loss of central vision for the range of near and distance acuity combined with lens removal for a total central visual acuity. The upper figure is to be used when the lens is present (as found in (d)), the middle figure is to be used when the lens is absent and a prosthetic lens has been implanted (as found in (e)), and the lower figure is to be used when the lens is absent with no implant (as found in (f)). If near acuity is reported in Revised Jaeger Standard or American Point-type, convert these findings to Near Snellen for rating purposes under (2)(c) of this rule when using this table.

(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using the Goldmann perimeter with a III/4e stimulus. The results may be scored in either one of the two following methods:

(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or

(b) A perimetric chart may be used which indicates the extent of retained vision for each of the eight standard 45% meridians out to 90%. The directions and normal extent of each meridian are as follows: [Ratings not included. See ED. NOTE.]

(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.

(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.

(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

(4) Ratings for ocular motility impairment resulting in binocular diplopia are determined as follows:

(a) Determine the single highest value of loss for diplopia noted on each of the standard 45% meridians as listed in the following table.

(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more is rated as 100% of the eye. As an example: Diplopia on looking horizontally off center from 30 degrees in a left direction is valued at 10%. Diplopia in the same eye when looking horizontally off center from 21 to 30 degrees in a right direction is valued at 20%. The impairments for diplopia in both ranges are added, so the impairment rating would be 10% plus 20% resulting in a total loss of ocular motility of 30%.

(5) To the extent that stereopsis (depth perception), glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields or ocular motility will be combined with an additional 5% when in the opinion of the physician the impairment is moderate, 10% if the impairment is severe.

(6) The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and loss of ocular motility and loss for other conditions specified in section (5) of this rule.

(7) The total rating for binocular loss is figured as follows:

(a) Find the percent of monocular loss for each eye.

(b) Multiply the percent of loss in the better eye by three.

(c) Add to that result the percent of loss in the other eye.

(d) Divide this sum by four. The result is the total percentage of binocular loss.

(e) This method is expressed by the formula: [Formula not included. See ED. NOTE.]

(8) Use the method (monocular or binocular) which results in the greater impairment rating.

[ED. NOTE: Formula and Ratings referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0575, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0370; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 6-1999, f. & cert. ef. 4-26-99; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0265
Conversion of Vision Loss Values to Whole Person Values

(1) The following table is used to convert vision loss in one eye to a whole person (WP) value for claims with a date of injury on or after January 1, 2005: [Table not included. See ED. NOTE.]

(2) The following table is used to convert vision loss in both eyes to a whole person (WP) value for claims with a date of injury on or after January 1, 2005: [Table not included. See ED. NOTE.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656

Hist.: WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0330
Shoulder Joint

(1) The following ratings are for loss of forward elevation (flexion) in the shoulder joint: [Ratings not included. See ED. NOTE.]

(2) The following ratings are for forward elevation (flexion) ankylosis in the shoulder joint: [Ratings not included. See ED. NOTE.]

(3) The following ratings are for loss of backward elevation (extension) in the shoulder joint: [Ratings not included. See ED. NOTE.]

(4) The following ratings are for backward elevation (extension) ankylosis in the shoulder joint: [Ratings not included. See ED. NOTE.]

(5) The following ratings are for loss of abduction in the shoulder joint: [Ratings not included. See ED. NOTE.]

(6) The following ratings are for abduction ankylosis in the shoulder joint: [Ratings not included. See ED. NOTE.]

(7) The following ratings are for loss of adduction in the shoulder joint: [Ratings not included. See ED. NOTE.]

(8) The following ratings are for adduction ankylosis in the shoulder joint: [Ratings not included. See ED. NOTE.]

(9) The following ratings are for loss of internal rotation in the shoulder joint: [Ratings not included. See ED. NOTE.]

(10) The following ratings are for internal rotation ankylosis in the shoulder joint: [Ratings not included. See ED. NOTE.]

(11) The following ratings are for loss of external rotation in the shoulder joint: [Ratings not included. See ED. NOTE.]

(12) The following ratings are for external rotation ankylosis in the shoulder joint: [Ratings not included. See ED. NOTE.]

(13) Shoulder surgery is rated as follows: [Ratings not included. See ED. NOTE.]

(14) Chronic dislocations of the shoulder joint or diastasis of a sternal joint, are valued at 15% impairment when a preponderance of medical opinion places permanent new restrictions on the worker which necessitate a reduction in the strength lifting category under OAR 436-035-0012.

(15) When two or more ranges of motion are restricted, add the impairment values for decreased range of motion.

(16) When two or more ankylosis positions are documented, select the one direction representing the largest impairment. That will be the impairment value for the shoulder represented by ankylosis.

(17) Valid losses of strength in the shoulder or back, substantiated by clinical findings, are valued based on the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength, as described in the following table and as modified under OAR 436-035-0011(7): [Ratings not included. See ED. NOTE.]

(18) Multiple or bilateral decreased strength impairment findings are determined by combining the values in section (17) of this rule.

[ED. NOTE: Examples & Ratings referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented.: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0610, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988, f. 8-22-88, cert. ef. 8-19-88; WCD 5-1988(Temp), f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0480; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91 WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 10-1998(Temp), f. & cert. ef. 10-28-98 thru 4-25-99; WCD 6-1999, f. & cert. ef. 4-26-99; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0340
Hip

(1) When a preponderance of objective medical evidence supports findings that reduced ranges of motion of the hip do not involve the pelvis or acetabulum, the impairment determination is valued according to OAR 436-035-0220. If the reduced ranges of motion are a residual of pelvic or acetabular involvement, the impairment is determined under this rule.

(2) The following ratings are for loss of forward flexion in the hip joint: [Ratings not included. See ED. NOTE.]

(3) The following ratings are for forward flexion ankylosis in the hip joint: [Ratings not included. See ED. NOTE.]

(4) The following ratings are for loss of backward extension in the hip joint: [Ratings not included. See ED. NOTE.]

(5) The following ratings are for backward extension ankylosis of the hip joint: [Ratings not included. See ED. NOTE.]

(6) The following ratings are for loss of abduction in the hip joint: [Ratings not included. See ED. NOTE.]

(7) The following ratings are for abduction ankylosis in the hip joint: [Ratings not included. See ED. NOTE.]

(8) The following ratings are for loss of adduction in the hip joint: [Ratings not included. See ED. NOTE.]

(9) The following ratings are for adduction ankylosis in the hip joint: [Ratings not included. See ED. NOTE.]

(10) The following ratings are for loss of internal rotation of the hip joint: [Ratings not included. See ED. NOTE.]

(11) The following ratings are for internal rotation ankylosis of the hip joint: [Ratings not included. See ED. NOTE.]

(12) The following ratings are for loss of external rotation of the hip joint: [Ratings not included. See ED. NOTE.]

(13) The following ratings are for external rotation ankylosis of the hip joint: [Ratings not included. See ED. NOTE.]

(14) When two or more ankylosis positions are documented, select the one direction representing the largest impairment. That will be the impairment value for the hip represented by ankylosis.

(15) A value of 13% is determined for a total hip replacement (both femoral and acetabular components involved). If a total hip replacement surgery occurs following an earlier femoral head replacement surgery under OAR 436-035-0230(5), both impairment values are rated.

(16) A value of 5% is awarded for a repeat total hip replacement surgery.

(17) Total value for loss of range of motion is obtained by adding (not combining) the values for each range of motion.

(18) The final value for the hip is obtained by combining (not adding) the values in sections (15), (16) and (17) of this rule.

(19) Healed displaced fractures in the hip may cause leg length discrepancies. Impairment is determined under OAR 436-035-0230.

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0481; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0350
General Spinal Findings

(1) The following ratings are for fractured vertebrae:

(a) For a compression fracture of a single vertebral body: [Tables not included. See ED. NOTE.]

(b) A fracture of one or more of the posterior elements of a vertebra (spinous process, pedicles, laminae, articular processes, or transverse processes) is valued per vertebra as follows: [Tables not included. See ED. NOTE.]

(2) For the purposes of this section, the cervical, thoracic, and lumbosacral regions are considered separate body parts. Values determined within one body part are first added, then the total impairment value is obtained by combining the different body part values. The following values are for surgical procedures performed on the spine. [Tables not included. See ED. NOTE.]

(3) For injuries that result in loss of strength in the back, refer to OAR 436-035-0330(17) and (18).

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0610, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988, f. 8-22-88, cert. ef. 8-19-88; WCD 5-1988(Temp), f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0490; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91 & cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-035-0360
Spinal Ranges of Motion

(1) For the purpose of determining impairment due to loss of spinal range of motion, sections (2) through (12) of this rule apply when the physician uses an inclinometer to measure impairment.

(2) The following ratings are for loss of flexion in the cervical region: [Ratings not included. See ED. NOTE.]

(3) The following ratings are for loss of extension in the cervical region: [Ratings not included. See ED. NOTE.]

(4) The following ratings are for loss of right or left lateral flexion in the cervical region: [Ratings not included. See ED. NOTE.]

(5) The following ratings are for loss of right or left rotation in the cervical region: [Ratings not included. See ED. NOTE.]

(6) The following ratings are for loss of flexion in the thoracic region: [Ratings not included. See ED. NOTE.]

(7) The following ratings are for loss of right or left rotation in the thoracic region: [Ratings not included. See ED. NOTE.]

(8) The following ratings are for loss of flexion in the lumbosacral region: [Ratings not included. See ED. NOTE.]

(9) The following ratings are for loss of extension in the lumbosacral region: [Ratings not included. See ED. NOTE.]

(10) The following ratings are for loss of right or left lateral flexion of the lumbosacral region: [Ratings not included. See ED. NOTE.]

(11) For a total impairment value due to loss of motion, as measured by inclinometer, in any of the cervical, thoracic or lumbosacral regions, add (do not combine) values for loss of motion for each region.

(12) In order to rate range of motion loss and surgery in one region, combine (do not add) the total range of motion loss in that region with the appropriate total surgical impairment value of the corresponding region. Combine the value from each region to find the total impairment of the spine.

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0620, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0500; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1991(Temp), f. 9-13-91, cert. ef. 10-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0370
Pelvis

(1) A fractured pelvis which heals well, leaving no displacement, receives no rating.

(2) The following ratings are for a fractured pelvis which heals with displacement and deformity: [Ratings not included. See ED. NOTE.]

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats.Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0610, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988(Temp), f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0510; WCD 2-1991, f. 3-26-91 & cert. ef. 4-1-91; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03

436-035-0375
Abdomen

For injuries that result in permanent damage to the abdominal wall, 5% impairment is given if the physician places permanent restriction(s) on the worker which necessitates a reduction in the strength/lifting category of the job that the worker was performing at the time of injury.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988, f. 8-22-88, cert. ef. 8-19-88; WCD 5-1988, f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0380
Cardiovascular System

(1) Impairments of the cardiovascular system are determined based on objective findings that result in the following conditions: valvular heart disease, coronary heart disease, hypertensive cardiovascular disease, cardiomyopathies, pericardial disease, or cardiac arrhythmias. Each of these conditions will be described and quantified. In most circumstances, the physician should observe the patient during exercise testing.

(2) VALVULAR HEART DISEASE: Impairment resulting from work related valvular heart disease is rated according to the following classes: [Ratings not included. See ED. NOTE.]

(3) CORONARY HEART DISEASE: Impairment resulting from work related coronary heart disease is rated according to the following classes: [Ratings not included. See ED. NOTE.]

(4) HYPERTENSIVE CARDIOVASCULAR DISEASE: Impairment resulting from work related hypertensive cardiovascular disease is rated according to the following classes: [Ratings not included. See ED. NOTE.]

(5) CARDIOMYOPATHY: Impairment resulting from work related cardiomyopathies is rated according to the following classes: [Ratings not included. See ED. NOTE.]

(6) PERICARDIAL DISEASE: Impairment resulting from work related pericardial disease is rated according to the following classes: [Ratings not included. See ED. NOTE.]

(7) ARRYTHMIAS: Impairment resulting from work related cardiac arrhythmias* is rated according to the following classes: [Ratings not included. See ED. NOTE.]

(8) For heart transplants an impairment value of 50% is given. This value is combined with any other findings of impairment of the heart. [Ratings not included. See ED. NOTE.]

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0640, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988, f. 8-22-88, cert. ef. 8-19-88; WCD 5-1988(Temp), f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-

0520; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0385
Respiratory System

(1) For the purpose of this rule, the following definitions apply:

(a) FVC is Forced Vital Capacity.

(b) FEV1 is Forced Expiratory Volume in the first second.

(c) Dco refers to diffusing capacity of carbon monoxide.

(d) VO2 Max is Measured Exercise Capacity.

(2) Lung impairment is determined according to the following classes: [Ratings not included. See ED. NOTE.]

(3) LUNG CANCER — All persons with lung cancers as a result of a compensable industrial injury or occupational disease are to be considered Class 4 impaired at the time of diagnosis. At a re-evaluation, one year after the diagnosis is established, if the person is found to be free of all evidence of tumor, then he or she should be rated according to the physiologic parameters in OAR 436-035-0385(2). If there is evidence of tumor, the person is determined to have Class 4 impairment.

(4) ASTHMA — Reversible obstructive airway disease due to a compensable occupational disease or illness is rated according to the classes of respiratory impairment described in section (2) of this rule. The impairment is based on the best of three successive tests performed at least one week apart at a time when the patient is receiving optimal medical therapy. In addition, a worker may also have impairment determined under OAR 436-035-0450.

(5) ALLERGIC RESPIRATORY RESPONSES — For workers who have developed an allergic respiratory response to physical, chemical, or biological agents refer to OAR 436-035-0450. Methacholine inhalation testing is permitted at the discretion of the physician. Where methacholine inhalation testing leaves the worker at risk, level of impairment may be based on review of the medical record.

(6) Impairment from air passage defects is determined according to the following classes: [Ratings not included. See ED. NOTE.]

(7) Residual impairment from a lobectomy is valued based on the physiological parameters found under section (2) of this rule.

(8) For injuries which result in impaired ability to speak, the following table will rate the worker's ability to speak in relation to: Audibility (ability to speak loudly enough to be heard); Intelligibility (ability to articulate well enough to be understood); and Functional Efficiency (ability to produce a serviceably fast rate of speech and to sustain it over a useful period of time).

(a) Class 1, 4% impairment: Can produce speech of sufficient intensity and articular quality to meet most of the needs of everyday speech communication; some hesitation or slowness of speech may exist; certain phonetic units may be difficult or impossible to produce; listeners may require the speaker to repeat.

(b) Class 2, 9% impairment: Can produce speech of sufficient intensity and articular quality to meet many of the needs of everyday speech communication; speech may be discontinuous, hesitant or slow; can be understood by a stranger but may have numerous inaccuracies; may have difficulty being heard in loud places.

(c) Class 3, 18% impairment: Can produce speech of sufficient intensity and articular quality to meet some of the needs of everyday speech communication; often consecutive speech can only be sustained for brief periods; can converse with family and friends but may not be understood by strangers; may often be asked to repeat; has difficulty being heard in loud places; voice tires rapidly and tends to become inaudible after a few seconds.

(d) Class 4, 26% impairment: Can produce speech of sufficient intensity and articular quality to meet few of the needs of everyday speech communication; consecutive speech limited to single words or short phrases; speech is labored and impractically slow; can produce some phonetic units but may use approximations that are unintelligible or out of context; may be able to whisper audibly but has no voice.

(e) Class 5, 33% impairment: Complete inability to meet the needs of everyday speech communication.

(9) Workers with successful permanent tracheostomy or stoma should be rated at 25% impairment of the respiratory system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988, f. 8-22-88, cert. ef. 8-19-88; WCD 5-1988(Temp), f. 9-2-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0390
Cranial Nerves/Brain

(1) Impairment of the First Cranial Nerve (Olfactory) resulting in either complete inability to detect odors or alteration of the sense of smell is 3% impairment.

(2) Ratings given for impairment of the Second Cranial Nerve (Optic) are figured according to their effects on vision under OAR 436-035-0260.

(3) Ratings given for impairment in the Third Cranial Nerve (Oculomotor), Fourth Cranial Nerve (Trochlear), and Sixth Cranial Nerve (Abducens) are determined according to their effects on ocular motility under OAR 436-035-0260.

(4) Ratings given for impairment of the Fifth Cranial Nerve (Trigeminal) are as follows:

(a) For loss or alteration of sensation in the Trigeminal distribution on one side: 10%; on both sides: 35%

(b) The rating given for loss of motor function in one Trigeminal Nerve is 5%.

(c) The rating given for loss of motor function of both Trigeminal Nerves is determined under OAR 436-035-0385 and 436-035-0420.

(5) Ratings given for impairment of the Sixth Cranial Nerve (Abducens) are described in section (3) of this rule.

(6) Ratings given for impairment of the Seventh Cranial Nerve (Facial) are as follows:

(a) No rating is given for loss of sensation from impairment of one or both Facial Nerves.

(b) If impairment of one or both Facial Nerves results in loss or alteration of the sense of taste, the rating is 3%.

(c) Motor loss on one side of the face due to impairment of the Facial Nerve is rated at 15% for a complete loss, or 5% for a partial loss.

(d) Motor loss on both sides of the face due to impairment of the Facial Nerve is rated at 45% for a complete loss, or 20% for a partial loss.

(7) Ratings given for impairment of the Eighth Cranial Nerve (Auditory) are determined according to their effects on hearing under OAR 436-035-0250. Other ratings for loss of function most commonly associated with this nerve include the following:

(a) For permanent disturbances resulting in disequilibrium which limits activities the impairment is rated according to the following:

(A) 8% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living are performed without assistance.

(B) 23% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living can be performed without assistance, and the worker is unable to operate a motor vehicle.

(C) 48% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living cannot be performed without assistance.

(D) 80% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living cannot be performed without assistance, and confinement to the home or other facility is necessary.

(b) Tinnitus which by a preponderance of medical opinion requires job modification is valued at 5%. No additional impairment value is allowed for "bilateral" tinnitus.

(8) Ratings given for impairment of the Ninth Cranial Nerve (Glossopharyngeal), Tenth Cranial Nerve (Vagus), and Eleventh Cranial Nerve (Cranial Accessory) are as follows:

(a) Impairment of swallowing due to damage to the Ninth, Tenth, or Eleventh Cranial Nerves is determined under OAR 436-035-0420.

(b) Speech impairment due to damage to the Ninth, Tenth, or Eleventh Cranial Nerves is rated according to the classifications in OAR 436-035-0385(8).

(9) Ratings given for impairment of the Twelfth Cranial Nerve (Hypoglossal) are as follows:

(a) No rating is allowed for loss on one side.

(b) Bilateral loss is rated as in section (8) of this rule.

(10) Impairment for injuries that have resulted in damage to the brain is determined based upon a preponderance of medical opinion which applies or describes the following criteria.

(a) The existence and severity of the claimed residuals and impairments must be objectively determined by observation or examination or a preponderance of evidence, and must be within the range reasonably considered to be possible, given the nature of the original injury, based upon a preponderance of medical opinion.

(b) The residuals must be a direct result of organic injury to the brain. For example, emotional or behavioral disturbances must result directly from injury to the brain. Emotional disturbances which are reactive to other residuals, but which are not directly organically based, such as frustration or depressed mood about memory deficits or work limitations, are not included under these criteria and must be addressed separately.

(c) The distinctions between Classes are intended to reflect, at their most fundamental level, the impact of the residuals on two domains: impairment of activities of daily living, and impairment of employment capacity.

(d) Where the residuals from the accepted condition and any direct medical sequelae place the worker between one or more classes, the worker is entitled to be placed in the highest class that describes the worker's impairment. There is no averaging of impairment values when a worker falls between classes.

(e) As used in these rules, Episodic Neurologic Disorder refers to and includes any of the following:

(A) Any type of seizure disorder;

(B) Vestibular disorder, including disturbances of balance or sensorimotor integration;

(C) Neuro-ophthalmologic or oculomotor visual disorder, such as diplopia;

(D) Headaches. [Ratings not included. See ED. NOTE.]

(11) For the purpose of section (10) of this rule, the Rancho Los Amigos-Revised levels are based upon the Eight States Levels of Cognitive Recovery developed at the Rancho Los Amigos Hospital and co-authored by Chris Hagen, PhD, Danese Malkumus, M.A., and Patricia Durham, M.S., in 1972. These levels were revised by Danese Malkumus, M.A., and Kathryn Standenip, O.T.R., in 1974, revised by Chris Hagen, PhD, in 1999 to include ten levels, referred to as Rancho-R.

(12) For brain damage that has resulted in the loss of use or function of any upper or lower extremities, a value may be allowed for the affected body part(s). Refer to the appropriate section of these standards for that determination.

[ED. NOTE: Ratings referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0645, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-030-0530; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-035-0395
Spinal Cord

(1) The spinal cord is concerned with sensory, motor, and visceral functions. Permanent impairment can result from various disorders affecting these functions. Injuries that result in damage to the spinal cord are determined based on a preponderance of objective medical opinion and the following classes: When a value is granted under section (1) of this rule, no additional impairment value is allowed for reduced range of motion in the spine. [Ratings not included. See ED. NOTE.]

(2) For spinal cord damage that has resulted in the loss of use or function of body part(s) other than upper and lower extremities, a value is given for other affected body part(s) or organ system(s). Refer to the appropriate section of these standards for that determination and combine with impairment valued under this rule.

(3) For spinal cord damage that has resulted in the loss of use or function of any upper or lower extremities, a value is given for the affected body part(s). Refer to the appropriate section of these standards for that determination.

(4) Episodic neurological disorders are determined under OAR 436-035-0390(10).

[ED. NOTE: Ratings referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 3-1996, f. 1-29-96, cert. ef. 2-17-96; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0400
Mental Illness

(1) Accepted mental disorders resulting in impairment must be diagnosed by a psychiatrist or other mental health professional as provided for in a Managed Care Organization certified under OAR chapter 436, Division 015.

(2) Diagnoses of mental disorders for the purposes of these rules follow the guidelines of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV (1994), published by the American Psychiatric Association.

(3)The physician describes permanent changes in mental function in terms of their affect on the worker's activities of daily living (ADLs), as defined in OAR 436-035-0005(1). Additionally, the physician describes the affect on social functioning and deterioration or decompensation in work or work-like settings as outlined in the AMA Guides to Evaluation of Impairment, 3rd Ed., Revised 1990.

(4) Loss of function attributable to permanent worsening of personality disorders may be stated as impairment only if it interferes with the worker's long-term ability to adapt to the ordinary activities and stresses of daily living. Personality disorders are rated as two classes with gradations within each class based on severity:

(a) Class 1: minimal (0%), mild (6%), or moderate (11%) A worker belongs in class 1 when:

(A) The worker shows little self-understanding or awareness of the mental illness;

(B) Has some problems with judgment;

(C) Has some problems with controlling personal behavior;

(D) Has some ability to avoid serious problems with social and personal relationships; and

(E) Has some ability to avoid self-harm.

(b) Class 2: minimal (20%), mild (29%), or moderate (38%) A worker belongs in class 2 when:

(A) The worker shows considerable loss of self control;

(B) Has an inability to learn from experience; and

(C) Causes harm to the community or to the self.

(5) Loss of function attributable to permanent symptoms of affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders is rated according to the following classes, with gradations within each class based on the severity of the symptoms/loss of function:

(a) Class 1: (0%) A worker belongs in Class 1 when one or more of the following residual symptoms are noted:

(A) Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities.

(B) Depressive symptoms: The activities of daily living can be carried out, but the worker might lack ambition, energy, and enthusiasm. There may be such depression-related, mentally-caused physical problems as mild loss of appetite and a general feeling of being unwell.

(C) Phobicsymptoms: Phobias the worker already suffers from may come into play, or new phobias may appear in a mild form.

(D) Psychophysiological symptoms: Are temporary and in reaction to specific stress. Digestive problems are typical. Any treatment is for a short time and is not connected with any ongoing treatment. Any physical pathology is temporary and reversible. Conversion symptoms or hysterical symptoms are brief and do not occur very often. They might include some slight and limited physical problems (such as weakness or hoarseness) that quickly respond to treatment.

(b) Class 2: minimal (6%), mild (23%), or moderate (35%). A worker belongs in Class 2 when one or more of the following residual symptoms/loss of functions are noted:

(A) Anxiety symptoms: May require extended treatment. Specific symptoms may include (but are not limited to) startle reactions, indecision because of fear, fear of being alone, and insomnia. There

is no loss of intellect or disturbance in thinking, concentration, or memory.

(B) Depressive symptoms: Last for several weeks. There are disturbances in eating and sleeping patterns, loss of interest in usual activities, and moderate retardation of physical activity. There may be thoughts of suicide. Self-care activities and personal hygiene remain good.

(C) Phobic symptoms: Interfere with normal activities to a mild to moderate degree. Typical reactions include (but are not limited to) a desire to remain at home, a refusal to use elevators, a refusal to go into closed rooms, and an obvious reaction of fear when confronted with a situation that involves a superstition.

(D) Psychophysiological symptoms: Require substantial treatment. Frequent and recurring problems with the organs get in the way of common activities. The problems may include (but are not limited to) diarrhea; chest pains; muscle spasms in the arms, legs, or along the backbone; a feeling of being smothered; and hyperventilation. There is no actual pathology in the organs or tissues. Conversion or hysterical symptoms result in periods of loss of physical function that occur more than twice a year, last for several weeks, and need treatment. Symptoms may include (but are not limited to) temporary hoarseness, temporary blindness, temporary weakness in the arms or the legs. These problems continue to return.

(c) Class 3: Minimal (50%), mild (66%), or moderate (81%) A worker belongs in Class 3 when one or more of the following residual symptoms/loss of functions are noted:

(A) Anxiety symptoms: Fear, tension, and apprehension interfere with work or the activities of daily living. Memory and concentration decrease or become unreliable. Long-lasting periods of anxiety keep returning and interfere with personal relationships. The worker needs constant reassurance and comfort from family, friends, and coworkers.

(B) Depressive symptoms: Include an obvious loss of interest in the usual activities of daily living, including eating and self-care. These problems are long-lasting and result in loss of weight and an unkempt appearance. There may be retardation of physical activity, a preoccupation with suicide, and actual attempts at suicide. The worker may be extremely agitated on a frequent or constant basis.

(C) Phobic symptoms: Existing phobias are intensified. In addition, new phobias develop. This results in bizarre and disruptive behavior. In the most serious cases, the worker may become homebound, or even room-bound. Persons in this state often carry out strange rituals which require them to be isolated or protected.

(D) Psychophysiological symptoms: Include tissue changes in one or more body systems or organs. These may not be reversible. Typical reactions include (but are not limited to) changes in the wall of the intestine that results in constant digestive and elimination problems. Conversion or hysterical symptoms include loss of physical function that occurs often and lasts for weeks or longer. Evidence of physical change follows such events. A symptomatic period (18 months or more) is associated with advanced negative changes in the tissues and organs. These include (but are not limited to) atrophy of muscles in the legs and arms. A common symptom is general flabbiness.

(6) Psychotic disorders are rated based on perception, thinking process, social behavior, and emotional control. Variations in these aspects of mental function are rated according to the following classifications with gradations within each class based on severity:

(a) Class 1: minimal (0%), mild (6%), or moderate (11%) A worker belongs in Class 1 when the following is established:

(A) Perception: The worker misinterprets conversations or events. It is common for persons with this problem to think others are talking about them or laughing at them.

(B) Thinking process: The worker is absent-minded, forgetful, daydreams too much, thinks slowly, has unusual thoughts that recur, or suffers from an obsession. The worker is aware of these problems and may also show mild problems with judgment. It is also possible that the worker may have little self-understanding or understanding of the problem.

(C) Social behavior: Small problems appear in general behavior, but do not get in the way of social or living activities. Others are not disturbed by them. The worker may be over-reactive or depressed or may neglect self-care and personal hygiene.

(D) Emotional control: The worker may be depressed and have little interest in work or life. The worker may have an extreme feeling of well-being without reason. Controlled and productive activities are possible, but the worker is likely to be irritable and unpredictable.

(b) Class 2: minimal (20%), mild (29%), or moderate (38%) A worker belongs in Class 2 when the following is established:

(A) Perception: Workers in this state have fairly serious problems in understanding their personal surroundings. They cannot be counted on to understand the difference between daydreams, imagination, and reality. They may have fantasies involving money or power, but they recognize them as fantasies. Because persons in this state are likely to be overly excited or suffering from paranoia, they are also likely to be domineering, peremptory, irritable, or suspicious.

(B) Thinking process: The thinking process is so disturbed that persons in this state might not realize they are having mental problems. The problems might include (but are not limited to) obsessions, blocking, memory loss serious enough to affect work and personal life, confusion, powerful daydreams or long periods of being deeply lost in thought to no set purpose.

(C) Social behavior: Persons in this state can control their social behavior if they are asked to do so. However, if left on their own, their behavior is so bizarre that others may be concerned. Such behavior might include (but is not limited to) over-activity, disarranged clothing, and talk or gestures which neither make sense nor fit the situation.

(D) Emotional control: Persons in this state suffer a serious loss of control over their emotions. They may become extremely angry for little or no reason, they may cry easily, or they may have an extreme feeling of well-being, causing them to talk too much and to little purpose. These behaviors interfere with living and work and cause concern in others.

(c) Class 3: minimal (50%), mild (63%), or moderate (75%) A worker belongs in Class 3 when the following is established:

(A) Perception: Workers in this state suffer from frequent illusions and hallucinations. Following the demands of these illusions and hallucinations leads to bizarre and disruptive behavior.

(B) Thinking process: Workers in this state suffer from disturbances in thought that are obvious even to a casual observer. These include an inability to communicate clearly because of slurred speech, rambling speech, primitive language, and an absence of the ability to understand the self or the nature of the problem. Such workers also show poor judgment and openly talk about delusions without recognizing them as such.

(C) Social behavior: Persons in this state are a nuisance or a danger to others. Actions might include interfering with work and other activities, shouting, sudden inappropriate bursts of profanity, carelessness about excretory functions, threatening others, and endangering others.

(D) Emotional control: Workers in this state cannot control their personal behavior. They might be very irritable and overactive or so depressed they become suicidal.

(d) Class 4: (90%) Workers who belong in Class 4 usually need to be placed in a hospital or institution. Medication may help them to a certain extent. A worker belongs in Class 4 when the following is established:

(A) Perception: Workers become so obsessed with hallucinations, illusions, and delusions that normal self-care is not possible. Bursts of violence may occur.

(B) Thinking process: Communication is either very difficult or impossible. The worker is responding almost entirely to delusions, illusions, and hallucinations. Evidence of disturbed mental processes may include (but are not limited to) severe confusion, incoherence, irrelevance, refusal to speak, the creation of new words or using existing words in a new manner.

(C) Social behavior: The worker's personal behavior endangers both the worker and others. Poor perceptions, confused thinking, lack of emotional control, and obsessive reaction to hallucinations, illusions, and delusions produce behavior that can result in the worker being inaccessible, suicidal, openly aggressive and assaultive, or even homicidal.

(D) Emotional control: The worker may have either a severe emotional disturbance in which the worker is delirious and uncontrolled or extreme depression in which the worker is silent, hostile, and self-destructive. In either case, lack of control over anger and rage might result in homicidal behavior.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0555, 5-1-85; WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; Renumbered from 436-065-0540; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0410
Hematopoietic System

(1) Anemia can be impairing when the cardiovascular system cannot compensate for the effects of the anemia. When a worker becomes anemic as a result of an injury or occupational disease, the following values are given:

(a) 0% when there are no complaints or evidence of disease and the usual activities of daily living can be performed; no blood transfusion is required; and the hemoglobin level is 10-12gm/100ml.

(b) 30% when there are complaints or evidence of disease and the usual activities of daily living can be performed with some difficulty; no blood transfusion is required; and the hemoglobin level is 8-10gm/100ml.

(c) 70% when there are signs and symptoms of disease and the usual activities of daily living can be performed with difficulty and with varying amounts of assistance from others; blood transfusion of 2 to 3 units is required every 4 to 6 weeks; and the hemoglobin level is 5-8gm/100ml before transfusion.

(d) 85% when there are signs and symptoms of disease and the usual activities of daily living cannot be performed without assistance from others; blood transfusion of 2 to 3 units is required every 2 weeks, implying hemolysis of transfused blood; and the hemoglobin level is 5-8gm/100ml before transfusion.

(2) White Blood Cell System impairments resulting from injury or occupational disease are rated according to the following classification system:

(a) Class 1: 5% impairment when there are symptoms or signs of leukocyte abnormality and no or infrequent treatment is needed and all or most of the activities of daily living can be performed.

(b) Class 2: 20% impairment when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed but most of the activities of daily living can be performed.

(c) Class 3: 40% impairment when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed and the activities of daily living can be performed with occasional assistance from others.

(d) Class 4: 73% impairment when there are symptoms and signs of leukocyte abnormality and continuous treatment is needed and continuous care is required for activities of daily living.

(3) Splenectomy is given an impairment value of 5%.

(4) Hemorrhagic Disorders acquired as a result of an injury or occupational disease may result in 5% impairment if many activities must be avoided and constant endocrine therapy is needed, or anticoagulant treatment with a vitamin K antagonist is required. Hemorrhagic disorders that stem from damage to other organs or body systems are not rated under this section but are rated according to the impairment of the other organ or body system.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0420
Gastrointestinal and Genitourinary Systems

(1) Impairments in mastication (chewing) and deglutition (swallowing) are determined based on the following criteria:

(a) Diet limited to semi-solid or soft foods — 8%

(b) Diet limited to liquid foods — 25%

(c) Eating requires tube feeding or gastrostomy — 50%

(2) Impairment of the upper digestive tract (esophagus, stomach and duodenum, small intestine, pancreas) is valued according to the following classes: [Classes not included. See ED. NOTE.]

(3) Colonic and rectal impairment is rated according to the following classes: [Classes not included. See ED. NOTE.]

(4) Anal impairment is rated according to the following classes: [Classes not included. See ED. NOTE.]

(5) Liver impairment is determined according to the following classes: [Classes not included. See ED. NOTE.]

(6) Biliary tract impairment is determined according to the following classes: [Classes not included. See ED. NOTE.]

(7) Impairment of the Upper Urinary Tract is determined according to the following classes: [Classes not included. See ED. NOTE.]

(8) Impairment of the Bladder: When evaluating permanent impairment of the bladder, the status of the upper urinary tract must also be considered. The appropriate impairment values for both are combined under OAR 436-035-0011(5). Impairment of the bladder is determined according to the following classes: [Classes not included. See ED. NOTE.]

(9) Urethra: When evaluating permanent impairment of the urethra, one must also consider the status of the upper urinary tract and bladder. The values for all parts of the urinary system are combined under OAR 436-035-0011(5). Impairment of the urethra is determined according to the following classes: [Classes not included. See ED. NOTE.]

(10) Penile Sexual Dysfunction: When evaluating permanent impairment due to sexual dysfunction of the penis, one must also consider the status of the urethra upper urinary tract and bladder. The values for all parts of the system are combined under OAR 436-035-0011(6). Loss or alteration of the gonads is valued under OAR 436-035-0430. Impairment due to sexual dysfunction of the penis is determined according to the following classes for men 40 to 65 years of age. [Classes not included. See ED. NOTE.]

(11) Cervix/Uterus: When evaluating permanent impairment of the cervix/uterus, one must also consider the status of the urethra, upper urinary tract and bladder. The values for all parts of the system are combined under OAR 436-035-0011(5). Loss or alteration of the gonads is valued under OAR 436-035-0430. Impairment of the cervix/uterus is determined according to the following classes: [Classes not included. See ED. NOTE.]

[ED. NOTE: Classes referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726
Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 5-1988(Temp), f. 8-22-88, cert. ef. 8-19-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1998, f. 5-13-98, cert. ef. 7-1-98 ; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-035-0430
Endocrine System

(1) The assessment of permanent impairment from disorders of the hypothalamic-pituitary axis requires evaluation of (1) primary abnormalities related to growth hormone, prolactin, or ADH; secondary abnormalities in other endocrine glands, such as thyroid, adrenal, and gonads, and; structural and functional disorders of the central nervous system caused by anatomic abnormalities of the pituitary. Each disorder must be evaluated separately, using the standards for rating the nervous system, visual system, and mental and behavioral disorders, and the impairments combined. Impairment of the hypothalamic-pituitary axis is determined according to the following classes: [Classes not included. See ED. NOTE.]

(2) Impairment of Thyroid function results in either hyperthyroidism or hypothyroidism. Hyperthyroidism is not considered to be a cause of permanent impairment, because the hypermetabolic state in practically all patients can be corrected permanently by treatment. After remission of hyperthyroidism, there may be permanent impairment of the visual or cardiovascular systems, which should be evaluated using the appropriate standards for those systems. Hypothyroidism in most instances can be satisfactorily controlled by the administration of thyroid medication. Occasionally, because of associated disease in other organ systems, full hormone replacement may not be possible. Impairment of thyroid function is determined according to the following classes: [Classes not included. See ED. NOTE.]

(3) Parathyroid: Impairment of Parathyroid function results in either hyperparathyroidism or hypoparathyroidism. In most cases of hyperparathyroidism, surgical treatment results in correction of the primary abnormality, although secondary symptoms and signs may persist, such as renal calculi or renal failure, which should be evaluated according to the appropriate standards. If surgery fails, or cannot be done, the patient may require long-term therapy, in which case the

permanent impairment may be classified according to the following: [Classes not included. See ED. NOTE.]

(4) Adrenal Cortex: Impairment of the Adrenal Cortex results in either hypoadrenalism or hyperadrenocorticism.

(a) Hypoadrenalism is a lifelong condition that requires long-term replacement therapy with glucocorticoids or mineralocorticoids for proven hormonal deficiencies. Impairments are rated as follows: [Classes not included. See ED. NOTE.]

(b) Hyperadrenocorticism due to the chronic side effects of non-physiologic doses of glucocorticoids (iatrogenic Cushing's syndrome) is related to dosage and duration of treatment and includes osteoporosis, hypertension, diabetes mellitus and the effects involving catabolism that result in protein myopathy, striae, and easy bruising. Permanent impairment ranges from 5% to 78%, depending on the severity and chronicity of the disease process for which the steroids are given. On the other hand, with diseases of the pituitary-adrenal axis, impairment may be classified according to severity: [Classes not included. See ED. NOTE.]

(5) Adrenal Medulla: Impairment of the Adrenal Medulla results from pheochromocytoma and is classified as follows: [Classes not included. See ED. NOTE.]

(6) Pancreas: Impairment of the pancreas results in either diabetes mellitus or in hypoglycemia.

(a) Diabetes mellitus is rated according to the following classes: [Classes not included. See ED. NOTE.]

(b) Hypoglycemia is rated according to the following classes: [Classes not included. See ED. NOTE.]

(7) Gonadal Hormones: A patient with anatomic loss or alteration of the gonads that results in a loss or alteration in the ability to produce and regulate the gonadal hormones receives a value of 3% impairment for unilateral loss or alteration and 5% for bilateral loss or alteration. Loss of the cervix/uterus or penile sexual function is valued under OAR 436-035-0420.

[ED. NOTE: Classes referenced are available from the agency.]

Stat. Auth.: ORS 656.726

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-035-0440
Integument and Lacrimal System

(1) If the worker has developed an immunologic reaction to physical, chemical or biological agents, impairment will also be valued under OAR 436-035-0450.

(2) Impairments of the integumentary system may or may not show signs or symptoms of skin disorder upon examination but are rated according to the following classes: [Classes not included. See ED. NOTE.]

(3) If either too little or too much tearing results in a worker's being restricted from regular work, and the condition is not an immunological reaction, a value is assigned as follows:

(a) 3% when the reaction is a nuisance but does not prevent most regular work-related activities; or

(b) 8% when the reaction prevents some regular work-related activities; or

(c) 13% when the reaction prevents most regular work-related activities.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 2-1988, f. 6-3-88, cert. ef. 7-1-88; WCD 7-1988, f. 12-21-88, cert. ef. 1-1-89; WCD 18-1990(Temp), f. 9-14-90, cert. ef. 10-1-90; WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0450
Immune System

When exposure to physical, chemical, or biological agents has resulted in the development of an immunological response, impairment of the immune system is valued as follows:

(1) 3% when the reaction is a nuisance but does not prevent most regular work related activities; or

(2) 8% when the reaction prevents some regular work related activities; or

(3) 13% when the reaction prevents most regular work related activities.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.005, 656.214, 656.268 & 656.726

Hist.: WCD 2-1991, f. 3-26-91, cert. ef. 4-1-91; WCD 6-1992, f. 2-14-92, cert. ef. 3-13-92; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-035-0500
Rating Standard for Individual Claims

(1) This rule applies to the rating of permanent disability under Chapter 656 in individual cases under ORS 656.726(4)(f) which requires the director to determine the rating standard in cases where the director finds that the worker's impairment is not addressed in the disability standards.

(2) Rating standards determined under ORS 656.726(4)(f) will be written into the director's order on reconsideration and will apply solely to the rating of that claim.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726, (§7, ch. 270, OL 2007)

Hist.: WCD 16-1992(Temp), Case #A58-7576 & Case #D60-5352, f. & ef. 12-31-92 - 6-29-93; WCD 2-1993(Temp), Case #A58-2159, B59-4533, E61-4228, & I59-2031, f. & ef. 4-28-93 - 10-25-93; WCD 4-1993, f. & cert. ef. 6-29-93; WCD 5-1993(Temp), Case #I64-3064, f. & cert. ef. 9-2-93 - 3-2-94; WCD 6-1993(Temp), Case #I64-3064, f. & cert. ef. 10-22-93 - 4-19-94; WCD 4-1994(Temp), f. & cert. ef. 5-26-94; WCD 6-1994(Temp), f. & cert. ef. 7-15-94; WCD 8-1994(Temp), f. & cert. ef. 8-31-94; WCD 11-1994(Temp), f. & cert. ef. 11-10-94; WCD 1-1995(Temp), f. & cert. ef. 1-26-95; WCD 2-1995(Temp), f. & cert. ef. 3-2-95; WCD 3-1995(Temp), f. & cert. ef. 4-13-95; WCD 4-1995(Temp), f. & cert. ef. 5-31-95; WCD 5-1995(Temp), f. & cert. ef. 7-11-95; WCD 14-1995(Temp), f. & cert. ef. 10-5-95; WCD 16-1995(Temp), f. & cert. ef. 11-2-95; WCD 19-1995(Temp), f. & cert. ef. 12-7-95; WCD 4-1996(Temp), f. & cert. ef. 2-1-96; WCD 11-1996(Temp), f. & cert. ef. 3-20-96; WCD 15-1996(Temp), f. & cert. ef. 7-3-96, WCD 18-1996, f. 8-6-96, cert. ef. 8-7-96; WCD 22-1996(Temp), f. & cert. ef. 10-31-96; WCD 1-1997, f. 1-9-97, cert. ef. 2-15-97; WCD 2-1997(Temp), f. & cert. ef. 1-15-97; WCD 3-1997(Temp), f. 3-12-97, cert. ef. 3-13-97; WCD 6-1997(Temp), f. & cert. ef. 5-14-97; WCD 12-1997(Temp), f. & cert. ef. 9-9-97; WCD 4-1998(Temp), f. & cert. ef. 3-31-98 thru 9-26-98; WCD 7-1998(Temp), f. 7-13-98, cert. ef. 7-15-98 thru 1-11-99; WCD 9-1998(Temp), f. & cert. ef. 10-15-98 thru 4-12-99; WCD 1-1999(Temp), f. 1-12-99, cert. ef. 1-15-99 thru 7-13-99; WCD 5-1999(Temp), f. & cert. ef. 4-15-99 thru 10-12-99; WCD 10-1999(Temp), f. & cert. ef. 7-15-99 thru 1-10-2000; WCD 12-1999(Temp), f. 10-14-99, cert. ef. 10-15-99 thru 4-12-00; WCD 1-2000(Temp), f. 1-12-00, cert. ef. 1-14-00 thru 7-12-00; WCD 5-2000(Temp), f. 4-13-00, cert. ef. 4-14-00 thru 10-10-00; WCD 7-2000(Temp), f. 7-14-00, cert. ef. 7-14-00 thru 1-9-01; WCD 8-2000(Temp), f. & cert. ef. 10-13-00 thru 4-10-01; WCD 1-2001(Temp), f. & cert. ef. 1-12-01 thru 7-10-01; WCD 3-2001(Temp) f. & cert. ef. 4-13-01 thru 10-9-01; WCD 6-2001(Temp), f. & cert. ef. 7-13-01 thru 1-8-02; WCD 9-2001(Temp), f. & cert. ef. 10-12-01 thru 4-9-02; WCD 1-2002(Temp), f. & cert. ef. 1-15-02 thru 7-13-02; WCD 5-2002(Temp), f. 4-12-02, cert. ef. 4-15-02 thru 10-11-02; WCD 8-2002(Temp), f. 7-12-02 cert. ef. 7-15-02 thru 1-10-03; WCD 11-2002(Temp), f. 10-11-02, cert. ef. 10-15-02 thru 4-12-03; WCD 1-2003(Temp), f. & cert. ef. 1-15-03 thru 7-13-03; WCD 2-2003, f. 1-15-03 cert. ef. 2-1-03; WCD 4-2003(Temp), f. 4-14-03, cert. ef. 4-15-03 thru 10-11-03; WCD 7-2003(Temp), f. & cert. ef. 7-15-03 thru 1-10-04; WCD 1-2004(Temp), f. & cert. ef. 1-21-04 thru 7-18-04; WCD 5-2004(Temp), f & cert. ef. 4-19-04 thru 10-15-04; WCD 7-2004(Temp), f. & cert. ef. 7-15-04 thru 1-10-05; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 3-2005(Temp), f. & cert. ef. 5-13-05 thru 11-8-05; Administrative correction 11-18-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 6-2006(Temp), f. & cert. ef. 7-17-06 thru 1-12-07; Administrative correction 1-16-07; WCD 5-2007(Temp), f. & cert. ef. 6-27-07 thru 12-23-07; WCD 6-2007(Temp), f. & cert. ef. 10-29-07 thru 4-25-08; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

DIVISION 40

HANDICAPPED WORKERS RESERVE

436-040-0001
Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726 and 656.628.

Stat. Auth.: ORS 656

Stats. Implemented: ORS 656.628 & 656.726

Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0001, 5-1-85

436-040-0002
Purpose

The purpose of these rules is to establish guidelines for the administration of the Workers with Disabilities Program established to encourage the employment or reemployment of workers with disabilities.

Stat. Auth.: ORS 656

Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007

Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0008, 5-1-85; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0003
Applicability of Rules

(1) These rules are effective December 26, 1990, and apply to all applications for relief submitted prior to May 1, 1990 and all requests for reimbursement from the Workers with Disabilities Program filed with the director on or after December 26, 1990 for injuries occurring on or after November 1, 1981.

(2) These rules carry out the provisions of ORS 656.628.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.236, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0003, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 6-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 22-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0005
Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "Compensation" means all benefits, including medical services and attorney fees, provided for a compensable injury to a subject worker or the worker's beneficiaries. However, it does not include expenses as defined by the National Council on Compensation Insurance, in its Workers' Compensation Statistical Plan, Part IV.

(2) "Deductible" means the initial $1,000 of cumulative compensation paid on qualifying claim(s) applied once per worker with a disability.

(3) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter.

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

(5) "Employer" means an employer who qualifies pursuant to the provisions of ORS 656.017, either as a carrier-insured employer or as a self-insured employer under ORS 656.407.

(6) "Worker with a disability" means a worker who is afflicted with, or subject to, any permanent physical or mental impairment, whether congenital or due to an injury or disease, including periodic impairment of consciousness or muscular control of such character that the impairment would prevent the worker from obtaining or retaining employment.

(7) "Workers with Disabilities Claim Reserve" means the total anticipated liability (paid plus future reimbursable costs) regardless of any relief granted under the Workers with Disabilities Program.

(8) "Workers with Disabilities Program" means the program established under ORS 656.628.

(9) "Paying Agency" means the insurer, self-insured employer, or designated representative of the self-insured employer, responsible for paying compensation for a compensable injury.

(10) "Settlement" means any agreement produced as a result of the act or process of settling differences between a paying agent and a worker with a disability, or disposition of a claim pursuant to ORS 656.236 or 656.289.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0005, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 6-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 22-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0006
Administration of Rules

For the purpose of administration of the Workers with Disabilities Program, orders of the division are deemed orders of the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0010, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0008
Administrative Review

(1) If a paying agency or employer is aggrieved by a decision of the division, the director may be petitioned for reconsideration.

(2) The director shall examine the application and such further evidence filed, and enter an order. Copies of the order will be sent to the paying agency, the division, and employer, if applicable. Granting or denying reimbursement from the Workers with Disabilities Program is at the sole discretion of the director. Pursuant to ORS 656.628(7), the director's order is final and not subject to review by any court or other administrative body.

(3) In adopting these rules, the director reserves the right to reexamine any liability created against the Workers' Benefit Fund and to modify or terminate such liability, where such action is justified.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD.6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0998, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0010
Criteria for Eligibility

(1) The criteria used to determine eligibility for relief from the Workers with Disabilities Program are:

(a) Without regard to employer knowledge, a worker must have a permanent physical or mental impairment, whether congenital or due to an injury or disease which would prevent the worker from obtaining or retaining employment. For the purpose of this section, a worker has a preexisting permanent impairment if it is equal to or greater than twenty five percent (25%) of the whole person.

(b) There must be a subsequent compensable injury or injuries:

(A) To the worker with a disability resulting in cumulative claim(s) costs in excess of $1,000; or

(B) To other workers employed by the disabled worker's employer resulting in cumulative claim(s) costs in excess of $1,000.

(c) The insurer or employer must demonstrate that the subsequent injury or injuries:

(A) Would not have been sustained except for the disabled worker's impairment; or

(B) Would not have occurred, to workers of the same employer, except for the act or omission of a worker with a disability which resulted from the disabled worker's impairment; or

(C) Resulted in disability which is at least one-fourth greater by reason of the worker's preexisting impairment, as determined by the division.

(2) An employer declared noncomplying in accordance with ORS 656.052 is not eligible for relief from the Workers with Disabilities Program for injuries to subject workers occurring during any period of noncompliance.

(3) A paying agency is not eligible for reimbursement from the Workers with Disabilities Program for any claim occurring to a worker during a period for which the employer is receiving premium reimbursement from the Reemployment Assistance Program, for that worker, pursuant to ORS 656.622(3).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0100, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 6-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 22-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0020
Limitation of Program

(1) Reimbursement is limited to the monies available in the Workers' Benefit Fund .

(2) In the event of insufficient reserves in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution which will proportionately distribute the available funds among the claims which have qualified for reimbursement from the Workers with Disabilities Program.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0200, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0030
Application for Determination of Relief From the Workers with Disabilities Program

(1) The paying agency must provide the director adequate evidence to establish eligibility for determination of relief from the Workers with Disabilities Program.

(2) When the deductible has been met and possible eligibility for relief becomes known, the paying agency shall make prompt application to the division requesting determination of relief from the Workers with Disabilities Program in a form prescribed by the director.

(3) The application shall be submitted prior to the date of the last valuation affecting an employer's experience rating, prior to the last valuation for retrospective rating, whichever is the last to occur and prior to the employer ceasing to do business. The application shall be supported by sufficient evidence establishing eligibility for reimbursement under the general provisions herein and in accordance with OAR 436-040-0010. For employers that are not experience rated, application shall be submitted prior to the date there would have been a last valuation, had the employer been so rated, and prior to the employer ceasing to do business. The preceding application time frames do not apply to self-insured employers or their paying agencies.

(4) To meet the requirements of OAR 436-040-0030(3), the paying agency shall:

(a) Specify the condition which caused permanent impairment and which constituted a handicap;

(b) Specify whether this request is based on a causal or contributory relationship pursuant to OAR 436-040-0010(1)(c);

(c) Provide documentation describing prior impairment: such as medical reports, direct information from the worker, employer documentation, prior Determination Orders, Opinion and Orders, and Orders on Review;

(5) The division will review the application to assure it is complete and the $1,000 deductible has been met. The application, supporting documentation, and claims involved will then be submitted to the division for an eligibility determination.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0300, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0040
Eligibility Determination

(1) The division shall determine whether a claim qualifies for reimbursement, and the percentage of the reimbursement.

(2) The division shall issue a determination order accepting or denying the application within 30 calendar days after receipt of the application and supporting documentation.

(3) The reimbursement percentage shown on the determination order will be:

(a) 100% after the $1,000 deductible in those cases qualifying under OAR 436-040-0010(1)(c)(A) and (B); or

(b) In direct proportion to the percentage the resulting disability was increased as a result of the preexisting impairment in those cases qualifying under OAR 436-040-0010(1)(c)(C).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; from 436-064-0310, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0050
Reimbursement

(1) Reimbursement will be made to the paying agency based on the percentage of reimbursement ordered by the division.

(2) Request for reimbursement shall not be made until the deductible has been met.

(3) Requests for reimbursement are not to include: costs incurred for conditions unrelated to the compensable claim; costs incurred due to inaccurate, untimely, or improper processing; expenses; and settlement amounts not approved by the division, to which the parties agreed after relief was granted.

(4) The division will authorize reimbursement to the paying agency quarterly after receipt and approval of documentation of compensation paid from the paying agency. Documentation shall include, but not be limited to:

(a) Net amounts paid separated into disability benefits by type, and medical benefits for corresponding quarterly time periods;

(b) The current Worker with a Disability Claim Reserve as defined in these rules;

(c) Payment certification statement; and

(d) Any other information deemed necessary by the director.

(5) For purposes of subsection 4(a) of this rule, "net amounts paid" means the total compensation paid less any recoveries, including but not limited to, third party recovery, Retroactive Program reimbursement and Rehabilitation Program reimbursement.

(6) Periodically the division will audit the physical file of the paying agency to validate the amount reimbursed. Reimbursement shall not be approved if, upon such audit, any of the following are found to apply:

(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

(b) Compensation has been paid for treatment of any condition unrelated to the compensable claim for which Workers with Disabilities Program relief was granted.

(c) The compensability of the accepted claim is questionable and the rationale for acceptance has not been reasonably documented, as required under generally accepted claims management procedures;

(d) The separate payments of compensation have not been documented, as required under generally accepted accounting procedures;

(e) For applications received after January 1, 1990, the subject employer was no longer doing business at the time of application for the Workers with Disabilities Program determination; that the employer was on a retrospective rating plan that was closed prior to the application for the Workers with Disabilities Program determination; or, if not on an open retrospective rating plan, that the last valuation for experience rating modification purposes that could affect the employer was completed prior to the application for the Workers with Disabilities Program determination;

(f) The insurer did not adjust the claims reserve value used in dividend, retrospective evaluation, or any claim valuation for experience rating determination to the percentage level specified in the order of acceptance, allowing for the $1,000 compensation minimum, or did not make the necessary monetary adjustments with the employer; or

(g) The insurance carrier is not able to provide applicable records relating to experience rating, retrospective rating or dividend calculations at the time of audit or within ten working days thereafter. Any reimbursements received on claims, for which the insurer is unable to provide records, will be returned to the division at least until the next annual audit is conducted and all applicable records are reviewed.

(7) The division will authorize reimbursement to insurance companies only for compensation which could reasonably be projected at the first of either to occur;

(a) The last claim evaluation which would affect the employer's experience rating modification or retrospective rating adjustment, whichever is later; or

(b) For applications received after January 1, 1990, the employer ceases to do business, if that occurs first.

(8) The insurance company shall submit a claim valuation to the division at the first to occur of:

(a) The last claim valuation date which would affect the employer's experience rating modification or retrospective rating adjustment, whichever is later (usually three and one half years after the inception of the policy period); or

(b) For applications received after January 1, 1990, the employer ceases to do business. The valuation shall include future reserves for the claim at that time. The division will verify the future reserves are reasonable and based on the appropriate valuation date. If the division determines the submitted claim valuation is unreasonable or based on inappropriate information, the division may establish the claim valuation or adjust the claim valuation period. The claim valuation, when approved by the division, shall be the maximum Worker with a Disability Claim Reserve used as the basis for reimbursement for the claim.

(9) When a claim is settled by a Compromise and Release or a Disputed Claims Settlement, the department shall review and modify the final reserve to reflect resulting changes in liability. The paying agent shall be notified of any change in the final reserve. A director review of this action will be considered only when paid claim costs have exceeded the established reserve.

(10) In the event that a denied claim is found compensable by a hearing referee, the Workers' Compensation Board, or the Court of Appeals, and that decision is reversed by a higher level of appeal, the paying agency shall receive reimbursement for claim payments required to be made while the claim was in accepted status.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0315, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 6-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 22-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0060
Effects on Rates; Reporting

(1) Where an order of acceptance has established the percentage of reimbursement to an insured, the incurred claim cost above $1,000, prior to reimbursement, shall be reduced by that percentage. The net incurred cost after such reduction shall be used in any dividend calculation, retrospective rating evaluation or experience rating computation, retroactively if necessary, and shall be reported at that net incurred cost to the rating organization. Any subsequent reevaluation of the claims reserve requirements under the rules of the Unit Statistical Plan Manual shall be similarly reduced by the percentage of reimbursement.

(2) The paying agency "eligible for" or receiving reimbursement from the Workers with Disabilities Program, shall report the subject claims in such method and manner as the insurance commissioner shall require. Notwithstanding the reporting requirements of the Insurance Commissioner and an authorized rating organization, the paying agency must be able to document that such reimbursed costs are not and will not be included in data reported that will affect the rates and/or dividend eligibility.

(3) If compensation reported to the appropriate rating organization subsequently becomes eligible for reimbursement from the Workers with Disabilities Program, the insured paying agency shall immediately file a "reevaluation of losses" report, pursuant to the Insurance Commissioner's rules, with a rating organization licensed by the Insurance Commissioner.

(4) If compensation used by the division for experience rating purposes becomes eligible for reimbursement from the Workers with Disabilities Program, the self-insured paying agency may file a request for reevaluation of experience rating modification(s) with the division. Any necessary calculation(s) will be made, retroactively if necessary, when the annual experience rating modification is calculated.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0320, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0070
Settlements

(1) Any settlement of the claim by the parties is not eligible for reimbursement from the Workers with Disabilities Program unless made with the prior written approval of the division.

(2) Requests for written approval of proposed settlements should include:

(a) A copy of the proposed settlement;

(b) Correspondence between the paying agency and the claimant or claimant's representative which establishes the basis for settlement or a statement from the paying agency of how the amount of the settlement was calculated;

(c) Additional medical reports not available at the time of the determination; and

(d) Other material which would support the proposed settlement as an appropriate manner to handle the claim.

(3) The paying agency shall submit settlements to the division in the format prescribed by the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0325, 5-1-85; WCD 6-1987, f. 12-18-87, ef. 1-1-88; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 6-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 22-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0080
Third Party Recoveries

(1) If a third party recovery is made prior to a claim qualifying for Workers with Disabilities Program relief, compensation recovered shall be credited against the compensation of the claim prior to any request for reimbursement.

(2) The Workers with Disabilities Program shall be a party to any third party recovery on a claim if payment from the program has been made prior to the third party recovery as provided in ORS 656.591 and 656.593(1)(c).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628, §286, ch. 70, OL 2007
Hist.: WCD 1-1982(Admin), f. 1-20-82, ef. 2-1-82; WCD 6-1983(Admin), f. 12-20-83, ef. 1-1-84; Renumbered from 436-064-0330, 5-1-85; WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0090
Assessment of Civil Penalties

The director, through the division and pursuant to ORS 656.745, may assess a civil penalty against an insurer. When the division imposes a penalty under this section, the order shall be issued in accordance with ORS 656.447, 656.704 and the contested case provisions of the Administrative Procedures Act (ORS chapter 183).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: WCD 3-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-040-0100
Suspension and Revocation of Authorization to Issue Guaranty Contracts

(1) Pursuant to ORS 656.447, the director may suspend or revoke the insurer's authority to issue guaranty contracts upon a determination that the insurer has failed to comply with its obligations under such contract or that it has failed to comply with the rules or orders of the director.

(2) For the purpose of this rule:

(a) "Suspension" and its variations means a stopping by the director of the insurer's authority to issue new guaranty contracts for a specified period of time.

(b) "Revocation" and its variations means a permanent revocation by the director of an insurer's authority to issue guaranty contracts.

(c) "Show-cause hearing" means an informal meeting with the director or designee in which the insurer shall be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke an insurer's authority to issue guaranty contracts.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show- cause hearing before the director and "show cause" why it should be permitted to continue to issue guaranty contracts.

(4) A show-cause hearing may be held at any time the director finds that an insurer has failed to comply with its obligations under a guaranty contract or that it failed to comply with rules or orders of the director.

(5) Following a show-cause hearing, the director may rescind the proposed order if the insurer establishes to the director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy lapses or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the director revoke the insurer's authority to issue guaranty contracts.

(8) When an insurer's authority to issue guaranty contracts has been revoked, the insurer may serve an existing account only until the policy lapses, is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer's authority to issue guaranty contracts has been in effect for five (5) years or longer, it may petition the director to restore its authority by submitting a plan in the form prescribed by the director, demonstrating its ability and commitment to comply with the workers' compensation law, these rules and orders of the director.

(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-040-0008.

(11) Any order of suspension or revocation issued by a referee or other person pursuant to ORS 656.447 and this rule is a preliminary order subject to revision by the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.628
Hist.: WCD 22-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

DIVISION 45

REOPENED CLAIMS PROGRAM

436-045-0001
Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726 and 656.625.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.625 & 656.726
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88

436-045-0002
Purpose

The purpose of these rules is to establish guidelines for administering disbursements made from the Reopened Claims Program established to reimburse compensation paid as a result of awards made by the Board or voluntary claim reopenings pursuant to ORS 656.278.

Stat. Auth.: ORS 656.625 & 656.726
Stats. Implemented: ORS 656.625 & 656.726
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-045-0003
Applicability of Rules

(1) These rules are effective January 1, 2002, and shall apply to all requests for reimbursement from the Reopened Claims Program.

(2) These rules apply to all awards ordered on claims opened by the Board pursuant to ORS 656.278 on or after January 1, 1988 and all voluntary claim reopenings on or after January 1, 2002.

(3) These rules carry out the provisions of ORS 656.625.

(4) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.236, 656.289 & 656.625
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 27-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 9-1991, f. 12-13-91, cert. ef. 1-1-92; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-045-0005
Definitions

As used in OAR 436-045-0001 through 436-045-0030 unless the context requires otherwise:

(1) "Board" means the Workers' Compensation Board of the Department of Consumer and Business Services.

(2) "Compensation" includes all benefits payable as a result of any order or award made by the Board or voluntary claim reopening pursuant to ORS 656.278.

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

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

(5) "Director" means the director of Department of Consumer and Business Services or the director's delegate for the matter.

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

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

(8) "Paying Agency" means the insurer, self-insured employer, self-insured employer group or designated representative of the self-insured employer/group, responsible for paying compensation for a compensable injury.

(9) "Reopened Claims Program" and "Program" means the program established pursuant to ORS 656.625.

(10) "Voluntary Claim Reopening" means any claim reopened by the insurer or self-insured employer to provide benefits or to grant additional medical or hospital care to the claimant pursuant to ORS 656.278.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 27-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-045-0006
Administration of Rules

Any orders issued by the divisions in carrying out the director's authority to enforce ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.704 & 656.726
Stats. Implemented: ORS 656.704 & 656.726
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98

436-045-0008
Administrative Review

(1) Any party as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

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

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

Stat. Auth.: ORS 656.704, 656.726(4), 656.745
Stats. Implemented: ORS 656.236, 656.289, 656.625, 656.704, 656.726(8), 656.740, 656.745
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1990 (Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 27-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-045-0010
Criteria for Eligibility

(1) In order to qualify for reimbursement from the Reopened Claims Program there must be:

(a) An order or award issued by the Board upon its own motion pursuant to ORS 656.278 and as provided by OAR chapter 438, division 12 or a voluntary claim reopening; and

(b) Verifiable compensation paid in accordance with the order or award issued by the Board or voluntary claim reopening, including permanent disability awarded as a result of a reopening due to a new or omitted medical condition pursuant to ORS 656.278(1)(b).

(2) Notwithstanding paragraph (1)(b) of this rule, reimbursement may be made from the Program for reasonable overpayments of temporary disability. Reasonable overpayments are those made from the date a worker becomes medically stationary, returns to work or is released to work until the insurer is notified or should have known of the status change.

(3) Costs for claims to subject workers of an employer who is in a noncomplying status as defined in ORS 656.052 are not eligible for reimbursement from the Program but remains a cost recoverable from the employer as provided by ORS 656.054(3).

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.236, 656.289 & 656.625
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-045-0020
Limitation of Program

(1) Reimbursement shall be limited to the monies available in the Workers' Benefit Fund.

(2) In the event of insufficient funds in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution which will proportionately distribute the available funds among the claims having qualified for reimbursement under the Program.

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.625
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98

436-045-0025
Dispositions

(1) In order for a disposition of a claim by the parties to be considered for reimbursement eligibility under the Reopened Claims Program, it must be submitted to the director during the period of time in which the claim remains open under the Board's Own Motion or voluntary claim reopening.

(2) Dispositions submitted in accordance with (1) are not eligible to receive reimbursement from the Reopened Claims Program unless made with the prior written approval of the director.

(3) Requests for written approval of proposed dispositions shall include:

(a) A copy of the proposed disposition which specifies the amount of the proposed contribution to be made from the Reopened Claims Program;

(b) A statement from the insurer indicating how the amount of the contribution was calculated;

(c) Any other information as required by the director.

(4) The director will not approve the disposition for reimbursement if the proposed contribution from the Program exceeds a reasonable projection of that claim's future liability to the Program under that Board's Own Motion reopening or voluntary claim reopening.

Stat. Auth.: ORS 656.236, 656.289 & 656.625
Stats. Implemented: ORS 656.236, 656.289 & 656.625
Hist.: WCD 7-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 27-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 9-1991, f. 12-13-91, cert. ef. 1-1-92; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-045-0030
Reimbursement

(1) Reimbursement shall be made by Compliance quarterly after receipt and approval of documentation of compensation paid by the paying agent.

(2) The director, by bulletin, shall prescribe the form and format for requesting reimbursement from the Program. Documentation to support the reimbursement request shall include but not be limited to:

(a) Net temporary disability compensation paid, net permanent disability paid, and net medical compensation paid for dates of injury prior to January 1, 1966. For purposes of this section, "net" compensation paid means the total compensation paid less any recoveries, including but not limited to, third party recovery, Retroactive Program reimbursement, and Workers with Disabilities Program reimbursement.

(b) Payment certification statement.

(c) Any other information deemed necessary by the director.

(3) Periodically Compliance shall audit the physical file of the paying agent to validate the amount reimbursed and to verify that the closing report is correct. Reimbursement shall not be approved if, upon such audit, it is found:

(a) Payments were not authorized in the Board's Own Motion order or voluntary claim reopening; or

(b) Payments of temporary disability compensation were made for periods of time during which the worker did not qualify as a "worker" pursuant to ORS 656.005(30); or

(c) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing; or

(d) The separate payments of compensation have not been documented, as required under generally accepted accounting procedures; or

(e) Medical payments for claims with injury dates prior to January 1, 1966 are in excess of what should have been paid if paid in accordance with OAR 436-009-0030 and properly audited as required by OAR 436-009-0020; or

(f) Permanent disability payments were made in claims reopened for other than a new medical or omitted condition.

Stat. Auth.: ORS 656.625
Stats. Implemented: ORS 656.625
Hist.: WCD 8-1987, f. 12-18-87, ef. 1-1-88; WCD 27-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 13-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

DIVISION 50

EMPLOYER/INSURER COVERAGE RESPONSIBILITY

436-050-0001
Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.407, 656.430, 656.455, 656.726, 656.850, 656.855, and 731.475.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.017, 656.018, 656.021, 656.023, 656.027, 656.029, 656.031, 656.037, 656.039, 656.126, 656.128, 656.140, 656.403, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.440, 656.443, 656.447, 656.455, 656.614, 656.745, 656.750, 656.850, 656.855 & 731.475
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCB 2-1976(Admin) (Temp), f. & ef. 4-12-76; WCB 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0001; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0002
Purpose

It is the purpose of the director that under the provision of ORS 656.726(4) rules be established to ensure the requirements of ORS 656.017 are met. One of the general charges to the director under the Workers' Compensation Law is the providing of compensation, regulation and enforcement in connection with ORS 656.001 to 656.794. To meet that responsibility the director has delegated to the division the responsibility of ensuring the requirements of the statutes, rules, and bulletins of the director are complied with as they relate to employer coverage.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.017
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCB 2-1976(Admin) (Temp), f. & ef. 4-12-76; WCB 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0008; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0003
Applicability of Rules

(1) These rules are effective November 28, 2007, to carry out the provisions of:

(a) ORS 656.017 — Employer required to pay compensation and perform other duties.

(b) ORS 656.029 — Independent contractor status.

(c) ORS 656.126 — Coverage while temporarily in or out of state.

(d) ORS 656.407 — Qualifications of insured employers.

(e) ORS 656.419 — Guaranty contracts.

(f) ORS 656.423 — Cancellation of coverage by employer.

(g) ORS 656.427 — Termination of guaranty contract or surety bond liability by insurer.

(h) ORS 656.430 — Certification of self-insured employer.

(i) ORS 656.434 — Certification effective until canceled or revoked; revocation of certificate.

(j) ORS 656.443 — Procedure upon default by employer.

(k) ORS 656.447 — Sanctions against insurer for failure to comply with contracts, orders or rules.

(l) ORS 656.455 — Records location and inspection.

(m) ORS 656.745 — Civil penalties.

(n) ORS 656.850 and 656.855 — Worker leasing companies.

(o) ORS 731.475 — Insurer's in-state location.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.704 and 656.726(4)

Stats. Implemented: ORS 656.017, 656.029, 656.126, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.443, 656.447, 656.455, 656.745, 656.850, 656.855, 731.475
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 10-1982(Admin), f. 9-30-82, ef. 10-1-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0003, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0005
Definitions

For the purpose of these rules unless the context requires otherwise:

(1) "Audited Financial Statement" means a financial statement audited by an outside accounting firm.

(2) "Board" means the Workers' Compensation Board of the Department of Consumer and Business Services.

(3) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(4) "Complete Records" means:

(a) Written records that segregate and show specifically for each employer the amounts due from the employer and paid by the insurer or self-insured employer for premiums for insurance coverage, premium assessments, and any other moneys due the director;

(b) Written records of claims for compensation made under ORS chapter 656; and

(c) Written records of guaranty contracts issued as required by ORS chapter 656.

(5) "Controlling Person" means a person having substantial ownership or who is an officer or director of a corporation; a member or manager of a limited liability company; a partner of a partnership; or an individual who possesses, directly or indirectly, the power to direct or cause the direction of the management, policies, or operation of a person offering worker leasing services.

(6) "Days" means calendar days unless otherwise specified.

(7) "Default" means failure of an employer, insurer or self-insured employer to pay the moneys due the director under ORS 656.506, 656.612 and 656.614 at such intervals as the director shall direct.

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

(9) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter, unless the context requires otherwise.

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

(11) "Double Coverage" means more than one guaranty contract is on file with the director for the same period of time.

(12) "Fiscal Year" means the twelve-month period beginning July 1 and ending June 30.

(13) "Governmental Subdivision" means cities, counties, special districts defined in ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456 or regional council of governments created under ORS chapter 190.

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

(15) "Insurer" means a guaranty contract insurer.

(16) "Leased Worker" means any worker provided by a worker leasing company on other than a "temporary basis" as described in OAR 436-050-0420.

(17) "Person" means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the State of Oregon.

(18) "Premium" means the monetary consideration for an insurance policy.

(19) "Premium Assessments" means moneys due the director under ORS 656.612 and 656.614.

(20) "Process Claims" and its variations is the determination of compensability and management of compensation by an Oregon certified claims examiner. Although determining compensability and managing compensation must be done from within this state pursuant to ORS 731.475 and this definition, the act of making payment may be done from out-of-state as directed from the Oregon place of business.

(21) "Reinstatement" means the continuation of workers' compensation insurance coverage without a gap under a guaranty contract.

(22) "Self-Insured Employer" means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(23) "Self-Insured Employer Group" means five (5) or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

(24) "State" means the State of Oregon.

(25) "Substantial ownership" means a percentage of ownership equal to or greater than the average percentage of ownership of all the owners, or ten percent, whichever is less.

(26) "Worker Leasing Company" means a "person," as described in section (17) of this rule, who provides workers, by contract and for a fee, as established in ORS 656.850.

(27) "Written" and its variations means that which is expressed in writing, including electronic transmission.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCB 2-1976(Admin)(Temp), f. & ef. 4-12-76; WCB 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 10-1982(Admin), f. 9-30-82, ef. 10-1-82; WCD 1-1983(Admin), f. 6-30-83, ef. 7-1-83; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0005; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0006
Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS Chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0010; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0008
Administrative Review and Contested Cases

(l) Any party as defined by ORS 656.005, including an Assigned Claims Agent pursuant to ORS 656.054, aggrieved by an action taken pursuant to these rules in which a worker's right to compensation or the amount thereof is directly in issue may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS Chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law except where otherwise provided in ORS Chapter 656.

(2) Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by sending a written request to the Workers' Compensation Division's administrator within 60 days after the order was mailed.

(3) A hearing will not be granted if the request:

(a) Fails to state the specific grounds for which the party contests the proposed order or assessment; or

(b) Is mailed or delivered to the administrator more than 60 days after the order was mailed.

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

(5) Any party described in section (1) aggrieved by an action taken pursuant to these rules by another person except as described in

sections (1) through (3) above may request administrative review by the division on behalf of the director. The process for administrative review of such matters shall be as follows:

(a) The request for administrative review shall be made in writing to the administrator of the Workers' Compensation Division within 90 days of the action. No administrative review shall be granted unless the request specifies the grounds upon which the action is contested and is received by the administrator within 90 days of the contested action unless the director or his designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) The review, including whether the request is timely and appropriate, may be conducted by the administrator, or the administrator's designee, on behalf of the director.

(c) In the course of said review, the person conducting the review may request or allow such input or information from the parties as he or she deems to be helpful.

(d) The determination by the person conducting the review will specify whether the determination constitutes a final order or whether an aggrieved party may request a hearing under section (4).

Stat. Auth.: ORS 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.254, 656.735, 656.740 (Sec. 9, Ch. 170, OL 2003), 656.745 & 656.750
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0998, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-87; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-050-0015
Suspension and Revocation of Authorization to Issue Guaranty Contracts

(1) Pursuant to ORS 656.447, the director may suspend or revoke the insurer's authority to issue guaranty contracts upon a determination that the insurer has failed to comply with its obligations under such contract or that it has failed to comply with the rules or orders of the director.

(2) For the purpose of this rule:

(a) "Suspension" and its variations means a stopping by the director of the insurer's authority to issue new guaranty contracts for a specified period of time.

(b) "Revocation" and its variations means a permanent revocation by the director of an insurer's authority to issue guaranty contracts.

(c) "Show-cause hearing" means an informal meeting with the director or designee in which the insurer shall be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke an insurer's authority to issue guaranty contracts.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show-cause hearing before the director and "show cause" why it should be permitted to continue to issue guaranty contracts.

(4) A show-cause hearing may be held at any time the director finds that an insurer has failed to comply with its obligations under a guaranty contract or has failed to comply with rules or orders of the director.

(5) Following a show-cause hearing, the director may rescind the proposed order if the insurer establishes to the director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy lapses or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the director revoke the insurer's authority to issue guaranty contracts.

(8) When an insurer's authority to issue guaranty contracts has been revoked, the insurer may serve an existing account only until the policy lapses, is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer's authority to issue guaranty contracts has been in effect for five years or longer, it may petition the director to restore its authority by submitting a plan in the form prescribed by the director, demonstrating its ability and commitment to comply with the workers' compensation law, these rules and orders of the director.

(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-050-0008.

(11) Any order of suspension or revocation issued by a referee or other person pursuant to ORS 656.447 and this rule is a preliminary order subject to revision by the director.

Stat. Auth.: ORS 656.407, 656.430, 656.455 & 656.726
Stats. Implemented: ORS 656.447
Hist. WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0040
Responsibility for Providing Coverage When a Contract is Awarded

(1) In the operation of ORS 656.029 a subject employer who fails to comply with ORS 656.017 is a "noncomplying employer" as defined by ORS 656.005.

(2) For the purposes of this rule:

(a) "Assistance of others" means one or more individuals directly and immediately aiding in a common undertaking.

(b) "Normal and customary part or process of the person's trade or business" refers to the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) Pursuant to ORS 656.037, a person contracting to pay remuneration for professional real estate activity as defined in ORS Chapter 696 to a qualified real estate broker or qualified principal real estate broker, as defined in ORS 316.209, is not an employer of the qualified broker.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.029 & 656.037
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0052; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0045
Non-Subject Workers

(1) As used in ORS 656.027(1):

(a) "Private employment contract" means direct employment of the worker by the owner of the private home.

(b) As used in this rule, "owner of the private home" means any person who occupies and either owns, leases or rents the private home, or any person related by blood or marriage to that person, or any person who by direction of that person or by order of a court has become responsible for managing the household affairs of that person.

(2) As used in ORS 656.027(19):

(a) "A person performing foster parent duties" means any person certified by the State Office for Services to Children and Families under ORS Chapter 418 as a foster parent, or any person employed by that person in the operation of a foster home as defined in ORS Chapter 418 and any rules promulgated thereunder.

(b) "A person performing adult foster care duties" means any person licensed by the Senior and Disabled Services Division or the Mental Health and Developmental Disability Services Division to operate an adult foster home, or any person employed by the operator to perform services of assistance to the residents of the adult foster home.

(3) As used in this rule, "adult foster home" means any family home or facility, licensed under ORS 443.705 to 443.825, in which room, board, and 24-hour care services are provided, for compensation, to five or fewer adults who are not related to the operator by blood or marriage.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.027
Hist.: WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0050
Corporate Officers, Partnerships; Limited Liability Company Members; Subjectivity

(1) Pursuant to ORS 656.027, a corporation, limited liability company, or partnership must elect in writing to its insurer to provide workers' compensation coverage for otherwise nonsubject workers. Such election must be made at the inception of a coverage policy and remain in effect until a revised written designation is given to the insurer. A self-insured employer must file the election with the director. If an entity does not file its initial election, or is not in compliance pursuant to ORS 656.017 and 656.407, then those exempt individuals shall be determined in the following order:

(a) For a corporation:

(A) President;

(B) Secretary, if any;

(C) Vice President, if any;

(D) Secretary/Treasurer, if any;

(E) Treasurer, if any;

(F) All other officers, if any.

(b) For a limited liability company or partners of a partnership:

(A) The member or partner with the largest ownership interest;

(B) The next largest ownership interest.

(c) If there is more than one person or the ownership interest is the same in any of the offices listed in subsections (a) and (b) of this rule, the sequence of those persons will be determined by whose birthday falls earlier in a year.

(2) Noncomplying corporations, noncomplying limited liability companies, or noncomplying partnerships, regardless of the number of employees, are limited to two exempt officers, members, or partners to be determined in accordance with section (1) of this rule.

(3) For purposes of clarifying terms used in ORS 656.027:

(a) "Commercial harvest of timber" means all commercial activities relating to harvest of timber from a parcel of property including, but not limited to, road building, marking of trees to be cut, timber falling, slash removal, and transportation of timber to the location where it will be processed into lumber or other products.

(b) "Director" means a person elected or appointed to a corporation's board of directors in accordance with its articles of incorporation or bylaws.

(c) "Eligible officer" means a corporate officer who is also a director of the corporation and who has a substantial ownership interest in the corporation.

(d) "Eligible partner" or "eligible member" means a partner or member who has substantial ownership in the business entity.

(e) "Noncomplying" means an employing legal entity of subject workers which is in violation of ORS 656.017(1).

(f) "Substantial ownership" means a percentage of ownership equal to or greater than the average percentage of ownership of all owners or ten percent, whichever is less.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.126 & 656.027
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0065, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 8-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0055
Extraterritorial Coverage

(1) Criteria to be used in determining whether a worker is temporarily in or out of state pursuant to ORS 656.126 may include, but are not limited to:

(a) The extent to which the worker's work within the state is of a temporary duration;

(b) The intent of the employer in regard to the worker's employment status;

(c) The understanding of the worker in regard to the employment status with the employer;

(d) The permanent location of the employer and its permanent facilities;

(e) The circumstances and directives surrounding the worker's work assignment;

(f) The state laws and regulations to which the employer is otherwise subject;

(g) The residence of the worker;

(h) The extent to which the employer's work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer's work; and

(i) Other information relevant to the determination.

(2) Within 30 days after coverage of an Oregon employer is effective, the insurer providing the coverage shall notify the employer in writing of the provisions of ORS 656.126 and this rule.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.126
Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-050-0060
Guaranty Contract Filing Requirements; Evidence of Authority

(1) Every guaranty contract issued by an insurer pursuant to ORS 656.419 shall:

(a) Contain information pursuant to, and be filed in accordance with, ORS 656.419 and this rule.

(b) Be in writing and shall include the employer FEIN or other federal tax reporting number; legal name of the employer; type of ownership; primary nature of business; employer mailing address; employer principal place of business address; specific insurer providing coverage; policy number; effective date of coverage; insurer representative signature; and statement of assumption of liability pursuant to ORS 656.419(1).

(c) Be submitted in a form and format prescribed by the director; and

(d) Be completed in its entirety prior to submission to the director.

(2) A National Council on Compensation Insurance (NCCI) classification code satisfies the required nature of business description in which an employer is engaged or proposes to engage.

(3) Incomplete, illegible, or incorrect guaranty contracts received by the director may not be considered filed.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.419 & 656.427
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 1-1983(Admin), f. 6-30-83, ef. 7-1-83; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0100; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0070
Requalifying Required when Employer Entity Changes

(1) An employer shall, if there is any change in the employing legal entity, requalify with the director in accordance with ORS 656.017. An employer shall within 10 days after a change in legal entity occurs, notify its insurer of such change. A change in legal entity includes, but is not limited to:

(a) When the employer is a sole proprietorship, partnership or corporation and changes to a sole proprietorship, partnership or corporation; or

(b) When partners of a partnership establish another separate and distinct partnership.

(2) When a change in the legal entity of an insured employer occurs, the insurer shall, within 30 days, file a written guaranty contract with the director as evidence of the change.

(3) Even though there is no change in legal entity, if there is a disassociation or admission of a partner of a partnership, the employer shall within 10 days after the change, notify its insurer of such change. The insurer shall, within 30 days of being notified of the change, file an endorsement to the guaranty contract on file that sets forth the disassociation or admission of the partner and the effective date of such disassociation or admission.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.419
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0105, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-050-0080
Personal Elections

(1) When a person makes an election under ORS 656.039, 656.128 or 656.140, the insurer must give the director notice of the election and of cancellation of the election. The election notice may be included as a "flag" type notice in a guaranty contract filing but should not include specific names for whom election is made. Specifics of an election of coverage for persons defined as nonsubject workers or not defined as subject workers must be filed with the insurer, or in the case of self insurance with the director, by written notice identifying by position held or by specific name which otherwise nonsubject worker is being made subject by the election.

(2) A personal election made under ORS 656.140 may be canceled by giving written notice to the insurer as provided by ORS 656.128.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.039, 128 & 656.140
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0110; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0090
Notice to the Director of Change of Name or Address of Insured Employer

Notice to the director of change of name or address as required by ORS 656.419, shall be given by filing in a form and format, or manner as prescribed by the director, a guaranty contract endorsement with the director as evidence of the change. A change of address includes:

(1) A change in the employer's mailing address; or

(2) A change in the employer's principal place of business in Oregon.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.419
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0115; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0100
Cancellation of Coverage by Employer; Reinstatement of Guaranty Contract; Carrier Liability

(1) An employer may cancel coverage with an insurer pursuant to ORS 656.423. An employer's cancellation of coverage with an insurer does not terminate a guaranty contract. Liability of an insurer under a guaranty contract under this chapter is terminated by an insurer taking action pursuant to ORS 656.427.

(2) An insurer may terminate liability on its guaranty contract or surety bond by giving the employer and director notice of termination in accordance with ORS 656.427 and this rule.

(3) Notice to the employer for terminating an insurer's guaranty contract filed with the director must be in writing, must include a statement that the filing with the director will terminate, and must state the effective date of termination as allowed under ORS 656.427.

(4) The insurer bears the burden of proof establishing that a termination notice was mailed to an employer. The notice and proof of mailing must be made available in Oregon upon request.

(5) Notice to the director of termination of a guaranty contract can be provided separately under OAR 436-160 or under this rule; or in a list if filing by hard copy submission under this rule. The notice under this rule must:

(a) Be in writing;

(b) Clearly identify the insurer;

(c) Include the employer(s) legal name; Federal Employer Identification Number (FEIN) or other tax reporting number; and the effective date of termination; and

(d) Be mailed or delivered to the director within ten calendar days after the effective date of the termination.

(6) Failure to provide timely notice to the director of termination of an insurer's guaranty contract may result in civil penalties pursuant to ORS 656.745.

(7) A guaranty contract termination notice may be rescinded and the guaranty contract reinstated if there will not be a lapse in the employer's coverage. If there is a lapse in the employer's coverage and the insurer reestablishes a policy for the employer, the insurer must file a new guaranty contract which reports the effective date of the new coverage.

(8) Pursuant to ORS 656.427(5), an employer may give notice to the insurer seeking continued coverage. The notice must be given before the effective date of the insurer guaranty contract termination and must be in writing. The notice must at least include a statement that other coverage has not been obtained and that the employer intends to become insured under the plan as established in ORS 656.730. Further application by the employer is not required. Pursuant to ORS 656.427(5), the insurer so notified must then insure continuing coverage and may take the additional steps to transfer the risk to the plan.

(9) If two or more guaranty contracts are in effect for one employer for the same time period, the insurer filing the employer's most recent arrangement for coverage shall have responsibility for processing claims occurring during the time period.

(10) If a guaranty contract is in effect and an active self insurance certification is on file with the director for the same employer for the same time period, the self insured employer shall have the responsibility of processing claims occurring during the time period as arranged under the self insurance certification.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented:ORS 656.423, 656.427 (ch. 656, OL 2007
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0120; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0110
Notice of Insurer's Place of Business in State; Coverage Records Insurer Must Keep in Oregon

(1) Every insurer that is authorized to issue workers' compensation coverage to subject employers as required by ORS Chapter 656 shall give the director notice of the location, mailing address, telephone number, and any other contact information in this state where the insurer processes claims and keeps written records of claims and guaranty contracts as required by ORS 731.475. The insurer must provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director. While the insurer may have more than one location in this state, the information provided to the director must reasonably lead an inquirer to a person who can respond to inquiries as to guaranty contract information and to access an in-state Oregon certified claims examiner who can respond within a reasonable time to specific claims processing inquiries. A response time of forty-eight (48) hours or less not including weekends or legal holidays would satisfy a reasonable expectation.

(2) Notice under section (1) of this rule shall be filed with the director within 30 days after the insurer becomes authorized and starts writing workers' compensation insurance policies for Oregon subject employers.

(3) If an insurer elects to use a service company to satisfy the purposes of ORS 731.475 with respect to all or any portion of its business, the insurer shall, prior to its effective date, file with the division a copy of the agreement between the insurer and each company, and shall give the division notice of the location and mailing address of each service company.

(4) For the purpose of this section, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the insurer shall include, but not be limited to:

(a) Processing claims and responding to specific claims processing inquiries;

(b) Keeping of records in a written form, not necessarily original form, and making those records available upon request;

(c) Accommodating in-state periodic audits of the director; and

(d) Providing copies of guaranty contracts, related information, and responding to inquiries to resolve coverage issues.

(5) If its place of business or that of a service company elected in lieu of an in-state place of business is changed, the insurer shall notify the director of the new location, mailing address, telephone number,

and any other contact information of the place of business at least 30 days prior to the effective date of the change.

(6) When an insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor. The insurer must also notify the director of which claims will be transferred. The notice to the director must include:

(a) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed; and

(b) A listing of the claims being transferred which identifies the sending processor's claim number, claimant name, claimant's social security number, and date of injury. The list should also include the employer's WCD number and WCD's claim number, if known.

(7) Records every insurer is required to keep in this state include all the written records of the insurer that show its insured employers have complied with ORS 656.017, including the records described by OAR 436-050-0120.

Stat. Auth.: ORS 731.475, 656.704 & 656.726(4)
Stats. Implemented: ORS 731.475
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 6-1984(Admin), f. & ef. 9-14-84; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0205; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-050-0120
Records Insurers Must Keep in Oregon; Removal and Disposition

(1) The records of claims for compensation that each insurer is required to keep in this state include:

(a) Written records used and relied upon in processing claims; and

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date, or an explanation of the time period between the date of issuance and mailing.

(2) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial has been affirmed by operation of law.

(3) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(4) When a denied claim is found to be compensable, the records of such claim are thereafter subject to section (3) of this rule.

(5) Claims records may be destroyed when all potential for benefits to the injured worker is gone.

(6) The records relating to guaranty contracts that insurers are required to keep in the state include:

(a) A written record of each guaranty contract, termination, cancellation, reinstatement, and endorsement issued under the Workers' Compensation Law;

(b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the Workers' Compensation Law; and

(c) Written records of all money due and all such money collected from insured employers for the director and required to be remitted to the director.

(7) If all remittances have been made, guaranty contract records may be disposed of after the end of three full calendar years following the calendar year in which the guaranty contract terminates.

Stat. Auth.: ORS 731.475, 656.704 & 656.726(4)
Stats. Implemented: ORS 731.475
Hist.: WCB 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0215; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0150
Qualifications of a Self-Insured Employer

(1) An employer shall qualify as a self-insured employer by:

(a) Establishing proof that the employer has an adequate staff qualified to process claims;

(b) Establishing proof of the financial ability to make certain the prompt payment of all compensation and other payments due under ORS 656;

(c) Obtaining excess insurance coverage in the amounts approved by the director; and

(d) Being registered and authorized to do business in this state pursuant to ORS Chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) An employer shall establish proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one person qualified in accordance with OAR 436-055-0070 and that is actually involved in the self-insured employer's claims processing.

(3) An employer shall establish proof of financial ability by providing a security deposit that the director determines is acceptable in accordance with OAR 436-050-0165, and in an amount as determined in accordance with OAR 436-050-0180.

(4) Failure of a certified self-insured employer to maintain the qualifications required in this rule shall result in revocation of the employer's self-insured certification. The employer will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the employer complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stat. Auth.: ORS 656.407, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0305; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 8-2003(Temp), f. & cert. ef. 7-18-03 thru 1-13-04; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0160
Applying for Certification as a Self-Insured Employer

(1) An employer applying for certification as a self-insured employer must submit the following information:

(a) An application in a form and format prescribed by the director to become a self-insured employer;

(b) Proof of the employer's claims processing ability by employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or by contracting with a service company that will have at least one person qualified in accordance with OAR 436-055-0070, that will be processing the employer's claims in this state, pursuant to ORS 656.455(1);

(c) The employer's audited financial statements or audited annual reports for the last three fiscal or calendar years. If the audited financial statements of a parent company are provided in lieu of statements for the employer, the director will not authorize the individual employer to be self-insured under its own program, unless a parental company guarantee can be obtained. Otherwise, it will be necessary for the parent company to be the self-insured employer or to separately insure the employer. In the context of this section, a parent company is a legal entity which owns a majority interest in the employer, or owns a majority interest in another entity or succession of entities which owns a majority interest in the employer;

(d) The employer's most recently promulgated experience rating modification worksheet and supporting documentation. Applicants with prior Oregon experience who do not submit this data will be assigned a 1.50 experience rating modification pending receipt of the data. All those without prior Oregon experience will be assigned a 1.00 experience rating modification;

(e) The type, retention and limitation levels of excess workers' compensation insurance the employer is planning to obtain as required by OAR 436-050-0170;

(f) If applicable, within 30 days after the date of certification, a service agreement between the employer and service company that has

been signed by both parties. The agreement shall also contain the location, mailing address, telephone number, and any other contact information of the service company;

(g) Evidence from a surety bond company, admitted to do surety business in this state, that they will issue a surety bond for the employer, as Principal, and the Oregon Department of Consumer and Business Services, Workers' Compensation Division, as Obligee; or evidence from a qualified bank that they will issue an irrevocable standby letter of credit for the employer with the Oregon Department of Consumer and Business Services, as the beneficiary;

(h) Evidence of an occupational safety and health loss control program in accordance with OAR 437-001 as required by ORS 656.430(10); and

(i) Evidence of authorization to do business in this state pursuant to ORS Chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) Within 30 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer that the request for certification as a self-insured employer is denied and the reason therefore; or, that the employer is qualified as a self-insured employer. If the employer qualifies as a self-insured employer, the notice shall include:

(a) The type and the amount of the security deposit required;

(b) Approval of the type, retention and limitation levels of the excess insurance; or

(c) The type, retention and limitation levels of excess insurance required.

(3) If approved, the certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(4) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (3) of this rule are met.

(5) Notwithstanding subsection (l)(c) of this rule, an employer making application may submit certified financial statements in lieu of audited financial statements or annual reports. However, the director may require the employer to submit audited financial statements if the certified financial statements submitted are insufficient to evaluate the employer's financial status.

Stat. Auth.: ORS 656.407, 656.430, 656.455 & 656.726
Stats. Implemented: ORS 656.430
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0310; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 8-2003(Temp), f. & cert. ef. 7-18-03 thru 1-13-04; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0165
Security Deposit Requirements

(1) For the purposes of this rule:

(a) "Employer" includes employer groups;

(b) "Self-insured employer" includes self-insured employer groups; and

(c) "ISLOC" means irrevocable standby letter of credit.

(2) An employer is required to provide a security deposit that is acceptable to the director, to establish proof of its financial ability, and to be qualified and certified as a self-insured employer or to be certified as a self-insured employer group. In accordance with ORS 656.407, a surety bond or an irrevocable standby letter of credit (ISLOC) may be accepted for the required security deposit if it complies with the following conditions and requirements:

(a) An ISLOC may be approved by the director as all or part of the security deposit. The director may approve the ISLOC if the issuing bank and the ISLOC meet the requirements of this rule:

(A) The ISLOC shall be issued by or confirmed by an Oregon state chartered bank from which funds will be immediately payable on demand or a federally chartered bank that has an Oregon branch office, from which funds will be immediately payable on demand. The bank issuing an ISLOC shall have at the time of issuance a credit rating as set forth below:

(i) An "Aaa," "Aa," or "A" long term certificate of deposit (CD) rating in the current monthly edition of "Moody's Statistical Handbook" prepared by Moody's Investors Service Inc., New York; or

(ii) An "AAA," "AA" or "A" long term certificate of deposit (CD) rating in the current quarterly edition or monthly supplement of "Financial Institutions Ratings" prepared by Standard & Poors Corporation, New York.

(B) Federally chartered instrumentalities of the United States operating under authority of the Farm Credit Act of 1971 as amended, are acceptable without rating.

(C) An ISLOC issued by a bank that does not meet the credit rating set forth in paragraph (A) at the time of issuance shall only be accepted with a confirming ISLOC issued by an Oregon state chartered bank or federally chartered bank with an Oregon branch office meeting the credit criteria of paragraph (A). The confirming ISLOC shall state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed.

(D) The issuing bank must use the Irrevocable Standby Letter of Credit, Form 440-3640, issued by the director.

(E) The ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date unless, at least 60 days before the expiry date, the director is notified in writing by registered mail or overnight delivery, that the bank has elected not to extend the ISLOC for another period.

(F) If the issuing bank or any confirming bank is closed at the time of expiry of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation.

(G) The ISLOC can be called immediately if:

(i) The self-insured employer has defaulted in payment of its workers' compensation liabilities or obligations, or in payments due to the director under ORS 656;

(ii) The self-insured employer has filed for bankruptcy;

(iii) The self-insured employer has failed to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or

(iv) The beneficiary has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer, and that neither has been provided, notwithstanding written notice to the self-insured employer.

(H) The credit shall be available by presentation of the beneficiary's draft drawn at sight on the issuing bank, payable within three business days, when accompanied by one of the statements contained in 436-050-0165(2)(a)(G) signed by the director of the Department of Consumer and Business Services, or the administrator of the Workers' Compensation Division, or their designated authorized representative.

(I) The ISLOC is not subject to any qualifications or conditions by the issuing bank or confirming bank and is each bank's individual obligation, which is in no way contingent upon reimbursement.

(J) An ISLOC shall include a statement that the funds provided by the ISLOC are not construed to be an asset of the self-insurer and a statement that if legal proceedings are initiated by any party with respect to the payment of any ISLOC, it is agreed that such proceedings shall be subject to the jurisdiction of Oregon courts and Oregon Law.

(K) Payment of any amount under an ISLOC shall be made only by wire transfer in the name of the "Department of Consumer and Business Services In Trust For [the legal name of the certified self-insured employer]" to a department account, with the State Treasurer, at a designated bank.

(L) An ISLOC shall be subject to the International Standby Practices 1998 (ISP98), ICC Publication No. 590, which is hereby incorporated by reference, and a reference to this publication shall be included in the text of the ISLOC. ICC Publication 590 may be obtained from the International Chamber of Commerce.

(M) All bank charges for the ISLOC are for the account of the applicant.

(N) Any amendment to the ISLOC must be approved and accepted by the director before the amendment is effective.

(O) If a bank's rating subsequent to the issuance of the ISLOC falls below the acceptable rating level as set forth in paragraph (A), the self-insured employer shall be required within 60 days of the publication of the lower credit rating to:

(i) Replace the ISLOC with a new ISLOC issued by an Oregon state chartered bank or with a federally chartered bank with an Oregon branch office with an acceptable credit rating;

(ii) Confirm the ISLOC by an Oregon state chartered bank or a federally chartered bank with an Oregon branch office that has an acceptable credit rating; or

(iii) Replace the ISLOC with a policy of insurance or a surety bond of equal amount that is approved by the director, as substitute security for the ISLOC, if the policy of insurance or surety bond covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC.

(P) Each self-insured employer that submits an acceptable ISLOC as its security deposit, shall furnish a memorandum of understanding with the ISLOC, on the department's Form 440-3529, which affirms the self-insured employer's acceptance of all of the following requirements:

(i) An ISLOC is furnished to the director instead of a surety bond or other forms of security that may be determined to be acceptable for certification as a self-insured employer or for continuing as a certified self-insured employer;

(ii) The self-insured employer understands the ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date the director is notified in writing by the bank that the irrevocable standby letter of credit will not be renewed;

(iii) The ISLOC may be replaced with an ISLOC or surety bond of equal amount or a policy of insurance that is accepted by the director as substitute security for the ISLOC, if the new ISLOC or surety bond or policy of insurance covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC to be replaced;

(iv) The self-insured employer shall affirm that the ISLOC, in the amount required, is being offered with the understanding that the ISLOC can be called immediately, at the director's discretion, if the director receives notice that the ISLOC will not be renewed; if the self-insured employer fails to pay its workers' compensation liabilities, obligations or payments due to the director under ORS 656; or the self-insured employer files bankruptcy; or the self-insured employer fails to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or the director has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer and that neither has been provided, notwithstanding written notice to the self-insured employer; and

(v) If legal proceedings are initiated by any party with respect to payment of any ISLOC, then it is agreed that the proceedings shall be subject to the jurisdiction of Oregon courts and application of Oregon Law(s).

(b) A surety bond may be accepted by the director as a security deposit or substitute security deposit for an ISLOC, government securities, monies, or time deposits. A surety bond may be accepted as all or part of the security deposit. The director, in each particular case, will determine if the surety bond submitted is acceptable, if the issuing Surety is acceptable, and if its language and format are acceptable.

(A) The surety bond must be issued by a Surety company authorized to transact surety business in Oregon;

(B) Surety Bond Form 440-824 shall be used for all surety bonds;

(C) Surety bonds submitted for the self-insured employer's security deposit shall be continuous in form;

(D) Surety bonds may be terminated by the surety company by giving the director and the Principal written notice stating that on a date not less than thirty days after the date the notice is received by the director, such termination shall be effective. Such termination shall in no way limit the liability of the Surety for subsequent defaults of the Principal's liability and/or obligations incurred under ORS 656 prior to the effective date of such termination;

(E) Surety Bond Rider Form 440-1810 shall be used for all department required increases or authorized decreases in the penal sum of the surety bond. The surety bond rider is not effective until it is accepted by the department;

(F) Surety bonds and all riders to the surety bonds shall be executed by the surety company's attorney in fact and the attorney in fact's appointment and power of attorney must accompany all surety bonds and riders submitted. The power of attorney must authorize the attorney in fact to execute the surety bond in the amount of the penal sum of the bond;

(G) The liability of a surety company under its surety bond may only be discharged in the event that:

(i) The Principal files acceptable substitute security as the security deposit that is accepted by the director as substitute security for the surety bond to be released, covering all past, present, existing and potential liability of the Principal under ORS 656 and covering all the Surety's liability under the surety bond to be released, in an amount required by the director; and

(ii) The surety bond is released as documented in writing from the director or the administrator of the Workers' Compensation Division, or their designated authorized representative.

(iii) A policy of insurance or an ISLOC of equal amount that is acceptable by the director, may be accepted as substitute security for the surety bond, if the policy of insurance or ISLOC covers all workers' compensation liabilities and obligations that would have been covered by the surety bond.

(H) The surety company or its parent shall have and maintain an acceptable credit rating in accordance with the following:

(i) Standard and Poors Insurer Financial Strength Rating of A or better rating; or

(ii) A.M. Best Company, Financial Strength Rating of B+ or better rating.

(I) A surety bond shall be replaced by the self-insured employer with an acceptable type of security deposit, within 30 days, after notice from the department that the Surety has been placed in conservatorship, or is seized, or declares insolvency, or the current credit rating is below the ratings required in subsection (H).

(c) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer's or a self-insured employer group's required security deposit prior to January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director. A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit shall complete a "Security Agreement and Notice to Intermediary," Form 440-4023, granting the department a security interest in and control over those financial assets.

(d) Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit, or for employers whose self-insurance certification is granted subsequent to January 1, 2004.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.430
Hist.: WCD 8-2003(Temp), f. & cert. ef. 7-18-03 thru 1-13-04; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0170
Excess Insurance Requirements

(1) A self-insured employer must have excess workers' compensation insurance coverage appropriate for the employer's potential liability under ORS 656.001 to 656.990 with an insurer authorized to do business in the state. The policy providing such coverage and any endorsements thereto must be filed with the director not later than 30 days after the date the coverage is effective. A self-insured public utility with assets in excess of $500 million as reflected by the employer's audited financial statement submitted in accordance with OAR 436-050-0160 or 436-050-0175, may obtain the required excess workers' compensation insurance coverage from an eligible surplus lines insurer.

(2) The excess insurance:

(a) Must include a provision for reimbursement to the director of all expenses paid by the director on behalf of the employer pursuant to ORS 656.614 and 656.443 in the same manner as if the director were the insured employer, subject to the policy limitations or amounts and limits of liability to the insured employer; and

(b) Coverage must be continuous and remain in effect from the date of certification until the certification is revoked or canceled; and

(c) Coverage must be specific on a per occurrence basis; and

(d) Coverage may include aggregate excess insurance.

(3) When an excess insurance policy is canceled by the excess insurer or the employer, a copy of such notice shall be filed with the director 30 days prior to the effective date of cancellation.

(4) Changes in the self-insured retention level and policy limits of the excess insurance require prior approval of the director. The director may require a reduction in the self-insured retention level or an increase in the policy limits. Those items considered in determining and approving the retention and limitation levels of the excess insurance will be the employer's:

(a) Financial status;

(b) Risk and exposure;

(c) Claim history; and

(d) The amount of the required security deposit.

(5) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to reduce the self-insured retention level or increase the policy limitation or amounts and limits of liability of the excess insurance.

(6) Excess insurance obtained under this section does not relieve any self-insured employer from full responsibility for claims processing and the payment of compensation required under ORS 656 and these rules. Regardless of the types and amounts of excess coverage a self-insured employer shall not transfer claims to the excess insurer(s) for processing.

(7) If a self-insured employer fails to comply with the requirements of this section, the employer's certification as a self-insured will be revoked. The employer will be given written notice of such revocation which will be effective 30 days from receipt of such notice. If the required excess insurance is obtained within the 30 days, the revocation is canceled and certification remains in effect.

Stat. Auth.: ORS 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.430
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0315; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-050-0175
Annual Reporting Requirements

(1) To determine the financial status of a self-insured employer and to evaluate the employer's continuity of operation, a self-insured employer shall annually file, within 120 days of the employer's fiscal year end, an audited financial statement or annual report with audited financial statement, including SEC Form 10K if issued, for the just completed fiscal year. All financial statements and annual financial reports filed, as required by this section, shall be retained by the director for a period of at least three years. In lieu of an audited financial statement or annual report, a self-insured employer may file a financial statement certified by the employer that the financial statement is true, accurate and presents the employer's financial condition and results of operations as of the date of the statement.

(2) Each self-insured employer shall submit an annual endorsement to their application for self-insurance in the form prescribed by the director. The endorsement shall be filed by March 1 of each year.

(3) Notwithstanding section (l) of this rule, the director may require an employer to submit an audited financial statement if the certified financial statement submitted is insufficient to evaluate the employer's financial status.

(4) The self-insured employer shall report claim loss data necessary by March 1 of each year for the purposes of experience rating modification, retrospective rating calculations and determining deposits.

(a) The report must be certified to be true and accurate by an authorized representative of the self-insured employer, and must include:

(A) A report of losses for each year in the experience rating period. The report must cover all claims incurred during the reporting period, and must be valued as of January 1 of the current year. Reports must include:

(i) Contract medical expenses;

(ii) Total medical deductible;

(iii) Number of claims for which the medical deductible is claimed;

(iv) For claims with incurred losses of $5,000 or less: total paid, outstanding reserves, and total incurred losses;

(v) Number of claims with incurred losses of $5,000 or less; and

(vi) For each claim with incurred losses exceeding $5,000: worker's name, date of injury, claim number, total paid, outstanding reserves, and total incurred losses. Claims must be listed in alphabetical order.

(B) A report of losses covering the self-insured period prior to the experience rating period. The report must list all open claims, and must be valued as of January 1 of the current year. The report must include:

(i) The worker's name, listed in alphabetical order;

(ii) Date of injury;

(iii) Claim number;

(iv) Total paid;

(v) Outstanding reserves; and

(vi) Total incurred losses.

(C) Identification of claims involving catastrophes, Workers with Disabilities Program, permanent total disability or fatal benefits, third party recoveries, and claims where the total incurred has or is expected to exceed the self-insured retention of the self-insured employer's excess insurance policy.

(b) The director will, by bulletin, provide guidelines for self-insured employers and their authorized representatives to use in submitting the required data.

(c) Each self-insured city or county that is exempted from the security deposit requirements in accordance with ORS 656.407(3) and OAR 436-050-0185 shall, in addition to the above, provide the procedures, methods, and criteria used in the process of determining the amount of their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported.

(5) If a self-insured employer fails to comply with the requirements of sections (1), (2), (3) or (4) of this rule, the director may impose any or all of the following sanctions:

(a) Require the self-insured employer to increase their deposit and premium assessments by 25%;

(b) Conduct an audit to obtain the necessary loss information at the self-insured employer's expense;

(c) Assess civil penalties for up to $250 per day that the information is not provided beyond the deadline; or

(d) Revoke the employer's certification as a self-insured.

(6) To ensure each self-insured employer's claims are valued appropriately for use in deposit, experience rating, and retrospective rating calculations, the director will perform routine test audits. If a self-insured employer's total claims values are found to be 10 percent or more below the director's determined values, the current experience rating will be recalculated using the director's determined values and will be used in the security deposit and retrospective rating calculations. In addition, penalties may be assessed.

Stat. Auth.: ORS 656.407, 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407 & 656.430
Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0180
Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit

(1) The deposit a self-insured employer is required by ORS 656.407 to maintain with the director shall be an amount not less than the greater of:

(a) $100,000; or

(b) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost , and the anticipated assessments payable to the director for the employer's next fiscal year; or

(c) The annual incurred losses for the self-insured's last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer's next fiscal year.

(2) Notwithstanding section (1) of this rule, if the employer is applying for self-insurance, the amount of the deposit shall not be less than the greater of:

(a) The anticipated assessments payable to the director for the employer's next fiscal year; plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the

applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer's Oregon operations for the employer's next fiscal year; or

(b) $300,000 plus $30,000 additional for each $100,000 the employer's net worth is below $2 million; or

(c) The amount of the approved self-insured retention level for the employer's excess workers' compensation insurance.

(3) In determining the amount of deposit the director will take into consideration:

(a) Financial ability of the employer to pay compensation and other payments due;

(b) Employer's probable continuity of operation;

(c) Retention and limitation levels of the employer's excess insurance in relation to the employer's financial status; and

(d) Balance of the Self-Insured Employers Adjustment Reserve.

(4) Assessments payable to the director referred to in this section include moneys and assessments due pursuant to ORS 656.506, 656.612, and 656.614.

(5) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to increase the amount of its deposit.

(6) "Claims processing administrative cost" shall be determined by developing a percentage rate to be applied against the employer's "unpaid losses." The rate will be based upon the information contained in Schedule P, Part ID of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year. The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:

(a) "Loss Expenses Unpaid" for losses incurred in the latest eight years, divided by;

(b) "Losses Unpaid" for losses incurred in the latest eight years.

(7) "Incurred but not reported" (IBNR) shall be calculated by applying a loss development factor against the employer's annual incurred losses. The loss development factor will be calculated annually by the director.

Stat. Auth.: ORS 656.407, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407
Hist.: WCB 2-1976(Admin)(Temp), f. & ef. 4-12-76; WCB 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0320; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0185
Deposit Exemption for Self-Insured Cities and Counties, Qualifications, Application Procedures, Conditions and Requirements, Revocation and Requalification

(1) A self-insured city or county may make application to be exempt from the security deposit requirements of ORS 656.407(2). Pursuant to ORS 656.407(3), the requirements to qualify for exemption are as follows:

(a) The city or county must be a certified self-insured employer, not a member of a self-insured employer group, in compliance with ORS 656.407(2) and OAR 436-050-0180 as an independently self-insured employer for the three consecutive years immediately prior to making application for the exemption; and

(b) The city or county must have in effect a workers' compensation loss reserve account that is actuarially sound and that is adequately funded as determined by the annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director pursuant to ORS Chapter 656. The workers' compensation loss reserve account shall also be dedicated to and expended only for payment of compensation and amounts due the director by the city or county under ORS Chapter 656.

(2) A written application requesting exemption from ORS 656.407(2) shall be submitted to the director no later than 45 days prior to the date the exemption is desired to become effective. The application shall include the following supporting documentation for review and approval:

(a) A copy of the city's or county's most recent annual audit as filed with the Secretary of State under ORS 297.405 to 297.740 that identifies the actuarially sound funded amount in the dedicated workers' compensation loss reserve if not previously filed as required by OAR 436-050-0175(1);

(b) A copy of the city's or county's current fiscal year's approved budget that states the budgeted amount for the funded workers' compensation loss reserve account;

(c) A resolution or ordinance passed by the city's or county's governing body that establishes an actuarially sound and adequately funded workers' compensation loss reserve account that dedicates the workers' compensation loss reserve account to and limits expenditures to only the payment of compensation and amounts due the director under ORS Chapter 656. The resolution shall also include the director's first lien and priority rights to the full amount of the workers' compensation loss reserve account required to pay the present discounted value of all present and future claims under ORS Chapter 656; and

(d) A statement giving the amount of the current reserves for present and future liabilities, the amount funded in the workers' compensation loss reserve account, the procedures, methods, and criteria used in the process of determining the amount funded in their actuarially sound workers' compensation loss fund, including procedures for determining the amount for injuries incurred but not reported. The statement shall include the city's or county's certification that the loss reserve account is actuarially sound and adequately funded if an actuarial study is not available.

(3) Within 45 days of receipt of all information required in section (2) of this rule, the director will review the application and supporting documentation and notify the city or county that the request for exemption under ORS 656.407(3) is approved or denied.

(a) If denied, the notice will provide the reasons for the denial, any requirements for reconsideration and the right to administrative review as provided by OAR 436-050-0008.

(b) If approved, the notice shall include:

(A) The confirmation of the effective date of exemption;

(B) Authorization for cancellation of any surety bond or ISLOC held as security pursuant to ORS 656.407(2) and OAR 436-050-0180; and

(C) Procedures for release of any government securities or time deposits held as security pursuant to ORS 656.407(2) and OAR 436-050-0180.

(4) Probable cause to believe the workers' compensation loss reserve account is not actuarially sound includes but is not limited to: The annual audited financial statement under ORS 297.405 to 297.740 not containing a statement by the auditor that the workers' compensation loss reserve account is adequately funded, or containing a disclaimer regarding the auditor's qualifications or ability to determine adequacy of the loss reserve account.

(5) A city or county that has been exempted from ORS 656.407(2) and desires to terminate its self-insurance certification or elects to discontinue maintaining an actuarially sound and adequately funded workers' compensation loss reserve shall:

(a) Submit written request to the director at least 60 days prior to: the desired effective date the self-insured certification is requested to be terminated; or the effective date that the qualifying workers' compensation loss reserve account is to be discontinued;

(b) If the self-insured certification is to be terminated, the request for termination shall comply with the requirements of OAR 436-050-0200. Prior to the effective date of termination the city or county shall provide a security deposit, as required by the director, in an amount determined pursuant to OAR 436-050-0180 and ORS 656.443; and

(c) If the city or county desires to remain self-insured the city or county shall requalify for self-insurance certification by depositing prior to the date the qualifying workers' compensation loss reserve account is to be discontinued, a security deposit as required by the director pursuant to ORS 656.407(2) and OAR 436-050-0180. Pursuant to ORS 656.407(3)(e) failure to deposit the required security deposit with the director prior to the date of discontinuance of the qualifying workers' compensation loss reserve account shall cause the city's or county's self-insurance certification to be automatically revoked as of that date.

Stat. Auth.: ORS 656.407, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407
Hist.: WCD 7-1991(Temp), f. 10-4-91, cert. ef. 10-7-91; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0190
Using Self-Insured Employers Surety Deposit/Self-Insured Employers Adjustment Reserve

(1) In the event a self-insured employer fails to or is unable to make all payments due under ORS Chapter 656, the director shall, on behalf of the employer, assure continued payments in accordance with ORS 656.407, 656.443 and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers' claims.

(2) If a self-insured employer defaults and is being serviced by one or more service companies, the director will, on behalf of the employer, designate those service companies to continue processing claims in accordance with the contracts in effect. At least 90 days prior to the time the contract expires, the service company can submit a proposal to continue processing the claims. The director will consider such proposal along with other options which may include referral of the claims for processing to an Assigned Claims Agent as secured under ORS 656.054.

(3) If a self-insured employer defaults and is self-administering, the director shall, on behalf of the employer, negotiate to have the employer's claims processed or may refer the claims for processing to an Assigned Claims Agent as secured under ORS 656.054.

(4) For the purposes of this rule:

(a) "Employer" includes employer groups.

(b) "Self-insured employer" includes self-insured employer groups.

Stat. Auth.: ORS 656.407, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407, 656.443 & 656.614
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0322; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0195
Requirements for Self-Insured Entity Changes

(1) If there is any change in the legal entity, changes in addresses, telephone numbers, and points of contact, or ownership changes, a self-insured employer shall notify the director in writing within 30 days after the change occurs.

(2) A self-insured employer shall submit requests to add or delete entities under its self-insured certification in the form and format, or manner, as prescribed by the director, and signed by an officer of the company. Each entity to be approved for inclusion in a self-insured employer's certification must enter into an agreement, signed by an officer of the entity being included in the self-insured employer's certification, making the entity jointly and severally liable for the payment of any compensation and moneys due to the director by the certified self-insured employer and/or any other entity included in the self-insured employer's certification.

(3) The director will determine, based on the information provided, the effect of the change on the deposit required and whether the entities can be combined for experience rating purposes.

(4) Failure to provide notification as required by this section may result in assessment of penalties and/or self-insurance certification revocation.

Stat. Auth.: ORS 656.407, 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407 & 656.430
Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0200
Self-Insured Certification Cancellation; Revocation

(1) A certification to a self-insurer issued by the director remains in effect until:

(a) Revoked as provided by OAR 436-050-0150 through 436-050-0230 and ORS 656.440; or

(b) Canceled by the employer with the approval of the director.

(2) If a self-insured employer wishes to cancel certification as a self-insured or cancel self-insurance for any legal entity included under the self-insurance certification, the employer shall make written request to the director. Such a request shall be submitted at least 60 days prior to the desired date of cancellation and include:

(a) What arrangements have been made to process present and future claims for which the employer is responsible;

(b) A statement of all present and future claims liabilities for all liabilities incurred during the period of self-insurance; and

(c) Any reports and/or moneys due the director pursuant to ORS 656.506, 656.612, and 656.614.

(3) If the employer will continue to have subject workers after the cancellation date, the employer must provide the director, prior to the desired date of cancellation, one of the following:

(a) A proof of coverage filing under ORS 656.017 and 656.419;

(b) Evidence of a worker leasing arrangement as allowed under ORS 656.850; or

(c) An assigned risk binder that demonstrates compliance with ORS 656.052.

(4) If the self-insured employer fails to provide the director evidence of subsequent coverage under section (3) prior to the desired date of cancellation, the self-insurance certification, including reports and moneys due the director under ORS 656.506, 656.612, and 656.614, will remain in effect.

(5) The certification of a self-insured employer may be revoked if:

(a) The employer fails to comply with ORS 656.407 or 656.430 and the rules adopted pursuant thereto; or

(b) The employer commits any violation for which a civil penalty could be assessed under ORS 656.745.

(6) Except as provided in OAR 436-050-0170(7), notice of certificate revocation will be issued in accordance with the provision of ORS 656.440.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.434 & 656.440
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0325; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0205
Notice of Self-Insurer's Personal Elections

When a person makes an election under ORS 656.039, 656.128 or 656.140, the self-insured shall notify the director in written form of the election and of any cancellation of the election within 30 days of the effective date.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.039, 656.128 & 656.140
Hist.: WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0210
Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Keep in Oregon

(1) Every employer certified as a self-insured employer shall give the director notice of location, mailing address, telephone number, and any other contact information of at least one location in this state where claims will be processed and claim records kept as well as other records as required by this rule and OAR 436-050-0220. The employer shall give notice of the location, mailing address, telephone number, and any other contact information upon application for certification.

(2) With the approval of the director, a self-insured employer may use one or more service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer shall file with the director a copy of the agreement entered into between the employer and each company, and shall give the director notice of the location, mailing address, telephone number, and any other contact information of each service company.

(3) If a self insured employer or service company for a self insured employer changes its place of business, the self insured employer shall notify the director of the new location, mailing address, telephone number, and any other contact information 30 days prior to the effective date of the change.

(4) When a self-insured employer changes claims processing locations, service companies, or self-administration, the employer must provide at least 10 days prior notice to:

(a) Workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor;

(b) The director of which claims will be transferred. The notice must include:

(A) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed; and

(B) A listing of the claims being transferred which identifies the sending processor's claim number, claimant name, claimant's social security number, and date of injury. The list should also include the employer's WCD number and WCD's claim number, if known.

(5) Written records every self-insured employer is required to keep in this state include, but are not limited to, the records described by OAR 436-050-0220.

(6) Notwithstanding section (1) of this rule, the director may approve up to two additional claims processing locations, if the self-insured employer can show:

(a) That meeting the requirements of section (1) of this rule will impose a financial or operational hardship on the employer;

(b) That such additional locations will result in improved claims processing performance of the employer; and

(c) That the auditing functions of the director can be met without unnecessary expense to the director.

(7) If, upon review of a self-insured employer's claims processing performance, the performance has not remained at the levels as described in OAR 436-060, approval for additional locations provided in section (6) shall be withdrawn.

(8) Notwithstanding section (1) of this rule, a self-insured employer may, with the prior approval of the director, make compensation payments from a single location other than the designated claims processing location. Approval of such a location may be revoked if at any time:

(a) Timeliness of compensation payment falls below the minimum standards as established in OAR 436-060;

(b) Written record of compensation payments is not available; or

(c) There is not sufficient written documentation to support the issuance of a check for compensation.

(9) Notwithstanding section (1) of this rule, a self-insured employer may, with prior approval of the director, have one additional location, in or out of state for maintaining payroll records pertaining to premium assessments and assessment/contributions.

Stat. Auth.: ORS 656.455, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.455
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0330; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0220
Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition

(1) The written records self-insured employers are required to keep in this state to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 include:

(a) A record of payroll by National Council on Compensation Insurance classification; and

(b) Complete records of all assessments, employer and employee contributions, and all such money due the director.

(2) The self-insured employer must maintain at a place of business in this state, those written records relating to their safety and health program as required by ORS 656.430(10) and in accordance with OAR 437-001.

(3) The records of claims for compensation that each self-insured employer is required to keep in this state include, but are not limited to:

(a) Written records used and relied upon in processing claims; and

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date, or an explanation of the time period between the date of issuance and mailing.

(c) A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments with cumulative totals. The record of disability payments should be limited to statutory benefits and not include any additional employer obligations. Expenses must not be included in any of the three columns required on the summary sheet. "Expenses" are defined in National Council on Compensation Insurance, Workers' Compensation Statistical Plan, Part IV.

(4) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial has been affirmed by operation of law.

(5) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(6) Notwithstanding sections (4) and (5) of this rule, if administrative or judicial review is requested, the claim records may not be removed from this state or disposed of until after either the review is concluded and the time for an appeal from such review has expired or at least one year after final payment of compensation has been made, whichever is the last to occur.

(7) During administrative or judicial review, if a denied claim is found to be compensable the records of such claim are thereafter subject to section (5) of this rule.

(8) Claim records may be destroyed when all potential for benefits to the injured worker is gone.

(9) Records retained as required by section (1) of this rule may be removed from the state or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Stat. Auth.: ORS 656.455, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.455
Hist.: WCD 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0335; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-050-0230
Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Notwithstanding OAR 436-050-0220, if a self-insured employer wishes to keep the claims records and process claims at a location outside this state, the employer may apply to the director for permission to do so. The application shall contain the reasons for the request and the location, mailing address, telephone number, and any other contact information where the records will be kept and the claims processed. The application must provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director. Upon receipt, the director will review the application and notify the employer that the request has been denied and the reason therefor; or, that the employer will be allowed to process claims from outside this state.

(2) The director may grant permission to the self-insured employer unless the employer has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of section (3) of this rule.

(3) A self-insured employer that keeps claims records and processes claims at a location outside this state shall:

(a) Process claims in an accurate and timely manner;

(b) Make reports to the director promptly as required by ORS Chapter 656 and the director's administrative rules;

(c) Pay to the director promptly all assessments and other money as it becomes due;

(d) Increase or decrease its security deposit promptly when directed to do so by the director pursuant to ORS 656.407(2); and

(e) Comply with the rules and orders of the director in processing and paying claims for compensation.

(4) After notice given as required by ORS 656.455(2), permission granted under this section will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of section (3) of this rule.

(5) A self-insured employer shall provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

Stat. Auth.: ORS 656.455, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.455
Hist.: WCD 18-1975(Admin), f. 12-19-75, ef. 1-1-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from

436-051-0340; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-050-0260
Qualifications of a Self-Insured Employer Group

Five or more employers may qualify as a self-insured employer group if the employers as a group:

(1) Incorporate or are a cooperative pursuant to ORS Chapter 60, 62, or 65. If the group is a governmental subdivision, it must have formed a governmental entity as provided under ORS 190.003 to 190.110;

(2) Designate a board of trustees and an administrator;

(3) Demonstrate a combined net worth of $1 million or more and have excess insurance with a retention of $100,000 or more; or the combined net worth of the employers as a group may be less than $1 million if the employers as a group obtain excess insurance with less than a $100,000 retention, in which case the net worth required may be reduced by the same percentage the retention is reduced below $100,000;

(4) Obtain excess insurance coverage of the type and amounts approved by the director;

(5) Demonstrate that accident prevention is likely to improve through self-insurance;

(6) Engage an adequate staff pursuant to OAR 436-055-0070 qualified to process claims;

(7) Develop a method approved by the director to notify the director of:

(a) The commencement or termination of membership by employers in the group, and the effect thereof on the net worth of the employers in the group; and

(b) Whether an employer who terminates membership in the group continues to be a subject employer; and if the employer remains a subject employer what arrangements have been made to continue coverage.

(8) Establish a safety and health loss prevention program as required by OAR 437-001;

(9) Create a common claims fund approved by the director;

(10) Designate an entity within or for the group responsible for centralized claims processing, payroll records, safety requirements, recording and submitting assessments and contributions and making such other reports as the director may require. With the approval of the director, a self-insured employer group may use service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer group shall file with the director a copy of the agreement entered into between the employer group and each company, and shall give the director notice of the location, mailing address, telephone number, and any other contact information of each service company;

(11) Establish proof of financial ability by providing a security deposit that the director determines is acceptable in accordance with OAR 436-050-0165; and in an amount as determined in accordance with OAR 436-050-0180; and

(12) Comply with the requirements of OAR 436-050-0165, 436-050-0170, 436-050-0175, 436-050-0180, 436-050-0195, 436-050-0200, 436-050-0205, 436-050-0210 and 436-050-0220. Failure to comply with these requirements will result in the actions prescribed in those rules.

(13) Every self-insured employer group shall maintain at least one place of business in this state where the employer processes claims, keeps written records of claims and other records as required by OAR 436-050-0210 to 436-050-0220.

(14) Failure of a certified self-insured employer group to maintain the qualifications required in this rule shall result in revocation of the self-insured employer group's certification. The group will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the self-insured employer group complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stat. Auth.: ORS 656.407, 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407 & 656.430
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0405; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0270
Applying for Certification as a Self-Insured Employer Group: Private Employers

(1) Employers applying for certification as a self-insured employer group must submit:

(a) An application for the group applying for self-insurance in a form and format prescribed by the director;

(b) Proof in the form of a certificate from the Corporation Division showing the employer group as a corporation or cooperative;

(c) A copy of the bylaws or corporate minutes which include:

(A) Designation of specific individuals as trustees for the corporation or cooperative and naming an administrator to administer the financial affairs of the group who, as obligee, shall furnish a fidelity bond with the group in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities; and

(B) The criteria utilized by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group.

(d) A current financial statement of each member making application which taken collectively shows the following:

(A) The combined net worth of all members making application for coverage shall not be less than $1 million unless the employers as a group have obtained excess insurance coverage with less than a $100,000 retention in which case the net worth will be reduced by the same percentage the retention is reduced below $100,000; and

(B) Working capital in an amount establishing financial strength and liquidity of the business.

(e) An individual report by employer showing the employer's payroll by class and description and loss information for the last four calendar years;

(f) With the exception of governmental subdivisions, an agreement jointly and severally binding each member for the payment of any compensation and moneys due to the director by the group and/or any member of the group. The agreement shall be in a form and format prescribed by the director;

(g) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(h) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the self-insured employer's claims processing. If one or more service companies are used, a service agreement between the employer group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted for approval of the director.

(i) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(j) A procedure for notifying the director of:

(A) The commencement or termination of employers within the group and the effect on the net worth of the group; and

(B) Arrangements made by an employer leaving the group to continue insurance coverage.

(k) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(l) The type of security deposit the employer group wishes to provide, with appropriate justification.

(2) Notwithstanding subsection (1)(d) of this rule, the director may require an audited financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer group that the request for certification as a self-insured

employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice shall include:

(a) The amount of security deposit required;

(b) Approval of the type, retention and limitation levels of the excess insurance as determined pursuant to OAR 436-050-0170; and

(c) The type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(5) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (4) of this rule are met.

Stat. Auth.: ORS 656.407, 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.407 & 656.430
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0410; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0280
Applying for Certification as a Self-Insured Employer Group: Governmental Subdivisions

(1) Governmental subdivisions applying for certification as a self-insured employer group must submit:

(a) An application for the group applying for self-insurance in a form and format prescribed by the director;

(b) Proof that the governmental subdivisions have formed an intergovernmental entity as provided under ORS 190.003 to 190.110;

(c) An intergovernmental agreement which includes:

(A) Designation of specific individuals as trustees for the group and naming an administrator to administer the financial affairs of the group who, as obligee, shall furnish a fidelity bond with the group in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities; and

(B) The criteria to be used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group.

(d) A current financial statement of each member making application which taken collectively shows the combined net worth of all members making application for coverage shall not be less than $1 million unless the employers as a group have obtained aggregate excess insurance coverage with less than a $100,000 retention in which case the net worth will be reduced by the same percentage the retention is reduced below $100,000;

(e) An individual report by employer showing the governmental subdivision's payroll by class and description and loss information for the last four calendar years;

(f) A resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(g) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(h) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is actually involved in the self-insured group's claims processing, that is certified in accordance with OAR 436-055-0070. If service companies are used, a service agreement between the group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted.

(i) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(j) A procedure for notifying the director of:

(A) The commencement or termination of governmental subdivisions within the group and the effect on the net worth of the group; and

(B) Arrangements made by a governmental subdivision leaving the group to continue insurance coverage.

(k) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(l) The type and amount of security deposit the group wishes to provide, with appropriate justification. In no case shall the amount be less than $300,000.

(2) Notwithstanding subsection (l)(d) of this rule, the director may require an audited or certified financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice shall include:

(a) The amount of the security deposit required; and

(b) Approval of the type, retention and limitation levels of the excess insurance as determined pursuant to OAR 436-050-0170; and the type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit, the appropriate excess insurance binder and if applicable, a service agreement between the employer and service company that has been signed by both parties.

(5) Unless a subsequent date is specified by the applicant, the effective date of certification will be the date the certification is issued.

Stat. Auth.: ORS 656.407, 656.430, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.430 & 656.407
Hist.: WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0290
Commencement/Termination of Employers with a Self-Insured Employer Group; Effect on Net Worth; Extension of Coverage; Change in Entity; Change of Address; Recordkeeping

(1) Prospective new members of a self-insured employer group shall submit an application to the board of trustees, or its administrator. The trustees, or administrator, may approve the application for membership pursuant to the bylaws of the self-insured group. Once approved, the administrator or board of trustees shall submit to the director an endorsement, within 30 days of the effective date of membership, in a form and format as approved by the director which shall be accompanied by:

(a) A current financial statement of the employer applying;

(b) An agreement signed by the administrator of the self-insured group and the employer, making the employer jointly and severally liable for the payment of any compensation and moneys due to the director by the group and/or any member of the group; or, if a governmental subdivision self-insured group, a resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(c) A statement showing the effect on the new worth of the group; and

(d) The employer's payroll by class and description and loss information for the last four fiscal or calendar years.

(2) Incomplete submissions or incorrectly completed endorsements to add new members received by the director will not be considered filed. Failure to file a correct and complete endorsement with the required supporting documentation within 30 days of the effective date of membership may result in the assessment of civil penalties.

(3) Individual members may elect to terminate their participation in a self-insured group or be subject to cancellation by the group pursuant to the bylaws of the group. Such cancellation or termination shall not be effective prior to approval by the director and only after the self-insured group has submitted the following information for review:

(a) A statement showing the effect of said termination on the net worth of the group;

(b) Evidence that the employer requesting termination has made alternate arrangements for coverage if the employer continues to employ; and

(c) The requested date of cancellation or termination.

(4) Upon receipt of the required information, the director may approve the cancellation or termination of the employer provided:

(a) Such cancellation or termination does not adversely affect the net worth of the group to the extent that the group would no longer qualify for a self-insured status; and

(b) Sufficient evidence has been presented to insure that the employer, if employing, retains workers' compensation coverage.

(5) Once approved, the group will be notified in writing of the effective date of cancellation or termination.

(6) An employer within a group shall, if there is a change in the employing legal entity, again apply for membership within the group, in accordance with this rule. A change in legal entity includes, but is not limited to:

(a) When a partner joins or leaves the partnership;

(b) When the employer is a sole proprietorship, partnership or corporation, and changes to a sole proprietorship, partnership or corporation; or

(c) When an employer sells an existing business to another person(s), except in the case of a corporation.

(7) An employer within a group shall, within 10 days after there is a change of address or assumed business name, notify the board of trustees, or administrator, of the change. The administrator or board of trustees shall, within 10 days, submit to the director an endorsement as notice of the change. A change of address includes, but is not limited to:

(a) Establishment of a new or additional location; or

(b) Termination of an existing location.

(8) The endorsement required by section (7) of this rule shall state specifically which location is being deleted and/or which is being added. It shall also identify the type of address, whether it is mailing, operating, or the principal place of business.

(9) The employer group is responsible for maintaining coverage records relating to each member, to include:

(a) The employer's application for membership in the group, with original signatures;

(b) The employer's liability agreement pursuant to OAR 436-050-0270(1)(f), or resolution pursuant to OAR 436-050-0280(1)(f), with original signatures;

(c) Cancellation or termination notices;

(d) Reinstatement applications and notices; and

(e) Records on the whereabouts of employers that have been canceled or have terminated their participation in the group.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.434 & 656.440
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0415; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-050-0300
Self-Insured Employer Group, Common Claims Fund

(1) A self-insured employer group shall establish under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payments of all compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law.

(2) Except as provided in section (5) of this rule, the balance of the common claims fund shall be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years.

(3) The self-insured group may, from time to time, be required by the director to increase the amount maintained in the common claims fund.

(4) By March 1 of each year, a self-insured employer group shall provide the director with adequate documentation to validate the balance in the common claims fund.

(5) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund shall be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.430
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0420; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0340
Group Self-Insurance Revocation

Notwithstanding ORS 656.440, the certification of a self-insured employer group may be revoked by the director after giving 30 days notice if:

(1) The employer group fails to comply with ORS 656.430(7) or (8), or the requirements contained in OAR 436-050-0260, 0270, 0280, 0290, or 0300;

(2) The employers within a group number less than five;

(3) The net worth of the group falls below that required by OAR 436-050-0260(3);

(4) The employer group commits any violation for which a civil penalty could be assessed under ORS 656.745; or

(5) Any false or misleading information is submitted by the employer group or any member of the group.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.434 & 656.440
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0440; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01

436-050-0400
Responsibility for Providing Coverage Under a Lease Arrangement

(1) Every worker leasing company providing workers to a client shall satisfy the requirements of ORS 656.017, 656.407, or 656.419.

(2) Every worker leasing company providing leased workers to a client shall also provide workers' compensation insurance coverage for any subject workers of the client, unless the client has an active guaranty contract on file with the director or is certified under ORS 656.430 as a self-insured employer. In the latter circumstance, the client's guaranty contract insurer or self-insured employer will be deemed to provide insurance coverage for all leased workers and subject workers of the client.

(3) If an insured client allows its guaranty contract to terminate or if a self-insured client, allows its certification to terminate and the client continues to employ subject workers or has leased workers, the client shall be considered a noncomplying employer unless the worker leasing company has made the filing with the director as provided in OAR 436-050-0410(1).

(4) A client can obtain leased workers from only one worker leasing company at a time unless the client has an active guaranty contract on file with the director or is certified under ORS 656.430 as a self-insured employer.

(5) A worker leasing company shall not provide workers' compensation coverage for another worker leasing company.

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 15-1994, f. 12-23-94, cert. ef. 2-1-95; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0410
Notice to Director of Lease Arrangement; Termination

(1) Within 14 days after the effective date of the lease arrangement or contract, a worker leasing company must file written notice with the director and its insurer, using Form 440-2465, that it is providing leased workers to a client and workers' compensation coverage. The notice must be correct and complete, and must include:

(a) The client's:

(A) Legal name;

(B) FEIN or other tax reporting number;

(C) Type of ownership;

(D) Primary nature of business;

(E) Mailing address; and

(F) Street address in Oregon;

(b) The worker leasing company's:

(A) Legal name;

(B) Mailing address;

(C) FEIN or other tax reporting number;

(D) WCD worker leasing license number, if any;

(E) Workers' compensation insurer's name (or "self-insured");

(F) Effective date of leasing contract;

(G) Contact name and phone number; and

(H) A signature of a representative of the worker leasing company.

(2) A worker leasing company may terminate its obligation to provide workers' compensation coverage by giving to its insurer, its client, and the director written notice of the termination. A notice of termination shall state the effective date and hour of termination, but the termination will be effective not less than 30 days after the notice is received by the director. Notice to the client under this section must be given by mail, addressed to the client at its last-known address.

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0420
Temporary Worker Distinguished from Leased Worker

(1) A person who provides a worker to work for a client will be considered to be providing the worker on a "temporary basis" only if there is contemporaneous written documentation, retained by either the client or the temporary service provider, which indicates the duration of the work to be performed and the worker is provided pursuant to ORS 656.850(1)(b), under one or more of the following conditions:

(a) Special situations to cover employee absences or employee leaves, including but not limited to such things as maternity leave, vacation, jury duty, or illness from which the permanent worker will return to work;

(b) To fill a professional skill shortage;

(c) To staff a seasonal workload;

(d) To staff a special assignment or project where the worker will be terminated or assigned to another temporary project upon completion;

(e) A student worker provided and paid by a school district or community college through a work experience program; or

(f) The work contract is part of the client's overall employment selection program, such as where new workers must satisfactorily pass a probationary period before being granted permanent employee status.

(2) If a person provides workers, by contract and for a fee, to work for a client and any such workers are not provided on a "temporary basis," that person will be considered a worker leasing company.

(3) If a person provides both leased workers and workers on a temporary basis, that person shall maintain written records that show specifically which workers are provided on a temporary basis. If the written records do not specify which workers are provided on a temporary basis, all workers are deemed to be leased workers.

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 15-1994, f. 12-23-94, cert. ef. 2-1-95; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0440
Qualifications, Applications, and Renewals for License as a Worker-Leasing Company

(1) Each person applying for initial license or renewal as a worker leasing company shall:

(a) Be either an Oregon corporation or other legal entity registered with the Oregon Secretary of State, Corporations Division to conduct business in this state;

(b) Maintain workers' compensation coverage pursuant to ORS 656.017; and

(c) Upon application approval and prior to licensure, pay the required licensing fee of $2,050.

(2) Each person applying for initial license or renewal as a worker leasing company must submit an application for license on Form 440-2466. The form and accompanying documentation must include:

(a) Legal name;

(b) Mailing address;

(c) In-state and out-of-state phone numbers;

(d) FEIN or other tax reporting number;

(e) Type of business;

(f) Physical address for Oregon principal place of business;

(g) Assumed business names;

(h) Name of workers' compensation insurer (or "self-insured") and policy number;

(i) WCD employer number, if any;

(j) Name(s) and contact information of the representative(s) at the Oregon location(s);

(k) List of controlling persons including their names, titles, residence addresses, telephone numbers, email addresses, and dates of birth;

(l) For a person applying for an initial license, a letter of verification and good standing from the controlling regulatory agency of those states in which a license or certification to provide workers by contract and for a fee was previously, or is currently held;

(m) Verification of compliance with tax laws from Oregon Employment Department, Oregon Department of Revenue, and the Internal Revenue Service, using Attachments A, B, and C of Form 440-2466, the worker leasing license application;

(n) A record of any present or prior experience of providing workers by contract and for a fee in any state, by the person or any controlling person, and an explanation of that experience;

(o) A record of any bankruptcies, liens, or any actions involving fraud, theft, embezzlement, forgery, or money laundering on the part of the person or any controlling person; such actions may include:

(A) Criminal convictions;

(B) Lawsuits;

(C) Guilty pleas; or

(D) Judgments

(p) Full details regarding any bankruptcy, liens, or action under subsection (o) of this section, including:

(A) The nature and dates of the action(s);

(B) Outcomes, sentences, and conditions imposed;

(C) Name and location of the court or jurisdiction in which any proceedings were held or are pending, and the dates of the proceedings; and

(D) The designation and license number for any actions against a license;

(q) Full details of any administrative actions against the person by a regulatory agency of any state regarding matters referenced in OAR 436-050-0440(2)(o) or worker leasing activities.

(r) A plan of operation which demonstrates how the worker leasing company will meet the requirements of ORS chapter 654, The Oregon Safe Employment Act, and collect the information necessary to establish each client's experience rating; and

(s) A notarized signature of an authorized representative of the applicant.

(3) The director may request additional information to further clarify the information and documentation submitted with the application. Under ORS 656.850(2), no person shall perform services as a worker leasing company in Oregon without first being licensed to do so.

(4) The director will review complete applications, and may conduct a background investigation of the person applying for a license or any controlling person. Information learned through a background investigation, or other information submitted during the application process, may be the basis for the director to refuse to issue or renew a license, or to disqualify the person from making further application.

(5) If the application is approved, the director will issue a license. Each license issued under these rules shall automatically expire two years after the date of issuance unless renewed by the licensee. A request for renewal of a worker leasing license must be submitted at least 45 days before the expiration date of the current worker leasing license.

(6) The director may refuse to issue or renew a license or may disqualify a person from applying for a license in the future for misrepresentation or failure to meet any of the requirements of ORS 656.850, 656.855, or these rules.

(7) A person may appeal the director's refusal to approve and issue or renew a license under this rule as provided in OAR 436-050-0008 and 436-001.

(8) "Disqualification," as used in this rule, means a prospective worker leasing company may reapply no sooner than two years from the disqualification date.

(9) A disqualification may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person or controlling person.

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0450
Recordkeeping and Reporting Requirements

(1) Every licensed worker leasing company must give notice to the director of one Oregon location where Oregon leasing records are kept. The notice must include the physical address, mailing address, telephone number, and any other contact information in this state.

(2) Every licensed worker leasing company must have at least one representative of the worker leasing company at the Oregon location authorized to respond to inquiries and make records available regarding leasing arrangements and client contracts.

(3) The following records must be kept at the Oregon location:

(a) Copies of signed worker leasing notices;

(b) Copies of signed notices of termination of leasing arrangements;

(c) Copies of signed contracts between the worker leasing company and clients; and

(d) Payroll records for all workers that identify leased workers subject to coverage by the worker leasing company; leased workers not subject to coverage by the worker leasing company; and, written records for all regular and temporary employees of the worker leasing company.

(4) The worker leasing company must notify the director within 30 days of the effective date of a change in any items listed in OAR 436-050-0440(2).

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0455
Reporting Requirements of a Self-Insured Worker-Leasing Company

(1) A self-insured worker leasing company shall maintain and report to the National Council on Compensation Insurance separate statistical data for each client whose coverage is provided by the self-insured employer. Reporting shall be according to the uniform statistical plan prescribed by the director according to ORS 737.225(4).

(2) Records relating to the client statistical data for self-insured worker leasing companies shall be made available for review by the National Council on Compensation Insurance upon request.

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0460
Suspension or Revocation of License

(1) Reasons for suspension or revocation of a worker leasing license include, but are not limited to:

(a) Insolvency, whether the worker leasing company's liabilities exceed their assets or the worker leasing company cannot meet its financial obligations;

(b) Judgments against or convictions, within the last ten years, of any worker leasing company or controlling person for the reasons identified in OAR 436-050-0440(2)(o),

(c) Administrative actions involving worker leasing activities resulting from failure to comply with the requirements of any state;

(d) Nonpayment of taxes, fees, assessments, or any other monies due the State of Oregon;

(e) If the worker leasing company has failed to comply with any provisions of ORS Chapters 654, 656, 659, 659A, 731 or 737; or any provisions of these rules; or

(f) If the worker leasing company is permanently or temporarily enjoined by a court from engaging in or continuing any conduct or practice involving any aspect of the worker leasing business.

(2) For the purposes of this rule:

(a) "Suspension" means a stopping by the director of the worker leasing company's authority to provide leased workers to clients for a specified period of time. A suspension may be in effect for a period of up to two years. When the suspension expires, the worker leasing company may petition the director to resume its worker leasing company activities.

(b) "Revocation" means a permanent stopping by the director of the worker leasing company's authority to provide leased workers to clients. After a revocation has been in effect for five years or longer, the worker leasing company may reapply for license.

(c) "Show-cause hearing" means an informal meeting with the director in which the worker leasing company shall be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a worker leasing company's authority to provide leased workers to clients.

(3) The director may revoke a license upon discovery of a misrepresentation in the information submitted in the worker leasing application.

(4) Suspension or revocation under this rule will not be made until the worker leasing company has been given notice and the opportunity to be heard through a show-cause hearing before the director and "show cause" why it should be permitted to continue to be licensed as a worker leasing company.

(5) A show-cause hearing may be held at any time the director finds that a worker leasing company has failed to comply with its obligations under a leasing contract or that it failed to comply with the rules or orders of the director.

(6) Appeal of proposed and final orders of suspension or revocation issued under this rule may be made as provided in OAR 436-050-0008 and 436-001.

(7) Notwithstanding section (4) of this rule, the director may immediately suspend or refuse to renew a license by issuing an "emergency suspension order" if the worker leasing company fails to maintain workers' compensation coverage; or if the director finds there is a serious danger to public health or safety.

(8) A suspension or revocation may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company's assets to another person.

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0470
Monitoring/Auditing

(1) The division will monitor and conduct periodic audits of employers as necessary to ensure compliance with the worker leasing company licensing and performance requirements.

(2) All pertinent records of the worker leasing company required by these rules must be disclosed upon request of the director.

(3) Pursuant to ORS 656.726 and 656.758, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

(4) For the purposes of this rule, both the worker leasing company and its clients shall be considered employers.

Stat Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855
Stats. Implemented: ORS 656.850 & 656.855
Hist.: WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

436-050-0480
Assessment of Civil Penalties

(1) The director may assess a civil penalty against an employer who fails to respond to requests for information and fails to meet the requirements of 436-050-0470. The matrix attached to these rules in Appendix "A" will be used in assessing these penalties. Assessment of a penalty does not relieve the employer of the obligation to provide a response.

(2) An employer failing to meet the requirements set forth in OAR 436-050-0410, 436-050-0450, and 436-050-0455, may be

assessed a civil penalty based on the matrix in Appendix "B", attached to these rules.

(3) An employer who is found to be operating a worker leasing company without having obtained a license or having failed to renew a license pursuant to ORS 656.850(2), may be assessed a civil penalty based on the matrix attached to these rules in Appendix "C".

(4) For the purposes of ORS 656.850(2), a violation is defined as any month or part of a month in which an employer provides leased workers to a client without having first obtained a worker leasing license.

(5) Any person or controlling person may also be subject to penalties under ORS 656.990.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth.: ORS 656.704, 656.726(4), 656.850 & 656.855

Stats. Implemented: ORS 656.850 & 656.855

Hist.: WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 3-2007(Temp), f. 5-31-07, cert. ef. 6-1-07 thru 11-27-07; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07

DIVISION 55

CERTIFICATION OF CLAIMS EXAMINERS

436-055-0001
Authority for Rules

These rules are promulgated under the Director's authority pursuant to ORS 656.726 and 656.780.

Stat. Auth.: ORS 656.726(4) & 656.780(1)

Stats. Implemented: ORS 656.780

Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94

436-055-0002
Purpose of Rules

The purpose of these rules is to establish standards for the certification of workers' compensation claims examiners pursuant to ORS Chapter 656.

Stat. Auth.: ORS 656.780(1)

Stats. Implemented: ORS 656

Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00

436-055-0003
Applicability of Rules

(1) These rules apply to the certification of all workers' compensation claims examiners on or after the effective date of these rules.

(2) The certification of any workers' compensation claims examiner valid on December 31, 1999, shall continue without expiration until December 31, 2000. However, this provision does not shorten any two year certification period.

(3) Any claims examiner certified on October 22, 1999, with a renewal date between October 23, 1999, and December 31, 1999, may present records to the insurer for renewal. The claims examiner's certification period shall be renewed for two years upon verification that the certified claims examiner met the continuing education requirements under the rules in effect on the date renewal was due, however no course taken after October 22, 1999, needs to be certfied.

(4) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.780

Stats. Implemented: ORS 656

Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00

436-055-0005
Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "Claims examiner" means anyone who has primary responsibility for decision making or benefit determination in a claim. This includes those who decide compensability of new claims or aggravations, calculate benefits, authorize payments, or who represent employers by direct contact with the department or Board. This definition does not include attorneys representing employers before the department or Board, or those who primarily perform clerical functions.

(2) "Claims Examiner Trainee" means a person hired by an insurance company, self-insured employer or third party administrator to decide compensability of new claims or aggravations, calculate benefits, or authorize payments, who works under the direct supervision of a certified claims examiner.

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

(4) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state; an assigned claims agent selected by the director under ORS 656.054; an employer certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407; or a third party administrator.

(5) "Party" includes anyone listed in ORS 656.005(21) and a third party administrator.

(6) "Process Claims" means the receipt, review and payment of compensation for workers' claims.

(7) "Temporary Claims Examiner" means a person with at least two years of prior claims processing experience hired by an insurance company, self-insured employer or service company to decide compensability of new claims or aggravations, calculate benefits, or authorize payments in Oregon workers' compensation claims, who works under the direct supervision of a certified claims examiner.

(8) "Third party administrator" means a service company who processes claims for an insurer or self-insurer under the conditions prescribed in ORS 731.475(3) and 656.455(1).

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656

Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00

436-055-0008
Administrative Review

(1) Any party that disagrees with a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740. The request for hearing must be mailed or delivered to the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a hearing request as provided in OAR 436-001-0019 within 60 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(3) Any person that disagrees with an action taken under these rules by another person, except as described in sections (1) and (2), may request administrative review by the director as follows:

(a) The request for administrative review must be mailed or delivered to the Administrator of the Workers' Compensation Division within 90 days of the action. The request must specify the grounds upon which the action is contested.

(b) The review will be conducted by the director.

(c) The director will review the relevant information submitted by all parties.

(d) The director will issue an administrative order that specifies whether the determination constitutes a final order or whether an aggrieved party may request a hearing under section (2).

Stat. Auth.: ORS 656.735(5)-(7), 656.745(4) & 656.726(4)

Stats. Implemented: ORS 656

Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0070
Certification of Claims Examiners

(1) Claims examiners shall be certified by the insurer upon satisfactory completion of an examination which demonstrates the individual's:

(a) Familiarity with the workers' compensation statutes;

(b) Ability to navigate the administrative rules found in this chapter;

(c) Capability to perform claim processing activities; and

(d) Understanding of activities related to interactions with independent medical examination providers that includes all the components in OAR 436-055-0085(2).

(2) Any person taking an examination may use a copy of ORS Chapter 656 and the Oregon Administrative Rules during the examination.

(3) A passing score on an examination shall be 80 percent or greater.

(4) Any examination completed through dishonest or fraudulent means shall be considered invalid.

(5) Certification will be for a three-year period. The certification date shall be the date of the examination.

(6) Certification shall be renewed at any time during the certification period by providing verification of completion of 24 hours of training during the current certification period, to include at least:

(a) Four hours of training on the workers' compensation statutes, administrative rules, and case law since the last certification; and

(b) For renewals on or after January 1, 2007, three hours of training related to interactions with independent medical examination providers that covers all the components in OAR 436-055-0085(2). The three hours of training may be completed in increments.

(7) Training may be provided in the form of a seminar, workshop, association meeting, forum, correspondence, video or similar course. It may include any of the following subjects:

(a) Medical case management including, but not be limited to, medical terminology, basic human anatomy and interpreting medical reports.

(b) Communication skills including, but not be limited to, courses in ethics, mediation, negotiation and dealing with angry people.

(c) Instruction dealing specifically with the processing of Oregon workers' compensation claims.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656
Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0085
Training for Interactions with Independent Medical Examination Providers

(1) Any training provided under OAR 436-055-0070 or 436-055-0100(4) relating to independent medical examination provider interaction must first be approved by the director.

(2) To be approved, a training curriculum for initial certification must incorporate the following components:

(a) Appropriate and ethical communication with independent medical examination providers;

(b) Insurers' rights and responsibilities;

(c) Injured workers' rights and responsibilities;

(d) Independent medical examination providers' standards of conduct requirement;

(e) IME complaint process and investigations by WCD; and

(f) Training specific to the requirements of ORS 656.325 and OAR 436-010.

(3) To be approved, a training curriculum for renewal of certification must incorporate some or all of the components in (2).

(4) Any person may develop training and receive approval by the director by submitting an application in a format prescribed by the director. The application must describe the training content that meets the criteria in section (2) of this rule, and specify the number of training hours for that topic.

(5) The director's approval will remain in effect until the content or number of hours of training change. At that time, the person will be required to resubmit an application that meets the requirements of sections (2) and (4) or (3) and (4) of this rule.

(6) The division will review an application and notify the applicant of the results within 30 days of receipt of the application. The division will reject incomplete applications.

(7) If an application is rejected or disapproved, the applicant will be notified of the reasons. The application may be resubmitted when the reasons for the rejection or disapproval have been corrected.

(8) The director will maintain a registry of approved training curricula.

Stat. Auth.: ORS 656.726
Statutes Implemented:ORS 656.780(1), OL Ch. 675, Sec. 3
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0100
Insurer Duties

(1) Insurers shall only employ claims examiners who are certified or that qualify as a claims examiner trainee or a temporary claims examiner.

(a) A claims examiner trainee must work under the direct supervision of a certified claims examiner, and may work for up to12 months in this status. An individual is limited to one12-month period as a claims examiner trainee.

(b) A temporary claims examiner must have at least two years prior claims processing experience and work under the direct supervision of a certified claims examiner. An individual may work for up to 90 days in any 12-month period as a temporary claims examiner.

(2) Insurers shall maintain a list of certified claims examiners who are employed by the insurer or who process claims for the insurer, claims examiner trainees and temporary claims examiners, and keep records sufficient to verify their certification and training. The list and records shall be subject to inspection by the director. The director may require submission of such lists and records in lieu of on-site inspection.

(3) Insurers may issue an initial certification or renewal for any individual pursuant to the standards set in OAR 436-055-0070.

(4) Insurers must ensure that training related to interactions with independent medical examination providers is provided for certified claims examiners in their employ.

(5) Insurers shall not misrepresent any information to a worker, employer or the director related to the certifications of its employees.

(6) Within 14 days of the termination of employment or upon receipt of a written request of a certified claims examiner, an insurer shall provide the certified claims examiner a complete copy of all records verifying the most recent acknowledgement of certification and any subsequent training.

(7) Insurers shall retain records verifying the certification and renewal of certified claims examiners who are employed by the insurer or who process claims for the insurer for six years from its most recent acknowledgement of current certification.

Stat. Auth.: ORS 656.780(1) & (2)
Stats. Implemented: ORS 656
Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-055-0110
Assessment of Civil Penalties

(1) Under ORS 656.745 the director may assess a civil penalty against an insurer which fails to comply with these rules.

(2) Under ORS 656.780 the director may assess a civil penalty against an insurer that fails to maintain or produce certification and training records or that employs anyone other than certified workers' compensation claims examiner to process workers' compensation claims. The insurer shall be subject to a penalty of not more than $2000 per violation. Each violation, or each day a violation continues, shall be considered a separate violation.

Stat. Auth.: ORS 656.447(1)(a), 656.745(2)(b) & 656.780(3)
Stats. Implemented: ORS 656
Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

DIVISION 60

CLAIMS ADMINISTRATION

436-060-0001
Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, and 656.726(4).

Stat. Auth.: ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210(2), 656.262(11), 656.264, 656.265(6), 656.325, 656.331, 656.704 & 656.726(4)
Hist.: WCB 18-1975, f. 12-19-75, ef. 1-1-76; WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0001, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02

436-060-0002
Purpose

The purpose of these rules is to prescribe uniform standards by which insurers shall process workers' compensation claims under ORS 656.726(4). The director has charged the Workers' Compensation Division with the administration and enforcement of the applicable statutes, these rules, and all bulletins pertaining to claims processing. Failure to process claims in accordance with these rules will subject insurers to civil penalty under ORS 656.745; to penalties payable to the claimant under ORS 656.262(11); and, to sanctions under ORS 656.447.

Stat. Auth.: ORS 656.262(11), 656.447, 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.262(11), 656.447, 656.704, 656.726(4) & 656.745
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0008, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 12-1992, f. 6-12-92, cert. ef. 7-1-92; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0003
Applicability of Rules

(1) These rules govern claims processing and carry out the provisions of:

(a) ORS 656.210. Temporary total disability;

(b) ORS 656.212. Temporary partial disability;

(c) ORS 656.230. Lump sum payments;

(d) ORS 656.262. Responsibility for processing and payment of compensation, sight drafts, claimant's duty to cooperate with an investigation, acceptance and denial and reporting of claims, and penalties for payment delays;

(e) ORS 656.264. Required reporting of information to the director;

(f) ORS 656.265. Notices of accidents from workers;

(g) ORS 656.268. Insurer claim closures, insurer recovery of overpayments;

(h) ORS 656.273 Aggravation for worsened conditions, procedures, limitations, additional compensation;

(i) ORS 656.277 Request for reclassification of nondisabling claim, nondisabling claim procedure;

(j) ORS 656.307. Determination of responsibility for compensation payments;

(k) ORS 656.325. Required medical examinations, suspension of compensation, injurious practices, claimant's duty to reduce disability, and reduction of benefits for failure to participate in rehabilitation;

(l) ORS 656.331. Notice to worker's attorney; and

(m) ORS 656.726(4). The director's powers and duties generally.

(2) The applicability of these rules is subject to ORS 656.202.

(3) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.210, 656.212, 656.230, 656.262, 656.264, 656.265, 656.268, 656.307, 656.325, 656.331, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0003, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-13-92, cert. ef. 2-1-92; WCD 1-1994(Temp), f. & cert. ef. 3-1-94; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 14-1996(Temp), f. & cert. ef. 5-31-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-060-0005
Definitions

For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means an actual worsening of the compensable condition(s) after the last award or arrangement of compensation, which is established by medical evidence supported by objective findings, and otherwise satisfies the statutory requirements of ORS 656.273.

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

(3) "Designated Paying Agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

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

(5) "Disposition" or "claim disposition" means the written agreement as provided in ORS 656.236 in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim. The term "compromise and release" has the same meaning.

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

(7) "Employer" means a subject employer as defined in ORS 656.023.

(8) "Employment on call" means sporadic, unscheduled employment at the call of an employer without recourse if the worker is unavailable.

(9) "Health insurance," as defined under ORS 731.162, means all insurance against bodily injury, illness or disability, and the resultant expenses, except for workers' compensation coverage.

(10) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

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

(12) "Lump sum" means the payment of all or any part of a permanent partial disability award in one payment.

(13) "Physical rehabilitation program" means any services provided to an injured worker to prevent the injury from causing continuing disability.

(14) "Suspension of compensation" means:

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

(b) Vocational assistance and payment of permanent partial disability benefits shall be stayed during the period of suspension.

(15) "Third party administrator" is the contracted agent for an insurer, as defined by these rules, authorized to process claims and make payment of compensation on behalf of the insurer.

(16) "Written" and its variations mean that which is expressed in writing, including electronic transmission.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0005, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-922; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-060-0006
Administrative Review

Any orders issued by the division in carrying out the director's authority to enforce ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0010, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02

436-060-0008
Administrative Review and Contested Cases

(1) Any party as defined by ORS 656.005, including an assigned claims agent as a designated processing agent under ORS 656.054, aggrieved by an action taken under these rules in which a worker's right to compensation or the amount thereof is directly in issue, may

request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law except where otherwise provided in ORS chapter 656.

(2) Contested case hearings of Sanctions and Civil Penalties: Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

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

(3) Hearings before an administrative law judge: Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (2), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(4) Administrative review by the director or designee: Any party aggrieved by an action taken under these rules by another person except as described in sections (1) through (3) above may request administrative review by the division on behalf of the director. The process for administrative review of such matters will be as follows:

(a) The request for administrative review must be made in writing to the Administrator of the Workers' Compensation Division within 90 days of the action. No administrative review will be granted unless the request specifies the grounds upon which the action is contested and is mailed or delivered to the administrator within 90 days of the contested action unless the director or the director's designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) In the course of the review, the division may request or allow such input or information from the parties deemed to be helpful.

Stat. Auth.: ORS 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.245, 656.260, 656.704, 656.726(4) & 656.740(1)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78, WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0998, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0009
Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

(1) Under ORS 192.430 and OAR 440-005-0015(1) the director, as custodian of public records, promulgates this rule to protect the integrity of claim file records and prevent interference with the regular discharge of the department's duties.

(2) The department rules on Access of Public Records, Fees for Record Search and Copies of Public Records are found in OAR 440-005. Payment of fees for access to records must be made in advance unless the director determines otherwise. Workers and insurers of record, their legal representatives and third-party administrators shall receive a first copy of any document free. Additional copies shall be provided at the rates set forth in OAR 440-005.

(3) Any person has a right to inspect nonexempt public records. The statutory right to "inspect" encompasses a right to examine original records. It does not include a right to request blind searches for records not known to exist. The director will retain or destroy records according to retention schedules published by the Secretary of State, Archives Division.

(4) Under ORS 192.502(19) workers' compensation claims records are exempt from public disclosure. Access to workers' compensation claims records will be granted at the sole discretion of the director in accordance with this rule, under the following circumstances:

(a) When necessary for insurers, self-insured employers and third-party claims administrators and their legal representatives for the sole purpose of processing workers' compensation claims. A request by telephone or facsimile transmission will be accepted, but requires provision of the claimant's social security number and insurer claim number in addition to the information required in section (7).

(b) When necessary for the director, other governmental agencies of this state or the United States to carry out their duties, functions or powers.

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim. Such circumstances include when workers' compensation claims file information is required by a public or private research organization in order to contact injured workers in order to conduct its research. The director may enter into such agreements with such institutions or persons as are necessary to secure the confidentiality of the disclosed records.

(d) When a worker or the worker's representative requests review of the workers' claim record.

(5) The director may release workers' compensation claims records to persons other than those described in section (4) when the director determines such release is in the public interest.

(a) For the purpose of these rules, a "public interest" exists when the conditions set forth in ORS 192.502(19) and subsections (4)(a) through (d) of this rule have been met. The determination whether the request to release workers' compensation claims records meets those conditions shall be at the sole discretion of the director.

(b) The director may enter into written agreements as necessary to ensure that the recipient of workers' compensation claims records under this section uses or provides the information to others only in accordance with these rules and the agreement with the director. The director may terminate such agreements at any time the director determines that one or more of the conditions of the agreement have been violated.

(6) The director may deny or revoke access to workers' compensation claims records at any time the director determines such access is no longer in the public interest or is being used in a manner which violates these rules or any law of the State of Oregon or the United States.

(7) Requests to inspect or obtain copies of workers' compensation claim records must be made in writing or in person and must include:

(a) The name, address and telephone number of the requester;

(b) The reason for requesting the records;

(c) A specific identification of the public record(s) required and the format in which they are required;

(d) The number of copies required;

(e) The account number of the requester, when applicable.

(8) Except as prescribed in subsections (4)(a) through (d), a person must submit to the division an attorney retainer agreement or release signed by the claimant in order to inspect or obtain copies of workers' compensation claims records. The director may refuse to honor any release which the director determines is likely to result in disclosed records being used in a manner contrary to these rules. Upon request, the director will review proposed release forms to determine whether the proposed release is consistent with the law and this rule.

Stat. Auth.: ORS 192.502, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0010
Reporting Requirements

(1) A subject employer must accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative. The employer must provide a copy of the "Report of Job Injury or Illness," Form 440-801 (Form 801) to the worker immediately upon request; the form must be readily available for workers to report their injuries. Proper use of this form satisfies ORS 656.265.

(2) A "First Medical Report," Form 440-827 (Form 827), signed by the worker, is written notice of an accident which may involve a compensable injury under ORS 656.265. The signed Form 827 shall start the claim process, but shall not relieve the worker or employer of the responsibility of filing a Form 801. If a worker reports a claim electronically, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records, under OAR 436-010-0240, necessary to process the claim.

(3) Employers, except self-insured employers, must report the claim to their insurers no later than five days after notice or knowledge of any claim or accident which may result in a compensable injury. The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a claim, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility. The report must provide the information requested on the Form 801, and include, but not be limited to, the worker's name, address, and social security number, the employer's legal name and address, and the data specified by ORS 656.262 and 656.265.

(4) For the purpose of this section, "first aid" means any treatment provided by a person who does not require a license in order to provide the service. If an injured worker requires only first aid, no notice need be given the insurer, unless the worker chooses to file a claim. If a worker signs a Form 801, the claim must be reported to the insurer. If the person must be licensed to legally provide the treatment or if a bill for the service will result, notice must be given to the insurer. When the worker requires only first aid and chooses not to file a claim, the employer must maintain records showing the name of the worker, the date, nature of the injury and first aid provided for five years. These records shall be open to inspection by the director, or any party or its representative. If an employer subsequently learns that such an injury has resulted in medical services, disability or death, the date of that knowledge will be considered as the date on which the employer received notice or knowledge of the claim for the purposes of processing under ORS 656.262.

(5) The director may assess a civil penalty against an employer delinquent in reporting claims to its insurer in excess of ten percent of the employer's total claims during any quarter.

(6) An employer intentionally or repeatedly paying compensation in lieu of reporting to its insurer claims or accidents which may result in a compensable injury claim may be assessed a civil penalty by the director.

(7) The insurer must process and file claims and reports required by the director in compliance with ORS Chapter 656, WCD administrative rules, and WCD bulletins. Such filings shall not be made by computer-printed forms, facsimile transmission (FAX), electronic data interchange (EDI), or other electronic means, unless specifically authorized by the director.

(8) When a claim is received and the insurer does not provide insurance coverage for the worker's employer on the date of injury, the insurer may check for other coverage or forward it to the director. The insurer must do one or the other within three days of determining they did not provide coverage on the date of injury. If the insurer checks for coverage and coverage exists, the insurer must send the claim to the correct insurer within the same three day period. If the insurer checks for coverage and coverage cannot be found, the insurer must forward the claim to the director within the same three day period.

(9) The insurer or self-insured employer and third party administrator, if any, must be identified on all insurer generated workers' compensation forms, including insurer name, third party administrator name (if applicable), address, and phone number of the location responsible for processing the claim.

(10) The insurer must file all disabling claims with the director within 14 days of the insurer's initial decision either to accept or deny the claim. To meet this filing requirement, the Insurer's Report, Form 440-1502 (Form 1502) accompanied by the Form 801, or its electronic equivalent, is to be submitted to the director. However, when the Form 801 is not available within a time frame that would allow a timely filing, a Form 1502, accompanied by a signed Form 827 when available, will satisfy the initial reporting requirement. If the Form 801 is not submitted at the time of the initial filing of the claim, the Form 801 must be submitted within 30 days from the filing of the Form 1502. A Form 801 prepared by the insurer in place of obtaining the form from the employer/worker does not satisfy the filing requirement of the Form 801, unless the employer/worker cannot be located, or the form cannot be obtained from the employer/worker due to lack of cooperation, or the form is computer-printed based upon information obtained from the employer and worker. The insurer must submit copies of all acceptance or denial notices not previously submitted to the director with the Form 1502. Form 1502 is used to report claim status and activity to the director.

(11) When submitting an initial compensability decision Form 1502, the insurer must report:

(a) The status of the claim;

(b) Reason for filing;

(c) Whether first payment of compensation was timely, if applicable;

(d) Whether the claim was accepted or denied timely; and

(e) Any Managed Care Organization (MCO) enrollment, and the date of enrollment, if applicable.

(12) The insurer must file an additional Form 1502 with the director within 14 days of:

(a) The date of any reopening of the claim;

(b) Changes in the acceptance or disability status;

(c) Any litigation order or insurer's decision that causes reopening of the claim or changes the acceptance or disability status;

(d) MCO enrollment that occurs after the initial Form 1502 has been filed;

(e) The insurer's knowledge that a previous Form 1502 contained erroneous information; or

(f) The date of any denial.

(13) A nondisabling claim must only be reported to the director if it is denied, in part or whole. It must be reported to the director within 14 days of the date of denial. A nondisabling claim which becomes disabling must be reported to the director within 14 days of the date of the status change.

(14) If the insurer voluntarily reopens a qualified claim under ORS 656.278, it must file a Form 3501 with the director within 14 days of the date the insurer reopens the claim.

(15) The insurer must report a new medical condition reopening on the Form 1502 if the claim cannot be closed within 14 days of the first to occur: acceptance of the new condition, or the insurer's knowledge that interim temporary disability compensation is due and payable.

(16) New condition claims that are ready to be closed within 14 days must be reported on the "Insurer Notice of Closure Summary," Form 440-1503 (Form 1503) at the time the insurer closes the claim. The Form 1503 must be accompanied by the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" letter.

(17) If, after receiving a claim from a worker or from someone other than the worker on the worker's behalf, the insurer receives written communication from the worker stating the worker never intended to file a claim and wants the claim "withdrawn," the insurer must submit a Form 1502 with a copy of the worker's communication to the director, if the claim had previously been reported.

(18) The director may issue a civil penalty against any insurer delinquent in reporting or in submitting Forms 801, 1502, 1503 or 1644 with a late or error ratio in excess of twenty percent during any quarter. For the purposes of this section, a claim or form shall be deemed to have been reported or submitted timely according to the provisions of ORS 656.726(4).

(19) Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms furnished by the director for that purpose. Reports for each calendar year must be filed not later than March 1 of the following year.

(20) If an insurer elects to process and pay supplemental disability benefits, under ORS 656.210(5)(a), the insurer does not need to inform the director of their election. The insurer must request reimbursement, under OAR 436-060-0500, by filing Form 3504 "Supplemental Disability Benefits Quarterly Reimbursement Request" with the director for any quarter during which they processed and paid supplemental disability benefits. If an insurer elects not to process and pay supplemental disability benefits, the insurer must submit Form 3530, "Supplemental Disability Election Notification," to the director. The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election. The election is

made by the insurer and applies to all third party administrators an insurer may use for processing claims.

(21) An insurer may change its election made under section (20):

(a) Annually; and

(b) Once after the division completes its first audit of supplemental disability payments made by the insurer.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.262, 656.264, 656.265(6), 656.704, 656.726(4), 656.745

Stats. Implemented: ORS 656.210, 656.262, 656.264, 656.265, 656.704, 656.726(4)

Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0100, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0015
Required Notice and Information

(1) When an injured worker's attorney has given written notice of representation, prior or simultaneous written notice must be given to the worker's attorney under ORS 656.331:

(a) When the director or insurer requests the worker to submit to a medical examination;

(b) When the insurer contacts the worker regarding any matter which may result in denial, reduction or termination of the worker's benefits; or

(c) When the insurer contacts the worker regarding any matter relating to disposition of a claim under ORS 656.236.

(2) The director shall assess a civil penalty against an insurer who intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) The insurer or the third party administrator must provide the pamphlet, "What Happens if I'm Hurt on the Job?," Form 440-1138 (Form 1138), to every injured worker who has a disabling claim with the first time-loss check or earliest written correspondence. For nondisabling claims, the information page, "A Guide for Workers Hurt on the Job," Form 440-3283 (Form 3283) may be provided in lieu of Form 1138, unless the worker specifically requests Form 1138.

(4) The insurer must provide Form 3283 to their insured employers for distribution to workers at the time a worker completes a Form 801, for all claims filed.

(5) The insurer must provide the "Notice to Worker," Form 440-3058 (Form 3058) or its equivalent to the worker with the initial notice of acceptance on the claim under OAR 436-060-0140(6). For the purpose of this rule, an equivalent to the Form 3058 must include all of the statutory and rule requirements.

(6) Additional notices the insurer must send to a worker are contained in OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180.

(7) When an insurer changes claims processing locations, third party administrators, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor.

(8) The insurer must provide the worker an explanation of any change in the wage used that differs from what was initially reported in writing to the insurer. Prior to claim closure on a disabling claim, the insurer must send the worker a notice documenting the wage upon which benefits were based and work disability, if applicable, will be determined when the claim is closed. The notice must also explain how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage. The insurer shall resolve disputes regarding wage calculations under OAR 436-060-0025(4).

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.331, 656.704, 656.726(4) & 656.745

Stats. Implemented: ORS 656.331, 656.704 & 656.726(4)

Hist.: WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0017
Release of Claim Document

(1) For the purpose of this rule:

(a) "Documents" include, but are not limited to, medical records, vocational records, written and automated payment ledgers for both time loss and medical services, payroll records, recorded statements, insurer generated records (insurer generated records exclude a claim examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications), all forms required to be filed with the director, notices of closure, electronic transmissions, and correspondence between the insurer, service providers, claimant, the division and/or the Workers' Compensation Board.

(b) "Possession" means documents making up, or relating to, the insurer's claim record on the date of mailing the documents to the claimant, claimant's attorney or claimant's beneficiary. Any documents that have been received by the insurer five or more working days prior to the date of mailing shall be considered as part of the insurer's claim record even though the documents may not have yet reached the insurer's claim file.

(2) The insurer must date stamp each document upon receipt with the date it is received. The date stamp must include the month, day, year of receipt, and name of the company, unless the document already contains the date information and name of recipient company, as in faxes, e-mail and other electronically transmitted communications.

(3) A request for copies of claim documents must be submitted to the insurer, self-insured employer, or their respective third party administrator, and copied simultaneously to defense counsel, if known.

(4) The insurer must furnish, without cost, legible copies of documents in its possession relating to a claim, upon request of the claimant, claimant's attorney or claimant's beneficiary, at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule. Except as provided in OAR 436-060-0180, an initial request by anyone other than the claimant or claimant's beneficiary must be accompanied by a worker signed attorney retention agreement or a medical release signed by the worker. The signed medical release must be in a form or format as the director may provide by bulletin. Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws. Upon the request of the claimant's attorney, a request for documents shall be considered an ongoing request for future documents received and generated by the insurer for 90 days after the initial mailing date under section (7) or until a hearing is requested before the Workers' Compensation Board. The insurer must provide such new documents to claimant's attorney every 30 days, unless specific documents are requested sooner by the attorney. Such documents must be provided within the time frame of section (7).

(5) Once a hearing is requested before the Workers' Compensation Board, the release of documents is controlled by OAR chapter 438. This rule applies subsequently if the hearing request is withdrawn or when the hearing record is closed, provided a request for documents is renewed.

(6) Upon request, the entire health information record in the possession of the insurer will be provided to the worker or the worker's representative. This includes records from all healthcare providers, except that the following may be withheld:

(a) Information which was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information,

(b) Psychotherapy notes,

(c) Information compiled for use in a civil, criminal, or administration action or proceeding; and

(d) Other reasons specified by federal regulation.

(7) The insurer must furnish copies of documents within the following time frames:

(a) The documents of open and closed files, and/or microfilmed files must be mailed within 14 days of receipt of a request, and copies of documents of archived files within 30 days of receipt of a request.

(b) If a claim is lost or has been destroyed, the insurer must so notify the requester in writing within 14 days of receiving the request

for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice.

(c) If no documents are in the insurer's possession at the time the request is received, the 14 days within which to provide copies of documents starts when the insurer does receive some documentation on the claim if that occurs within 90 days of receipt of the request.

(d) Documents are deemed mailed when addressed to the last known address of the claimant, claimant's beneficiary or claimant's attorney and deposited in the U.S. Mail.

(8) The documents must be mailed directly to the claimant's or beneficiary's attorney, when the claimant or beneficiary is represented. If the documents have been requested by the claimant or beneficiary, the insurer must inform the claimant or beneficiary of the mailing of the documents to the attorney. The insurer is not required to furnish copies to both the claimant or beneficiary and the attorney. However, if a claimant or beneficiary changes attorneys, the insurer must furnish the new attorney copies upon request.

(9) The director may assess a civil penalty against an insurer who fails to furnish documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

(10) Rule violation complaints about release of requested claims documents must be in writing, mailed or delivered to the division within 180 days of the request for documents, and must include a copy of the request submitted under section (3). When notified by the director that a complaint has been filed, the insurer must respond in writing to the division. The response must be mailed or delivered to the director within 21 days of the date of the division's inquiry letter. A copy of the response, including any attachments, must be sent simultaneously to the requester of claim documents. If the division does not receive a timely response or the insurer provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), a civil penalty may be assessed under OAR 436-060-0200 against the insurer. Assessment of a penalty does not relieve the insurer of the obligation to provide a response.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 656.360, 656.362, 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 3-1991, f. 4-18-91, cert. ef. 6-1-91; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0018
Nondisabling/Disabling Reclassification

(1) When the insurer changes the classification of an accepted claim, the insurer must submit an "Insurer's Report," Form 440-1502 to the director, indicating a change in status within 14 days from the date of the new classification. A notice of change of classification must be communicated by issuing a Modified Notice of Acceptance. This notice must include an explanation of the change in status and must be sent to the director, the worker, and the worker's attorney if the worker is represented. If the claim qualifies for closure, the insurer must close the claim under ORS 656.268(5).

(2) The insurer must reclassify a nondisabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in this rule. A claim is disabling if any of the following criteria apply:

(a) Temporary disability is due and payable; or

(b) The worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or

(c) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary.

(3) Under ORS 656.262(6)(b)(F) and (7)(a) the insurer must issue a Modified Notice of Acceptance and change the classification from nondisabling to disabling upon acceptance of a new or omitted condition that meets the disabling criteria in this rule.

(4) If a claim has been classified as nondisabling for less than one year after the date of acceptance and the worker believes the claim was or has become disabling, the worker may request reclassification by submitting a written request for review of the classification status to the insurer under ORS 656.277.

(5) Within 14 days of the worker's request, the insurer must review the claim and,

(a) If the classification is changed to disabling, provide notice under this rule; or

(b) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must send a Notice of Refusal to Reclassify to the worker and the worker's attorney, if the worker is represented. The notice must include the following statement, in bold print:

"If you disagree with this Notice of Refusal to Reclassify, you must appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing of this notice or you will lose your right to appeal. The address and telephone number of the Workers' Compensation Division are."

(6) A worker dissatisfied with the decision in the Notice of Refusal to Reclassify may appeal to the director. Such appeal must be made no later than the 60th day after the Notice is mailed. The appeal must include a copy of the insurer's Notice of Refusal to Reclassify.

(7) For claims that are reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights begin with the first valid closure of the claim.

(8) For claims that are not reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights continue to run from the date of injury.

(9) When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation according to the provisions of ORS 656.273.

(10) Failure of the insurer or self-insured employer to respond timely to a request for reclassification may result in penalties under OAR 436-060-0200.

(11) Notwithstanding (12), once a claim has been accepted and classified as disabling for more than one year from date of acceptance, all aspects of the claim are classified as disabling and remain disabling. Any additional conditions or aggravations subsequently accepted must be processed according to provisions governing disabling claims, including closure under ORS 656.268.

(12) If a claim has been classified as disabling and the insurer determines the criteria for a disabling claim were never satisfied, the insurer may reclassify the claim to nondisabling. The insurer must notify the worker and the worker's representative, if applicable, by issuing a Modified Notice of Acceptance.

(a) The Modified Notice of Acceptance must advise the worker that he or she has 60 days from the date of the notice to appeal the decision.

(b) Appeals of such reclassification decisions are made to the Appellate Review Unit for issuance of a Director's Review order.

(13) The worker's appeal must be in writing. The worker may use the form specified by the director for requesting review of the insurer's claim classification decision.

(14) The worker's appeal under section (6) or (12) must be copied to the insurer.

(15) A worker need not be represented by an attorney to appeal the insurer's classification decision.

(16) The director will acknowledge receipt of the request in writing to the injured worker, the worker's attorney, if any, and the insurer, and initiate the review.

(17) Within 14 days of the director's acknowledgement, 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 insurer may be subject to penalties under OAR 436-060-0200 for failure to provide claim documents in a timely manner.

(18) Within the same 14 days, the worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time.

(19) After receiving and reviewing the required documents, the director will issue a Director's Review order.

(20) The worker and the insurer have 30 days from the mailing date of the Director's Review order to appeal the director's decision to the Hearings Division of the Workers' Compensation Board.

(21) The director may reconsider, abate, or withdraw any Director's Review order before the order becomes final by operation of law.

Stat. Auth.: ORS 656.268, 656.726, 1995 OL Ch. 332 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656. 273, 656.277, 656.745, 656.726,
Hist.: WCD 2-2004, f. 2-19-04, cert. ef. 2-29-04, Renumbered from 436-030-0045; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0019
Determining and Paying the Three Day Waiting Period

(1) Under ORS 656.210 and 656.212, the three day waiting period is three consecutive calendar days beginning with the first day the worker loses time or wages from work as a result of the compensable injury, subject to the following:

(a) If the worker leaves work but returns and completes the work shift without loss of wages, that day shall not be considered the first day of the three day waiting period.

(b) If the worker leaves work but returns and completes the work shift and receives reduced wages, that day shall be considered the first day of the three day waiting period.

(c) If the worker does not complete the work shift, that day shall be considered the first day of the three day waiting period even if there is no loss of wages. For the purpose of this rule, an attending physician's or authorized nurse practitioner's authorization of temporary disability is not required to begin the waiting period; however, the waiting period would not be due and payable unless authorized.

(2) Under ORS 656.210(3), no disability payment is due the worker for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a compensable injury, unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. For the purpose of this rule, admittance as an inpatient to a hospital can be any time following the date of the injury, but must be within 14 days of the first onset of total disability to waive the three day waiting period.

(3) If compensation is due and payable for the three day waiting period, the worker must be paid for one-half day for the initial work day lost if the worker leaves the job during the first half of the shift and does not return to complete the shift. No compensation is due for the initial day of the waiting period if the worker leaves the job during the second half of the shift.

(4) If a worker is employed with varying days off or cyclic work schedules, the three day waiting period shall be determined using the work schedule of the week the worker begins losing time or wages as a result of the injury. If the worker is no longer employed with the employer at injury or does not have an established schedule when the worker begins losing time/wages, the three day waiting period and scheduled days off shall be based on the work schedule of the week the worker was injured.

Stat. Auth.: ORS 656.210, 656.212, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210 & 656.212
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-060-0020
Payment of Temporary Total Disability Compensation

(1) An employer may pay compensation under ORS 656.262(4) with the approval of the insurer under ORS 656.262(12). Making such payments does not constitute a waiver or transfer of the insurer's duty to determine the worker's entitlement to benefits, or responsibility for the claim to ensure timely benefit payments. The employer must provide adequate payment documentation as the insurer may require to meet its responsibilities.

(2) Under ORS 656.005(30), no temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:

(a) A person who, prior to reopening under ORS 656.267, 656.273 or 656.278, was not working and had not made reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.

(b) A person who was a full time student for at least six months in the 52 weeks prior to injury elects to return to school full time, unless the person can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.

(3) No temporary disability is due and payable for any period of time where the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it under ORS 656.262(4)(d), unless the worker has been unable to receive treatment for reasons beyond the worker's control. Before withholding temporary disability under this section, the insurer must inquire of the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. If no valid reason is found or the worker refuses to respond or cannot be located, the insurer must document its file regarding those findings. The insurer must provide the division a copy of the documentation within 20 days, if requested. If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may stop temporary disability payments and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments. When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of time loss, unless otherwise denied.

(4) Authorization from the attending physician or authorized nurse practitioner may be oral or written. The insurer at claim closure, or the division at reconsideration of the claim closure, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician or authorized nurse practitioner ceases to authorize temporary disability or for any period of time not authorized by the attending physician or authorized nurse practitioner under ORS 656.262(4)(g).

(5) An insurer may suspend temporary disability benefits without authorization from the division under ORS 656.262(4)(e) when all of the following circumstances apply:

(a) The worker has missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner;

(b) The insurer has sent a certified letter to the worker and a letter to the worker's attorney, at least ten days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician or authorized nurse practitioner; stating the time and date of the appointment; and giving the following notice, in prominent or bold face type:

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

(c) The insurer verifies that the worker has missed the rescheduled appointment;

(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice, in prominent or bold face type:

"Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."

(6) If temporary disability benefits end because the insurer or employer:

(a) Speaks by telephone with the attending physician or authorized nurse practitioner, or the attending physician's or authorized nurse practitioner's office, and negotiates a verbal release of the worker to return to any type of work as a result, when no return to work was previously authorized; and

(b) The worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work; then

(c) The insurer must:

(A) Document the facts;

(B) Communicate the release to the worker by mail within 7 days; the communication to the worker of the negotiated return to work release may be contained in an offer of modified employment; and

(C) Advise the worker of their reinstatement rights under ORS Chapter 659A.

(7) When concurrent temporary disability is due the worker as a result of two or more accepted claims, the insurers may petition the

division to make a pro rata distribution of compensation due under ORS 656.210 and 656.212. The insurer must provide a copy of the request to the worker, and the worker's attorney if represented. The division's pro rata order shall not apply to any periods of interim compensation payable under ORS 656.262 and also does not apply to benefits under ORS 656.214 and 656.245. Claims subject to the pro rata order approved by the division must be closed under OAR 436-030 and ORS 656.268, when appropriate. The insurers shall not unilaterally prorate temporary disability without the approval of the division, except as provided in section (8) of this rule. The division may order one of the insurers to pay the entire amount of temporary disability due or make a pro rata distribution between two or more of the insurers. The pro rata distribution ordered by the division shall be effective only for benefits due as of the date all claims involved are in an accepted status. The order pro rating compensation will not apply to periods where any claim involved is in a deferred status.

(8) When concurrent temporary disability is due the worker as a result of two or more accepted claims involving the same worker, the same employer and the same insurer, the insurer may make a pro rata distribution of compensation due under ORS 656.210 and 656.212 without an order by the division. The worker must receive compensation at the highest temporary disability rate of the claims involved.

(9) If a closure under ORS 656.268 has been found to be premature and there was an open ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.

(10) If a denied claim has been determined to be compensable, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability.

Stat. Auth.: ORS 656.210(2), 656.245, 656.262, 656.307(1)(c), 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210, 656.212, 656.262, 656.307, 656.704, 656.726(4) & Sec. 1(30), Ch. 865, OL 2001
Hist.: WCB 12-1970, f. 9-21-70, ef. 10-25-70; 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0212, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90, Former sec. (6), (7), (8), (9) & (10) Renumbered to 436-060-0025(1) - (10); WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 14-1996(Temp), f. & cert. ef. 5-31-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0025
Rate of Temporary Disability Compensation

(1) The rate of compensation shall be based on the wage of the worker at the time of injury, except in the case of an occupational disease, for which the rate of compensation will be based on the wage as outlined in ORS 656.210(2)(d)(B). Employers shall not continue to pay wages in lieu of statutory temporary total disability payments due. However, under ORS 656.018(6) the employer is not precluded from supplementing the amount of temporary total disability paid the worker. Employers must separately identify workers' compensation benefits from other payments and shall not have payroll deductions withheld from such benefits.

(2) Notwithstanding section (1), under ORS 656.262(4)(b), a self-insured employer may continue the same wage with normal deductions withheld (e.g. taxes, medical, and other voluntary deductions) at the same pay interval that the worker received at the time of injury. If the pay interval or amount of wage changes (excluding wage increases), the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law. The claim shall be classified as disabling. The rate of temporary total disability that would have otherwise been paid had continued wages not occurred and the period of disability will be reported to the division.

(3) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210 and this rule. "Regularly employed" means actual employment or availability for such employment.

(a) Monthly wages shall be divided by 4.35 to determine weekly wages. Seasonal workers paid monthly must have their weekly wages determined under OAR 436-060-0025(5).

(b) For workers employed through union hall call board insurers must compute the rate of compensation on the basis of a five-day work week at 40 hours a week, regardless of the number of days actually worked per week.

(4) The insurer shall resolve wage disputes by contacting the employer to confirm the correct wage and then contacting the worker with that information. If the worker does not agree, the worker may bring the dispute to the division for resolution.

(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule.

(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

(A) Insurers must use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers with multiple employers at the time of injury who qualify under ORS 656.210(2)(b) and OAR 436-060-0035, insurers shall average all earnings for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers must use the actual weeks of employment (excluding any extended gaps) with the employer at injury or all earnings, if the worker qualifies under ORS 656.210(2)(b) and OAR 436-060-0035, up to the previous 52 weeks. For the purpose of this rule, gaps shall not be added together and must be considered on a claim-by-claim basis; the determination of whether a gap is extended must be made in light of its length and of the circumstances of the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in writing.

(B)(i) Where there has been a change in the wage earning agreement due only to a pay increase or decrease during the 52 weeks prior to the date of injury, insurers must use the worker's average weekly hours worked for the 52 week period, or lesser period as required in (5)(a)(A) of this section, multiplied by the wage at injury to determine the worker's current average weekly earnings.

(ii) Where there has been a change in the wage earning agreement due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, during the 52 weeks prior to the date of injury, insurers must average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A).

(iii) For workers employed less than four weeks under a changed wage earning agreement as described in this subsection, insurers must use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

(iv) For determining benefits under this rule for occupational disease claims, insurers must use the wage at the date of disability, if the worker was working at the time of medical verification of the inability to work, or the wage at the date of last regular employment, if the worker was not working due to the injury at the time of medical verification of the inability to work in place of "the date of injury."

(b) Workers employed through a temporary service provider on a "temporary basis," or a worker-leasing company as defined in OAR 436-050, must have their weekly wage determined by the method provided in subsection (a) of this section. However, each job assignment shall not be considered a new wage earning agreement.

(c) For workers paid salary plus considerations (e.g. rent, utilities, food, etc.) insurers must compute the rate on salary only if the considerations continue during the period the worker is disabled due to the injury. If the considerations do not continue, the insurer must use salary plus a reasonable value of those considerations. Expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage.

(d) Earnings from a second job will be considered for calculating temporary partial disability only to the extent that the post-injury income from the second job exceeds the pre-injury income from the second job (i.e., increased hours or increased wage).

(e) For workers employed where tips are a part of the worker's earnings insurers must use the wages actually paid, plus the amount of tips required to be reported by the employer under section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater.

(f) Insurers shall consider overtime hours only when the worker worked overtime on a regular basis. Overtime earnings must be included in the computation at the overtime rate. For example, if the worker worked one day of overtime per month, use 40 hours at regular wage and two hours at the overtime wage to compute the weekly rate. If overtime varies in hours worked per day or week, use the averaging method described in subsection (a). One-half day or more will be considered a full day when determining the number of days worked per week.

(g) 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.

(h) Incentive pay shall be considered only when regularly earned. If incentive pay earnings vary, use the averaging method described in subsection (a).

(i) Covered workers with no wage earnings such as volunteers, jail inmates, etc., must have their benefits computed on the same assumed wage as that upon which the employer's premium is based.

(j) For workers paid by commission only or commission plus wages insurers must use the worker's average commission earnings for previous 52 weeks, if available. For workers without 52 weeks of earnings, insurers must use the assumed wage on which premium is based. Any regular wage in addition to commission must be included in the wage from which compensation is computed.

(k) For workers who are sole proprietors, partners, officers of corporations, or limited liability company members including managers, insurers must use the assumed wage on which the employer's premium is based.

(l) For school teachers or workers paid in a like manner, insurers must use the worker's annual salary divided by 52 weeks to arrive at weekly wage. Temporary disability benefits shall extend over the calendar year.

(m) For workers with cyclic schedules, insurers must average the hours of the entire cycle to determine the weekly wage. For purposes of temporary disability payments, the cycle shall be considered to have no scheduled days off. For example: A worker who works ten hours for seven days, has seven scheduled days off, then repeats the cycle, is considered to have a 14 day cycle. The weekly wage and payment schedule would be based on 35 hours a week with no scheduled days off.

(6) When a working shift extends into another calendar day, the date of injury shall be the date used for payroll purposes by the employer.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.210(2), 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210, 656.704, 656.726(4) & Sec. 3(2)(a)-(c), Ch. 865, OL 2001
Hist.: WCB 12-1970, f. 9-21-70, ef. 10-25-70; 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0212, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90, Renumbered from 436-060-0020 former sections (6), (7), (8), (9) & (10); WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0030
Payment of Temporary Partial Disability Compensation

(1) The amount of temporary partial disability compensation due a worker shall be determined by:

(a) Subtracting post-injury wage earnings by the worker from any kind of work from

(b) The wage used to compute the rate of compensation at the time of injury; then

(c) Dividing the difference by the wage earnings used in subsection (b) to arrive at the percentage of loss of wages; then

(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of wages in subsection (c).

(2) Notwithstanding section (1), for workers whose rate of compensation is based on an assumed wage, "post-injury wage earnings" will be that proportion of the assumed wage which the hours worked during the period of temporary partial disability represent as a percentage of the hours worked prior to the injury.

(3) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) from the date an injured worker begins wage earning employment, prior to claim closure, unless the worker refuses modified work under ORS 656.268(4)(c)(A) through (F). If the worker is with a new employer and upon request of the insurer to provide wage information, it shall be the worker's responsibility to provide documented evidence of the amount of any wages being earned. Failure to do so shall be cause for the insurer to assume that post-injury wages are the same as or higher than the worker's wages at time of injury.

(4) For the purpose of section (5) of this rule:

(a) "Commute" means the lesser of the distance traveled from the worker's residence at the time of injury to the work site or the worker's residence at the time of the modified work offer to the work site;

(b) "Where the worker was injured" means the location where the worker customarily reported or worked at the time of injury; and

(c) "Temporary employees" has the same meaning as defined in OAR 436-050-0420.

(5) Under ORS 656.325(5)(a), an insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when an injured worker fails to begin wage earning employment, under the following conditions:

(a) The employer or insurer:

(A) Notifies the attending physician or authorized nurse practitioner of the physical tasks to be performed by the injured worker;

(B) Notifies the attending physician or authorized nurse practitioner of the location of the modified work offer; and

(C) Asks the attending physician or authorized nurse practitioner if the worker can, as a result of the compensable injury, physically commute to and perform the job.

(b) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities and the commute is within the physical capacity of the worker; and

(c) The employer or insurer has confirmed the offer of employment in writing to the worker stating:

(A) The beginning time, date and place;

(B) The duration of the job, if known;

(C) The wages;

(D) An accurate description of the physical requirements of the job;

(E) That the attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute within the worker's physical capacity;

(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;

(ii) The offer is not with the employer at injury;

(iii) The offer is not at a work site of the employer at injury;

(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or

(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and

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

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

(6) Under ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

(a) The employer has a written policy of offering modified work to injured workers;

(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1);

(c) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and

(d) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(7) Under ORS 656.325(5)(c), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1);

(b) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

(c) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(8) 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. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. 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 shall be included in this section. 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 shall be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a). This section does not apply to those situations described in sections (5), (6), and (7) of this rule.

(9) When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 shall continue until:

(a) The attending physician or authorized nurse practitioner verifies that the worker can no longer perform the modified job and is again temporarily totally disabled;

(b) The compensation is terminated by order of the division or by claim closure by the insurer under ORS 656.268; or

(c) The compensation is lawfully suspended, withheld or terminated for any other reason.

(10) In determining failure on the part of the worker in section (5) and for purposes of subsection (1)(a), "post-injury wages" are the wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater, and any unemployment, sick or vacation leave payments received.

(11) If temporary disability benefits end because the insurer or employer:

(a) Speaks by telephone with the attending physician or authorized nurse practitioner, or the attending physician's or authorized nurse practitioner's office, and negotiates a verbal release of the worker to return to any type of work as a result, when no return to work was previously authorized; and

(b) The worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work; then

(c) The insurer must:

(A) Document the facts;

(B) Communicate the release to the worker by mail within 7 days; the communication to the worker of the negotiated return to work release may be contained in an offer of modified employment; and

(C) Advise the worker of their reinstatement rights under ORS Chapter 659A.

(12) The insurer must provide the injured worker and the worker's attorney a written notice of the reasons for changes in the compensation rate, and the method of computation, whenever a change is made.

Stat. Auth.: ORS 656.212, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.212, 656.325(5), 656.704, 656.726(2) & Ch. 865(12)(4)(c) OL 2001

Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0222, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 1-1994(Temp), f. & cert. ef. 3-1-94; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

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

(1) For the purpose of this rule:

(a) "Assigned processing administrator" is the company or business whom the director has selected and authorized to process and pay supplemental disability benefits on behalf of the director, when the insurer has elected not to process and pay these benefits.

(b) "Primary job" means the job at which the injury occurred.

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

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

(e) "Supplemental disability" means wage loss replacement for the secondary job(s) that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210.

(f) "Verifiable documentation" means information which provides:

(A) Identification of the Oregon subject employer(s) and the time period that establishes the worker held the secondary job, in addition to the primary job, at the time of injury; and

(B) Adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.

(g) "Insurer" includes third party administrator.

(2) The insurer shall establish the temporary disability rate by multiplying the weekly wage, determined under OAR 436-060-0025, from the primary employer by 66 2/3% (.6667). If the result meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits.

(3) Within five business days of receiving notice or knowledge of employment in addition to the primary job on a claim on which the temporary disability rate for the primary job does not meet or exceed the maximum rate, the insurer must send a worker an initial notice informing the worker what type of information the insurer or the assigned processing administrator must receive to determine the worker's eligibility for supplemental disability. If the insurer has elected not to process and pay these benefits, the insurer must copy the assigned processing administrator with the notice to the worker. The notice must contain the name, address, and telephone number of the assigned processing administrator, and must also clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator.

(4) The initial notice in section (3) must also inform the worker that if the verifiable documentation is not received, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred. If the insurer later receives the documentation, the insurer must determine the worker's eligibility for supplemental disability benefits and, if the worker is found eligible, re-calculate the temporary disability rate. Additional benefits due, but not yet paid because of the worker's prior failure to provide documenta-

tion, must be paid retroactively. Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this paragraph will not result in a penalty under ORS 656.262(11).

(5) Within 14 days of receiving the worker's verifiable documentation, the insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the decision to the worker and the worker's representative, if any, in writing. The letter must also advise the worker why he/she is not eligible when that is the decision and how to appeal the decision, if the worker disagrees with the decision.

(6) A worker is eligible if:

(a) The worker was employed at the secondary job by an Oregon subject employer at the time of the injury,

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

(c) The worker's temporary disability rate from wages at the primary job does not meet or exceed the maximum rate under section (2) of this rule.

(7) The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding all earnings the worker received from all subject employment, under ORS 656.210(2)(a)(B). In no case shall an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer.

(8) If the temporary disability rate from the primary employer does not meet or exceed the maximum rate, the insurer or the assigned processing administrator must combine the weekly wages, determined under OAR 436-060-0025, for each employer and multiply by 66 2/3% (.6667) to establish the combined disability rate up to the maximum rate. This is the base amount on which the worker's combined benefits will be calculated.

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

(10) The worker's scheduled days off for the job at which the injury occurred shall be used to calculate and pay supplemental disability.

(11) To establish the combined partial disability benefits when the worker has post injury wages from either job, the insurer or the assigned processing administrator must use all post injury wages from both primary and all secondary employers. The insurer or the assigned processing administrator must calculate the amount due the worker based on the combined wages at injury and combined post injury wages using the temporary partial disability calculation in OAR 436-060-0030. The insurer or the assigned processing administrator must then calculate the amount due from the primary job based only on the primary wages at injury and the primary post injury wages. That amount shall be subtracted from the amount due the worker; the remainder is the supplemental disability amount.

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

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

(14) Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job. The nondisabling claim will not change to disabling status due to payment of supplemental disability. When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(15) If the insurer has elected to process and pay supplemental disability under ORS 656.210(5)(a), the insurer must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability simultaneously with any temporary disability due. Reimbursement for supplemental disability paid will be made under OAR 436-060-0500.

(16) If the insurer has elected not to process and pay supplemental disability, the assigned processing administrator must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability due once each 14 days.

(17) A worker who is eligible for supplemental disability under section (5) of this rule has an on-going responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(18) If the insurer has elected not to process and pay supplemental disability, the insurer must cooperate and communicate with the assigned processing administrator and both must retain documentation of shared information, as necessary, to coordinate benefits due.

(19) Supplemental disability applies to occupational disease claims the same as injury claims. Supplemental disability benefits for an occupational disease shall be based on the worker's combined primary and secondary wages at the time there is medical verification the worker is unable to work because of the disability.

(20) When an insurer elects to pay supplemental disability under ORS 656.210(5)(a) and OAR 436-060-0010(20) and receive reimbursement under OAR 436-060-0500, the insurer must maintain a record of supplemental disability paid to the worker, separate from temporary disability paid as a result of the job at injury.

(21) 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 before the Hearings Division of the Workers' Compensation Board. If the worker chooses to request a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule. Disputes that arise about the rate of supplemental disability may be resolved under OAR 436-060-0025(5) and may be submitted at any time. However, the insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation. By requesting resolution of the dispute under OAR 436-060-0025(5), the worker authorizes the Workers' Compensation Division to contact the secondary job employer to verify information provided by the worker to resolve the dispute.

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

(23) In the event of a third party recovery, previously reimbursed supplemental disability benefits are a portion of the paying agency's lien.

(24) Remittance on recovered benefits shall be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and 656.593.

Stat. Auth.: ORS 656.210, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210, 656.325(5), 656.704, 656.726(4) & Sec. 3(2)(a), Ch. 865, OL 2001
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-060-0040
Payment of Permanent Partial Disability Compensation

(1) Permanent partial disability exceeding $6,000 may be paid monthly by the insurer. If it is paid monthly, it must be paid at 4.35 times the weekly temporary disability rate at the time of closure.

(2) If a claim is reopened as a result of a new medical condition or an aggravation of the worker's accepted condition(s) and temporary disability is due, any permanent partial disability benefits due must continue to be paid concurrently with temporary disability benefits.

(3) If the worker begins a training program after claim closure, the insurer must suspend the payment of any work disability award, but continue to pay any impairment award.

(4) The insurer must stop temporary disability compensation payments and resume any award payments suspended under ORS 656.268(9) upon the worker's completion or ending of the training, unless the worker is not then medically stationary. If no award payment

remains due, temporary disability compensation payments must continue pending a subsequent claim closure.

Stat. Auth.: ORS 656.268(9), 656.704 & 656.726(4)
Stats. Implemented: ORS 656.268(9), 656.704 & 656.726(4)
Hist.: WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0232, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0045
Payment of Compensation During Worker Incarceration

(1) A worker is not eligible to receive temporary disability compensation for periods of time during which the worker is incarcerated for commission of a crime. All other compensation benefits must be provided the worker as if the worker were not incarcerated, except as provided in OAR 436-120. For the purpose of this rule:

(a) A worker is incarcerated for commission of a crime when:

(A) In pretrial detention; or

(B) Imprisoned following conviction for a crime.

(b) A worker is not incarcerated if the worker is on parole or work release status.

(2) Temporary disability compensation, if due and payable, must be paid the worker within 14 days of the date the insurer becomes aware the worker is no longer incarcerated.

(3) A worker who is incarcerated shall have the same right to claim closure under ORS 656.268 as a worker who is not incarcerated. Any permanent disability awarded must be paid the same as if the worker were not incarcerated.

Stat. Auth.: ORS 656.160, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.160, 656.704 & 656.726(4)
Hist.: WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 19-1990(Temp), f. & cert. ef. 9-18-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-060-0055
Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

Under ORS 656.262(5) the director will establish the maximum reimbursable amount for medical services. The maximum reimbursable amount will be published annually by Bulletin No. 345. The costs of medical services for nondisabling claims must first be paid by the insurer. Then the insurer may be reimbursed by the employer if the employer so chooses. Such choice does not relieve the employers of their claim reporting requirements or the insurers of their responsibility to determine entitlement to benefits and process the claims accurately and timely. Also, when paid by the employer, such costs cannot in any way be used to affect the employer's experience rating modification or otherwise be charged against the employer. To enable the director to ensure these conditions are met, insurers and employers must comply with the following process and procedures:

(1) Notwithstanding the choice made by the employer under section (2) of this rule, the employer and insurer must process the nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, may reimburse the medical service costs paid by the insurer if the employer has chosen to make such payments. The method and manner of reimbursement by the employer shall be as prescribed in section (3) of this rule. In no case, however, shall the employer have less than 30 days to reimburse the insurer.

(2) Prior to the commencement of each policy year, the insurer must send a notice to the insured or prospective insured, advising of the employer's right to reimburse medical service costs up to the maximum amount established by the director on accepted, nondisabling claims. The notice must advise the employer:

(a) Of the procedure for making such payments as outlined in section (3) of this rule;

(b) Of the general impact on the employer if the employer chooses to make such payments;

(c) That the employer is choosing not to participate if the employer does not respond in writing within 30 days of receipt of the insurer's notice;

(d) That the employer's written election to participate in the reimbursement program remains in effect, without further notice from the insurer, until the employer advises otherwise in writing or is no longer insured by the insurer; and

(e) That the employer may participate later in the policy period upon written request to the insurer, however, the earliest reimbursement period shall be the first completed period, established under subsection (3)(a) of this rule, following receipt of the employer's request.

(3) If the employer wishes to make such reimbursement, and so advises the insurer in writing, the procedure for reimbursement shall be:

(a) Within 30 days following each three month period after policy inception or a period mutually agreed upon by the employer and insurer, the insurer must provide the employer with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim.

(b) The employer, no later than 30 days after receipt of the list, must identify those claims and the dollar amount the employer wishes to pay for that period and reimburse the insurer accordingly.

(c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection (3)(b) of this rule shall be deemed notice to the insurer that the employer does not wish to make a reimbursement for that period.

(d) Notwithstanding subsection (3)(b) of this rule, the employer and insurer may, by written agreement, establish a period in excess of thirty (30) days for the employer to reimburse the insurer.

(e) The insurer shall continue to bill the employer for any payments made on the claims within 27 months of the inception of the policy period. Any further billing and reimbursement will be made only by mutual agreement between the employer and the insurer.

(4) Insurers must maintain records of amounts reimbursed by employers for medical services on nondisabling claims. Insurers, however, shall not modify an employer's experience rating or otherwise make charges against the employer for any medical services reimbursed by the employer. For employers on retrospective rated plans, medical costs paid by the employer on nondisabling claims must be included in the retrospective premium calculation, but the amount paid by the employer shall be applied as credits against the resulting retrospective premium.

(5) If a claim changes from a nondisabling to a disabling claim and the insurer has recovered reimbursement from the employer for medical costs billed by the insurer prior to the change, the insurer shall exclude those amounts reimbursed from any experience rating, or other individual or group rating plans of the employer. If the employer is on a retrospective rated plan, premium calculation shall be as provided in section (4) of this rule.

(6) Insurers who do not comply with the requirements of this rule or in any way prohibit an employer from reimbursing the insurer under section (3) of this rule, shall be subject to a penalty as provided by OAR 436-060-0200(7).

(7) Self-insured employers must maintain records of all amounts paid for medical services on nondisabling claims in accordance with OAR 436-050-0220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed the maximum amount established by the director.

Stat. Auth.: ORS 656.262(5), 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.262(5), 656.704 & 656.726(4), Ch. 518 OL 2007
Hist.: WCD 10-1987(Temp), f. 12-18-87, ef. 1-1-88; WCD 4-1988, f. 6-27-88, cert. ef. 7-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0060
Lump Sum Payment of Permanent Partial Disability Awards

(1) Under ORS 656.230, in all cases where an award for permanent partial disability does not exceed $6,000, the insurer must pay all of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the insurer may approve an application from the worker or worker's representative for lump sum payment of all or part of the award. The insurer may 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 law;

(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) The worker is enrolled and actively engaged in training according to the rules adopted pursuant to ORS 656.340 and 656.726. For dates of injury prior to January 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after January 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(A) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;

(B) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or

(C) Has temporarily withdrawn from such a program.

(2) When an insurer receives a request for a lump sum application from the worker or the worker's representative, the insurer must send the lump sum application form to the requestor within ten business days.

(3) For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.

(4) If the insurer agrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, they must make the lump sum payment within 14 days of receipt of the signed application.

(5) If the insurer disagrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must respond to the requestor within 14 days of receiving the request explaining the reason for denying the lump sum request.

(6) A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement under ORS 656.236 does not require further approval by the insurer.

(7) When a partial payment is approved by the insurer, it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid under ORS 656.216. Denial or partial approval of a request does not prevent another request by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.230, 656.704 & 656.726(4), (§1, Ch. 270, OL 2007

Hist.: WCB 6-1966, f. & ef. 6-24-66; WCB 5-1974, f. 2-13-74, ef. 3-11-74; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0250, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

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

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1). Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-010-0265. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) The division will consider requests to authorize suspension of benefits on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial.

(3) A worker must submit to independent medical examinations reasonably requested by the insurer or the director. The insurer may request no more than three separate independent medical examinations for each open period of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(7).

(4) The insurer may contract with a third party to schedule independent medical examinations. If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice is required to be sent on the insurer's stationery and must conform with the requirements of OAR 436-060-0095(5).

(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be simultaneously notified in writing of the scheduled medical examination under ORS 656.331. The notice shall be sent at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, must contain the following:

(a) The name of the examiner or facility;

(b) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(c) The date, time and place of the examination;

(d) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the examination;

(f) That the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;

(g) That an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;

(h) That the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and

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

"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271."

(6) The insurer must include with each appointment notice it sends to the worker:

(a) A form for requesting reimbursement;

(b) The director's brochure, Form 440-3923, "Important Information about Independent Medical Exams"; and

(c) Form 440-0858, "Worker Independent Medical Exam (IME) Survey."

(7) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(8) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or

certified mail or by personal service as for a summons. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.325 and OAR 436-060-0095;

(b) The claim status and any accepted or newly claimed conditions;

(c) What specific actions of the worker prompted the request;

(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

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

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

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

(h) A copy of the letter required in section (5) and a copy of any written verification received under subsection (8)(g);

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

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

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

(9) If the division consents to suspend compensation, the suspension shall be effective from the date the worker fails to attend an examination or such other date the division 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.

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

(11) If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(7).

(12) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(13) The division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(14) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656.325, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.325, 656.704 & 656.726(4)

Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94, Renumbered from 436-060-0085(1),(2),(4); WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2000, f. 12-22-00, cert. ef. 1-1-01; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-060-0105

Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension under ORS 656.325(2) when the worker commits insanitary or injurious acts which imperil or retard recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.

(2) The insurer must demand in writing the worker either immediately cease actions which imperil or retard recovery or immediately begin to change the inappropriate behavior and participate in activities needed to help the worker recover from the injury. Such actions include insanitary or injurious practices, refusing essential medical or surgical treatment, or failing to participate in a physical rehabilitation program. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy shall be sent simultaneously to the worker's attorney:

(a) A description of the unacceptable actions;

(b) Why such conduct is inappropriate, including the fact that the conduct is harmful and/or retards the worker's recovery, as appropriate;

(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and,

(d) The following notice of the consequences should the worker fail to correct the problem, in prominent or bold face type:

"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

(3) For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under a physician's or authorized nurse practitioner's care or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the physician or authorized nurse practitioner which is designed to help the worker reach maximum recovery and become medically stationary.

(4) The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c). 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.

(5) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request must include the following information:

(a) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;

(b) A description of the actions of the worker which prompted the request, including whether such actions continue;

(c) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided any reasons, whichever is appropriate;

(d) How, when and with whom the worker's failure or refusal was verified;

(e) A copy of the letter required in section (2);

(f) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all physician or authorized nurse practitioner recommendations; and

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

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."

(6) Any delay in obtaining confirmation or in requesting consent for 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.

(7) If the division concurs with the request, it shall issue an order suspending compensation from a date established under section (5)

until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the division may require the worker to demonstrate cooperation before restoring compensation.

(8) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests. When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed.

(9) The insurer must make all reasonable efforts to assist the worker to restore benefits when the worker demonstrates the willingness to make such efforts.

(10) If the worker makes no effort to reinstate benefits within 60 days of the date of the consent order, the insurer must close the claim under OAR 436-030-0034.

(11) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(12) The division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(13) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

(14) The director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation or vocational assistance program prescribed for the worker under ORS Chapter 656 and OAR chapter 436. Such benefits shall be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate. When an insurer submits a request to reduce benefits under this section, the insurer must:

(a) Specify the basis for the request;

(b) Include all supporting documentation;

(c) Send a copy of the request, including the supporting documentation, to the worker and the worker's representative, if any, by certified mail; and

(d) Include the following notice in prominent or bold face type:

"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division grants this request, you may lose all or part of your benefits."

(15) The division shall promptly make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.

Stat. Auth.: ORS 656.325, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.325, 656.704 & 656.726(4)

Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94, Renumbered from 436-060-0085(1),(2),(4),(5); WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2000, f. 12-22-00, cert. ef. 1-1-01; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0135

Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) When the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(13), the division will suspend compensation under ORS 656.262(14) by order under conditions set forth in this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation. The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation prior to issuance of the order.

(2) A worker must submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques reasonably requested by the insurer. For the purposes of this rule, "personal and telephonic interviews" may be audio or video taped by one or more of the parties if prior written notice is given of the intent to record or tape an interview.

(3) The division will consider requests for suspension of benefits under ORS 656.262(14) only after the insurer has notified the injured worker in writing of the worker's obligation to cooperate as required by section (4) or (5) of this rule and only in claims where there has been no acceptance or denial issued.

(4) For suspension of benefits to be granted under this rule, the insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements, and must give the worker at least 14 days to cooperate. The notice must be sent to the worker and copied to the worker's attorney, if represented, and must advise the worker of the date, time and place of the interview and/or any other reasonable investigation requirements. If the insurer contracts with a third party, such as an investigation firm, to investigate the claim, the notice shall be on the insurer's stationery and must conform with the requirements of this section. The notice must inform the worker that the interview, deposition, and/or any other investigation requirements are related to the worker's compensation claim. The notice must also contain the following statement in prominent or bold face type:

"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you fail to reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

(5) The request for suspension must be sent to the division after the 14 days in section (4) have expired. Any delay in requesting suspension may result in authorization being denied. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information sufficient to show the worker's failure to cooperate:

(a) That the insurer requests suspension of benefits under ORS 656.262(14) and this rule;

(b) Documentation of the specific actions of the worker or worker's representative that prompted the request;

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

(d) A copy of the notice required in section (4) of this rule; and

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

(6) After receiving the insurer's request as required in section (5) of this rule, the division will promptly notify all parties that the worker's benefits will be suspended in five working days unless the worker or the worker's attorney contacts the division by telephone or mails a letter documenting that the failure to cooperate was reasonable or unless the insurer notifies the division that the worker is now cooperating. The notice of the division will also advise that the insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired.

(7) If the worker cooperates after the insurer has requested suspension, the insurer must notify the division immediately to withdraw the suspension request. The division will notify all the parties. An order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(8) If the worker documents the failure to cooperate was reasonable the division will not suspend payment of compensation. However, an order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(9) If the worker has not documented that the failure to cooperate was reasonable, the division will issue an order suspending all or part of the payment of compensation to the worker. The suspension will be effective the fifth working day after notice is provided by the division as required by section (6) of this rule. The suspension of compensation shall remain in effect until the worker cooperates with the investigation. If the worker makes no effort to reinstate compensation within

30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(14) and OAR 436-060-0140(10).

(10) Under ORS 656.262(13), an insurer who believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the division will consider assessment of a civil penalty against the attorney of not more than $1,000. The worker's attorney must have the opportunity to dispute the allegation prior to the issuance of a penalty. Notice under this section must be sent to the division. A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:

(a) What specific actions of the attorney prompted the request;

(b) Any reasons given by the attorney for failing to participate in the interview; and

(c) A copy of the request for interview sent to the attorney.

(11) Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.262(14)(15), 656.704, 656.726(4) & Sec. 7(6)(a), Ch. 865, OL 2001

Hist.: WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0137
Vocational Evaluations; and Suspension of Compensation

(1) A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director. The insurer may request no more than three separate vocational evaluations, except as provided under this rule.

(2) When the insurer has obtained the three vocational evaluations allowed under ORS 656.206 and wishes to require the worker to attend an additional evaluation, the insurer must first request authorization from the director. Insurers that fail to first request authorization from the director may be assessed a civil penalty. The process for requesting authorization is as follows:

(a) The insurer must submit a request for authorization to the director in a form and format as prescribed by the director, which includes but is not limited to: the reasons for an additional vocational evaluation; the conditions to be evaluated; dates, times, places, and purposes of previous evaluations; copies of previous vocational evaluation notification letters to the worker; and any other information requested by the director; and

(b) The insurer must provide a copy of the request to the worker and the worker's attorney.

(3) The director will review the request and determine if additional information is needed. Upon receipt of a request for additional information from the director, the parties will have 14 days to respond. If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.

(4) The director's decision approving or denying more than three vocational evaluations may be appealed to the Hearings Division of the Workers' Compensation Board within 60 days of the order.

(5) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.

(6) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must conform with the requirements of OAR 436-060-0137(7).

(7) The notice must be sent to the worker at least 10 days prior to the evaluation. The notice sent for each evaluation, including those which have been rescheduled, must contain the following:

(a) The name of the vocational assistance provider or facility;

(b) A statement of the specific purpose for the evaluation;

(c) The date, time and place of the evaluation;

(d) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the evaluation;

(f) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and

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

"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you fail to attend or fail to cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombudsman for Injured Workers at 1-800-927-1271."

(8) The insurer must pay the costs of the vocational evaluation and related services reasonably necessary to allow the worker to attend the evaluation. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(9) When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director under ORS 656.206, the division may suspend the worker's compensation.

(10) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;

(b) What specific actions of the worker prompted the request;

(c) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;

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

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

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

(g) A copy of the letter required in section (5) and a copy of any written verification received under subsection (5)(f);

(h) Any other information which supports the request; and

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

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division grants this request, you may lose all or part of your benefits. "

(11) If the insurer fails to comply with this rule, the division may deny the request for suspension.

(12) If the division suspends compensation, the suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the division deems appropriate until the date the worker attends the evaluation. The worker is not entitled to compensation during or for the period of suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified.

(13) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance.

(14) The division may also:

(a) Modify or set aside the suspension order before or after filing of a request for hearing;

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error; or

(c) Reevaluate the necessity of continuing a suspension.

(15) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.206, OL Ch. 461, Sec.1
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0140
Acceptance or Denial of a Claim

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

(2) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(3) The insurer must give the claimant written notice of acceptance or denial of a claim within:

(a) 90 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical condition claim for claims with a date of injury prior to January 1, 2002; or

(b) 60 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical or omitted condition claim for claims with a date of injury on or after January 1, 2002; or

(c) 90 days after the employer's notice or knowledge of the claim if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, regardless of the date of injury.

(4) The director may assess a penalty against any insurer delinquent in accepting or denying a claim beyond the days required in (3) in excess of 10 percent of their total volume of reported disabling claims during any quarter.

(5) A notice of acceptance must comply with ORS 656.262(6)(b) and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's representative, if any, and the worker's attending physician, and specify to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) Of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) Of the employment reinstatement rights and responsibilities under ORS chapter 659A;

(e) Of assistance available to employers from the Reemployment Assistance Program under ORS 656.622;

(f) That expenses personally paid for claim related expenses up to a maximum established rate must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses;

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(6) On fatal claims, the notice must be addressed "to the estate of" the worker and the requirements in (5)(a) through (h) shall not be included.

(7) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice. When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015. Additionally, when reopening a claim, the notice of acceptance must specify the condition(s) for which the claim is being reopened. Under ORS 656.262(6)(b)(F) the insurer must modify acceptance from time to time as medical or other information changes. An insurer must issue a "Modified Notice of Acceptance" (MNOA) when they:

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

(b) Accept an aggravation claim;

(c) Change the disabling status of the claim; or

(d) Amend a notice of acceptance, including correcting a clerical error.

(8) Notwithstanding OAR 436-060-0140(7)(d), to correct an omission or error in an "Updated Notice of Acceptance at Closure" (UNOA), under OAR 436-030-0015(1)(e), the insurer must add the word "Corrected" to the UNOA.

(9) When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267.

(10) A notice of denial must comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438, and must:

(a) Specify the factual and legal reasons for the denial, including the worker's right to request a Worker Requested Medical Examination and a specific statement indicating if the denial was based in whole or part on an independent medical examination, under ORS 656.325, and one of the following statements, as appropriate:

(A) "Your attending physician agreed with the independent medical examination report"; or

(B) "Your attending physician did not agree with the independent medical examination report"; or

(C) "Your attending physician has not commented on the independent medical examination report"; and

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283.

(c) If the denial is under ORS 656.262(14), it must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291.

(d) If paragraph (10)(a)(B) above applies, the denial notice must also include the division's Web site address and toll free Infoline number for the worker's use in obtaining a brochure about the Worker Requested Medical Examination.

(11) The insurer must send notice of the denial to each provider of medical services and health insurance when compensability of any portion of a claim for medical services is denied when any of the following applies:

(a) The denial is sent to the worker;

(b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or

(c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made. The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

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

(13) Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include the costs of medical benefits or burial.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.262, 656.325, 656.704, 656.726(4)
Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0305, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 12-1992, f. 6-12-92, cert. ef. 7-1-92; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0147
Worker Requested Medical Examination

(1) The director shall determine the worker's eligibility for a Worker Requested Medical Examination (Exam) under ORS 656.325(1). The worker is eligible for an exam if the worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability as required by ORS 656.319(1)(a); and the denial was based on one or more Independent Medical Examination reports with which the attending physician or authorized nurse practitioner disagreed.

(2) The worker must submit a request for the exam to the director. A copy of the request must be sent simultaneously to the insurer or self-insured employer. The request must include:

(a) The name, address, and claim identifying information of the injured worker;

(b) A list of physicians, including name(s) and address(es), who have previously provided medical services to the worker on this claim or who have previously provided medical services to the worker related to the claimed condition(s);

(c) The date the worker requested a hearing and a copy of the hearing request;

(d) A copy of the insurer's denial letter; and

(e) Document(s) that demonstrate that the attending physician or authorized nurse practitioner did not concur with the independent medical examination report(s).

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

(a) Acted as attending physician or authorized nurse practitioner;

(b) Provided medical consultations and/or treatment to the worker;

(c) Examined the worker at an independent medical examination; or

(d) Reviewed the worker's medical records on this claim. For the purpose of this rule, "Attending Physician" and "Independent Medical Examination" have the meanings defined in OAR 436-010-0005 and 436-010-0265(1), respectively.

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

(5) The director will notify all parties in writing of the physician selected, or will provide the worker or the worker's representative a list of appropriate physicians.

(6) If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's representative's response must be in writing, signed, and received by the director within ten business days of providing the list.

(b) The worker or the worker's representative may eliminate the name of one physician from the list.

(c) If the worker or the worker's representative does not respond as provided in this section, the director will select a physician.

(d) The director will notify the parties in writing of the physician selected.

(7) The worker and/or the worker's legal representative shall schedule the exam with the selected physician and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the notification date in (6) of this rule. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(8) The insurer must send the physician the worker's complete medical record on this claim and the original questions asked of the independent medical examination(s) physician(s) no later than 14 days prior to the date of the scheduled exam.

(9) The worker or the worker's representative shall communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days prior to the scheduled date of the exam. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(10) Upon completion of the exam the physician must address the original independent medical examination(s) questions and the questions from the worker or the worker's representative under section (9) of this rule and send the report to the worker's legal representative, if any, or the worker, and the insurer within 5 working days.

(11) The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Delivery of medical services to injured workers shall be in accordance with OAR 436-010.

(12) If the worker fails to attend the scheduled Worker Requested Medical Exam, the insurer must pay the physician for the missed examination. The insurer is not required to pay for another examination unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

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

Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented:ORS 656.325(1), 656.704, 656.726(4)
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0150
Timely Payment of Compensation

(1) Benefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail or deposited in the worker's or beneficiary's account by approved electronic equivalent. Payments falling due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day prior to or the first working day following the weekend or legal holiday. Subsequent payments may revert back to the payment schedule prior to the weekend or legal holiday.

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

(a) Each Sunday;

(b) New Year's Day on January 1;

(c) Martin Luther King, Jr.'s Birthday on the third Monday in January;

(d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;

(e) Memorial Day on the last Monday in May;

(f) Independence Day on July 4;

(g) Labor Day on the first Monday in September;

(h) Veterans Day on November 11;

(i) Thanksgiving Day on the fourth Thursday in November; and

(j) Christmas Day on December 25.

(k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday shall be a legal holiday. Each time a holiday falls on Saturday, the preceding Friday shall be a legal holiday.

(l) Additional legal holidays shall include every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) First payment of time loss must be timely. An insurer's performance is in compliance when 90 percent of payments are timely. The director may assess a penalty against an insurer falling below these norms during any quarter.

(4) Compensation withheld under ORS 656.268(12) and (13), and 656.596(2), shall not be deemed untimely provided the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(5) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:

(a) The date of the employer's notice or knowledge of the claim, provided the attending physician or authorized nurse practitioner has authorized temporary disability. Temporary disability accrued prior to

the date of the employer's notice or knowledge of the claim shall be due within 14 days of claim acceptance;

(b) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim;

(c) The start of authorized vocational training under ORS 656.268(9), if the claim has previously been closed;

(d) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;

(e) The date of any division order, including, but not limited to, a reconsideration order, which orders payment of temporary disability. If a reconsideration order has been appealed by the insurer, the appeal stays payment of temporary disability benefits except those which accrue from the date of the order, under ORS 656.313;

(f) The date of a notice of claim closure issued by the insurer which finds the worker entitled to temporary disability;

(g) The date a notice of closure is set aside by a reconsideration order;

(h) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the signature date and from the courts, it is the date of the appellate judgment;

(i) The date the division refers a claim to the insurer for processing under ORS 656.029;

(j) The date the division refers a noncomplying employer claim to an assigned claims agent under ORS 656.054; or

(k) The date a claim disposition is disapproved by the Board or Administrative Law Judge, if temporary disability benefits are otherwise due;

(l) The date the division designates a paying agent under ORS 656.307;

(m) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; and

(n) The date an insurer voluntarily rescinds a denial of a disabling claim.

(6) Temporary disability must be paid to within seven days of the date of payment at least once each 14 days. When making payments as provided in OAR 436-060-0020(1), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals.

(7) Permanent disability and fatal benefits must be paid no later than the 30th day after:

(a) The date of a notice of claim closure issued by the insurer;

(b) The date of any litigation order which orders payment of permanent total disability or fatal benefits. Permanent total or fatal benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the signature date and from the courts it is the date of the appellate judgment;

(c) The date of any division order, including, but not limited to, a reconsideration order, which orders payment of compensation for permanent disability;

(d) The date any litigation authorizing permanent partial disability becomes final; or

(e) The date a claim disposition is disapproved by the Board or Administrative Law Judge, if permanent disability benefits are otherwise due.

(f) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(9) and OAR 436-060-0040(2).

(8) Subsequent payments of permanent disability and fatal benefits are made in monthly sequence. The insurer may adjust monthly payment dates, but must inform the beneficiary prior to making the adjustment. No payment period shall exceed one month without the division approval.

(9) The insurer must notify the worker or beneficiary in writing when compensation is paid of the specific purpose of the payment, the time period for which the payment is made, and the reimbursable expenses. The insurer must maintain records of compensation paid for each claim where benefits are due and payable. If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for non-payment or reduction of each item.

(10) Payment of a Claim Disposition Agreement must be made no later than the 14th day after the Board or Administrative Law Judge mails notice of its approval of the agreement to the parties, unless otherwise stated in the agreement.

(11) Under ORS 656.126(6), when Oregon compensation is more than the compensation under another law for the same injury or occupational disease, or compensation paid the worker under another law is recovered from the worker for the same injury or occupational disease, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.262(4), 656.268(9), 656.273, 656.278, 656.289, 656.307, 656.313, 656.704 & 656.726(4)
Hist.: WCB 9-1966, f. & ef. 11-14-66; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0310, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-060-0155
Penalty to Worker for Untimely Processing

(1) Under ORS 656.262(11), the director may require the insurer to pay an additional amount to the worker as a penalty when the insurer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim.

(2) Requests for penalties under this section must be in writing, stating what benefits have been delayed or remain unpaid, and mailed or delivered to the division within 180 days of the alleged violation.

(3) For the purpose of this section, "violation" is either:

(a) A late payment or the nonpayment of any single payment due, in which case a request for penalty must be mailed or delivered to the director within 180 days of the date payment was due; or

(b) A continuous nonpayment or underpayment such as with yearly cost of living increases for temporary disability compensation. In these instances, a request for penalty must be mailed or delivered to the director within 180 days of the date of the last underpayment. All prior underpayments will be considered as one violation, regardless of when the first underpayment occurred.

(4) When notified by the director that additional amounts may be due the worker as a penalty under this rule, the insurer must respond in writing to the division. The response must be mailed or delivered to the division within 21 days of the date of the division's inquiry letter, with copies of the response, including any attachments, sent simultaneously to the worker and the worker's attorney (if represented). If an insurer fails to respond or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), assessment of a civil penalty may occur under OAR 436-060-0200. In addition, failure to provide copies of the response to the worker and/or attorney timely may result in the assessment of a $50.00 civil penalty under OAR 436-060-0200.

(5) When no written reason for delay is provided by the insurer as required in section (4) and no reason for the delay is evident from the worker's or division's records, the delay shall be considered unreasonable, unless the worker has provided insufficient information to assess a penalty. In such cases, a civil penalty may be assessed under OAR 436-060-0200.

(6) The director will only consider a penalty issue where the assessment and payment of additional amounts described in ORS 656.262(11) is the sole issue of any proceeding between the parties. If a proceeding on any other issue is initiated before the Hearings Division of the Workers' Compensation Board between the same parties prior to the director issuing an order under this section, and the director is made aware of the proceeding, jurisdiction over the penalty proceeding before the director shall immediately rest with the Hearings Division and result in referral of the proceedings to the Hearings Division.

If the director has not been made aware of the proceeding before the Hearings Division and issues a penalty order which becomes final, the penalty of the director will stand.

(7) The director will use the matrix attached to these rules in **Appendix "B"** in assessing penalties. When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule.

(8) Penalties ordered under this rule must be paid to the worker no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty will be due within 14 days of the date the order upholding the penalty becomes final. Failure to pay penalties in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(9) Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties. In cases where the parties wish to resolve such disputes and the assessment and payment of additional amounts described in ORS 656.262(11) is the sole issue of a proceeding between the parties, and the violation(s) occurred within the last 180 days in accordance with section (3), then a stipulation must be submitted to the division for approval. The stipulation must specify:

(a) The benefits delayed and the amounts;

(b) The time period(s) involved;

(c) If applicable, the name of the medical provider(s) and the date(s) of service(s) relating to medical bills; and

(d) The amount of the penalty not to exceed 25 percent of the amount of compensation delayed.

(10) Payment of the penalty is due within 14 days after the date the division approves the stipulation, unless otherwise stated in the stipulation. Failure to pay penalties in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(11) Any other agreements between the parties to pay a penalty without benefit of a stipulation approved by the division will not be acknowledged as a violation as it applies to the matrix attached to these rules.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth.: ORS 656.262(11), 656.704, 656.726(4) & 656.745

Stats. Implemented: ORS 656.262(11), 656.704 & 656.726(4)

Hist.: WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0160
Use of Sight Draft to Pay Compensation Prohibited

Insurers shall not use a sight draft to pay any benefits due a worker or beneficiary under ORS Chapter 656. Such benefits include temporary disability, permanent disability and reimbursement of costs paid directly by the worker.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.704 & 656.726(4)

Hist.: WCB 18-1975, f. 12-19-75, ef. 1-1-76; WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0315, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02

436-060-0170
Recovery of Overpayment of Benefits

(1) Insurers may recover overpayment of benefits paid to a worker as specified by ORS 656.268(13), unless authority is granted by an Administrative Law Judge or the Workers' Compensation Board.

(2) Insurers may recover an overpayment from any benefits currently due on any claim the worker has with that insurer. Insurers must explain in writing the reason, amount and method of recovery to the worker and the worker's attorney or to the worker's survivors.

(3) When overpaid benefits are offset against monthly permanent partial disability award payments, the recovery shall be from the total amount of the award with the remainder of the award being paid out at 4.35 times the temporary total disability rate and no less than $108.75, starting with the first month's payment.

Stat. Auth.:ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.268(13) & (15), 656.704 & 656.726(4)

Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; WCD 3-1984(Admin), f. & ef. 4-4-84; Renumbered from 436-054-0320, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-060-0180
Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

(b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.

(c) "Responsibility" means liability under the law for the acceptance and processing of a compensable claim.

(2) The division will designate by order which insurer must pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

(a) Which subject employer is the true employer of a worker;

(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(c) Which of two or more employers or their insurers is responsible for paying compensation for one or more on-the-job injuries and/or occupational diseases; or

(d) Which of two or more employers is responsible when there is joint employment.

(3) With the consent of the Workers' Compensation Board, Own Motion claims are subject to the provisions of this rule.

(4) Upon learning of any of the situations described in section (2), the insurer must expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable. For the purposes of this rule, insurers identified in a potential responsibility dispute under ORS 656.307 must, upon request, share claim related medical reports and other information without charge pertinent to the injury in order to expedite claim processing. The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute shall constitute authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240. No insurer who shares information in accordance with this rule shall bear any legal liability for disclosure of such information.

(5) Upon learning of any of the situations described in section (2), the insurer must immediately notify any other affected insurers of the situation. Such notice must identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice must identify each period of exposure which the insurer believes responsible for the compensable injury by the following:

(a) Name of employer;

(b) Name of insurer;

(c) Specific date of injury or period of exposure; and

(d) Claim number, if assigned.

(6) Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent by writing to the division and sending a copy of the request to the worker and the worker's representative, if any. The request shall not be contained in or attached to any form or report the insurer is required to submit under OAR 436-060-0010 or in the denial letter to the worker required by OAR 436-060-0140. Such a request, or agreement to designation of a paying agent, is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer. The insurer's written request to the division must contain the following information:

(a) Identification of the compensable injury(s);

(b) That the insurer is requesting designation of a paying agent under ORS 656.307;

(c) That the insurer acknowledges the injury is otherwise compensable;

(d) That responsibility is the only issue;

(e) Identification of the specific claims or exposures involved by

(A) Employer;

(B) Insurer;

(C) Date of injury or specific period of exposure; and

(D) Claim number, if assigned;

(f) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; and

(g) Confirmation the worker has been advised of the actions being taken on the worker's claim.

(7) The division will not designate a paying agent where there remains an issue of whether the injury is compensable against a subject Oregon employer, or if the 60 day appeal period of a denial has expired without a request for hearing being received by the Board or the division receiving a request for a designation of paying agent order, or if an insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim.

(8) When notified by the division that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the division, the worker, insurers involved and other interested parties within 21 days of the date of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), a civil penalty will be assessed under OAR 436-060-0200.

(9) Insurers receiving notice from the division of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6).

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

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

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

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

(d) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement.

(e) If one claim is under "Own Motion" jurisdiction, the Own Motion claim even if not the claim with the lowest temporary total disability rate.

(f) If more than one claim is under "Own Motion" jurisdiction, the Own Motion claim with the lowest temporary total disability rate.

(11) By copy of its order, the division will refer the matter to the Workers' Compensation Board to set a proceeding under ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(12) The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015(9) unless relieved of the responsibility by an order of the Administrative Law Judge or resolution through mediation or arbitration under ORS 656.307(6). The parties to an order under this section shall not settle any part of a claim under ORS 656.236 or 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers. Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the prior approval of the director. The Consumer and Business Services Fund shall not be obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order. Compensation paid under the order must include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due must be for periods subsequent to periods of disability already paid by any insurer.

(13) After a paying agent is designated, if any of the insurers determine compensability is or will be an issue at hearing, they must notify the division. Any insurer must notify the division and all parties to the order of any change in claim acceptance status after the designation of a paying agent. When the division receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the division shall order termination of any further benefits due from the original order designating a paying agent.

Stat. Auth.: ORS 656.307, 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.307, 656.308, 656.704 & 656.726(4)
Hist.: WCD 1-1980(Admin), f & ef. 1-11-80; WCD 5-1980(Admin)(Temp), f & ef. 4-29-80; WCD 7-1980(Admin), f. 9-5-80, ef. 10-1-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0332, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0190
Monetary Adjustments Among Parties and Department of Consumer and Business Services

(1) An order of the director under ORS 656.307 and OAR 436-060-0180 applies only to the period prior to the order of the Administrative Law Judge determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Consumer and Business Services Fund, unless the director concludes payment was made before the Administrative Law Judge's order was received by the paying agent designated under OAR 436-060-0180. Any monetary adjustment necessary after the Administrative Law Judge's order shall be handled under OAR 436-060-0195.

(2) When all litigation on the issue of responsibility is final, the insurer ultimately held to be responsible must, prior to paying any compensation, contact any nonresponsible insurer to learn what compensation has already been paid. When contacted by the responsible insurer, the nonresponsible insurer must provide the requested information necessary for the responsible insurer to make a timely payment to the worker, medical providers or others, but in any case no later than 20 days after the date of the notification. Failure to respond to the responsible insurer's inquiry in a timely manner may result in nonreimbursement otherwise due from the responsible insurer or from the Consumer and Business Services Fund.

(3) The responsible insurer must reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid which the responsible insurer is responsible for, but has not already paid within 30 days of receiving sufficient information to adequately determine the benefits paid and the relationship to the condition(s) involved. Any balance remaining due the worker, medical providers or others must be paid in a timely manner under OAR 436-009 and 436-060-0150. Payment of compensation which results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer shall not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) The division shall direct any necessary monetary adjustment between the parties involved which is not otherwise ordered by the Administrative Law Judge or voluntarily resolved by the parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except in the situation described in section (3). Failure to make monetary adjustments within 30 days of an order by the division will subject the insurer to civil penalties under OAR 436-060-0200. Only compensation paid as a result of an order by the director under OAR 436-060-0180 and consistent with this rule shall be recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) When the division determines improper or untimely claim processing by the designated paying agent has resulted in unnecessary costs, the division may deny reimbursement from the responsible insurer and the Consumer and Business Services Fund.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.307(3), 656.704 & 656.726(4)
Hist.: WCB 5-1970, f. 6-3-70, ef. 6-25-70; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 5-1980(Admin)(Temp), f. & ef. 4-29-80; WCD 7-1980(Admin), f. 9-5-80, ef. 10-1-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0334, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0195
Miscellaneous Monetary Adjustments Among Insurers

(1) The director may order monetary adjustments between insurers under authority provided by ORS 656.726(4) and 656.202 where

a claimant has a right to compensation, but there is a dispute between insurers that does not fall under the director's authority in ORS 656.307 and OAR 436-060-0190. Any failure to obtain reimbursement from an insurer under this rule shall not be recoverable from the Consumer and Business Services Fund. The purpose of this rule is to ensure the claimant properly receives all compensation due under the workers' compensation law, but is not unduly compensated for more than the law intended.

(2) When any litigation on issues in question is final, insurers must make any necessary monetary adjustments among themselves consistent with the determination of coverage for compensation paid to the worker, medical providers and others for which they are responsible and payment has not already been made within 30 days of receiving sufficient information to adequately determine the benefits paid and the relationship to the condition(s) involved. Any balance due after making such adjustments must be paid in a timely manner to the worker, medical providers and others under OAR 436-009 and 436-060-0150.

(3) The division may direct any necessary monetary adjustment between parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except where an insurer unduly compensates a claimant while having knowledge such compensation has already been paid by another insurer. Notwithstanding, each insurer has its own independent obligation to process its claim and pay interim compensation due until the claim is either accepted or denied. When notified by the division that a dispute over monetary adjustment exists the insurer must provide a written response to questions or issues raised, including supporting documentation, to the division, insurers involved and other interested parties within 21 days of the date of the notification.

(4) Failure to respond to the division's inquiries or make monetary adjustments within 30 days of an order by the division will subject the insurer to civil penalties under OAR 436-060-0200.

(5) When the division determines improper or untimely claim processing by an insurer resulted in unnecessary costs, the division may deny monetary adjustment between the insurers.

Stat. Auth.: ORS 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02 ; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05

436-060-0200
Assessment of Civil Penalties

(1) The director through the division and under ORS 656.745 shall assess a civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due.

(2) A penalty under section (1) will only be assessed after all litigation on the matter has become final by operation of the law. For the purpose of section (1):

(a) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS 656.745(1) or to engage in the conduct so described in that section; and

(b) "Repeatedly" means more than once in any twelve month period.

(3) Under ORS 656.745, the director may assess a civil penalty against an employer or insurer who fails to comply with rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(4) An employer or insurer failing to meet the time frame requirements set forth in OAR 436-060-0010, 436-060-0017, 436-060-0018, 436-060-0030, 436-060-0060, 436-060-0147, 436-060-0155 and 436-060-0180 may be assessed a civil penalty up to $2,000.

(5) An insurer who willfully violates OAR 436-060-0160 shall be assessed a civil penalty of up to $2,000.

(6) An insurer that does not accurately report timeliness of first payment information to the division may be assessed a civil penalty of $500 for reporting inaccurate information plus $50 for each violation, or $10,000 in the aggregate for all violations within any three month period. For the purposes of this section, a violation consists of each situation where a first payment was reported to have been made timely, but was found upon audit to have actually been late.

(7) Notwithstanding section (3) of this rule, an employer or insurer who does not comply with the claims processing requirements of ORS Chapter 656, and rules and orders of the director relating thereto may be assessed a civil penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period.

(8) Any employer or insurer which misrepresents themselves in any manner to obtain workers' compensation claims records from the director, or which uses such records in a manner contrary to these rules, is subject to a civil penalty of $1,000 for each occurrence. In addition, the director may suspend or revoke an employer's or insurer's access to workers' compensation claims records for such time as the director may determine. Any other person determined to have misrepresented themselves or who uses records in a manner contrary to these rules shall have access to these records suspended or revoked for such time as the director may determine.

(9) For the purpose of section (7), statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, and 656.335.

(10) In arriving at the amount of penalty, the division may consider, but is not limited to:

(a) The ratio of the volume of violations to the volume of claims reported, or

(b) The ratio of the volume of violations to the average volume of violations for all insurers or self-insured employers, and

(c) Prior performance in meeting the requirements outlined in this section.

(11) Insurer performance data is reviewed every quarter based on reports submitted by the insurer during the previous calendar quarter. Civil penalties will be issued for each of the performance areas where the percentages fall below the acceptable standards of performance as set forth in these rules. The standard for reporting claims to the division will allow insurers to report claims by filing a Form 1502 accompanied by a Form 827 where the Form 801 is not available. Penalties will be issued in accordance with the matrix set forth in **Appendix "C."**

(12) Under ORS 656.262(13), an injured worker's attorney that is not willing or available to participate in an interview at a time reasonably chosen by the insurer within 14 days of the request for interview may be assessed a civil penalty not to exceed $1,000 if the director finds the attorney's actions unreasonable.

[ED. NOTE: Appendices & Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, 656.335, 656.704, 656.726(4) & 656.745
Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0981, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 3-1991, f. 4-18-91, cert. ef. 6-1-91; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

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

(1) When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, reimbursement of the supplemental amount shall be made by the director quarterly, after receipt and approval of documentation of compensation paid by the insurer or the third party administrator. The director will reimburse the insurer, in care of a third party administrator, if applicable.

(2) Requests for reimbursement must be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include, but may not be limited to:

(a) Identification and address of the insurer responsible for processing the claim;

(b) The worker's name, WCD file number, date of injury, social security number, and the insurer claim number;

(c) Whether the claim is disabling or nondisabling;

(d) The primary and secondary employer's legal names;

(e) The primary and secondary employer's WCD registration numbers;

(f) The weekly wage of all jobs at the time of the injury separated by employer;

(g) The dates for the period(s) of supplemental disability due and payable to the worker. Dates must be inclusive (e.g., 1-16-02 through 1-26-02);

(h) The amount of supplemental disability paid for the periods in (2)(g);

(i) The quarter and year in which the payment was made;

(j) A signed payment certification statement verifying the payments; and

(k) Any other information required by the director.

(3) In addition to the supplemental disability reimbursement, the division shall calculate and the insurer shall be paid an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

(4) Periodically the division will audit the physical file of the insurer responsible for processing the claim to validate the amount reimbursed. Reimbursement will be disallowed and repayment will be required if, upon such audit, it is found:

(a) Payments exceeded statutory amounts due, excluding reasonable overpayments, as determined by the division;

(b) Compensation has been paid as a result of untimely or inaccurate claims processing; or

(c) Payments of compensation have not been documented, as required by OAR 436-050.

(5) Supplemental disability benefits due subject workers of an employer who is in a noncomplying status as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(3).

(6) Claim Dispositions or Stipulated Settlements, under ORS 656.236 or 656.289 which include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless made with the prior written approval of the director.

(a) Requests for written approval of proposed dispositions must include:

(A) A copy of the proposed disposition or settlement which specifies the 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 approve the disposition for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.704, 656.726(4) & Sec. 3(5)(a), Ch. 865, OL 2001
Stats. Implemented: ORS 656.210, 656.704 & 656.726(4)
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-060-0510
Reimbursement of Permanent Total Disability Benefits from the Workers' Benefit Fund

(1) The insurer may request reimbursement of permanent total disability benefits paid after the date of the notice of closure under ORS 656.206(6)(a) (Oregon Laws 2005, chapter 461; section 1).

(2) Requests for reimbursement must be filed within one year of the date of the final order upholding the notice of closure and include:

(a) Sufficient information to identify the insurer and the injured worker;

(b) The net dollar amount of permanent total disability benefits paid ("Net dollar amount" means the total compensation paid less any recoveries, including, but not limited to, third party recovery or amounts reimbursable from the Retroactive Program or Reopened Claims Program.); and

(c) A statement certifying that payment has been made.

(3) If any of the monies are due under the Retroactive Program or Reopened Claims Program, any reimbursement request must be submitted under OAR 436-075 or 436-045, respectively.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.206, 656.605, OL 2005 Ch. 461, Sec.1
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

DIVISION 70

WORKERS' BENEFIT FUND ASSESSMENT

436-070-0001
Authority for Rules

These rules are adopted under the director's authority contained in ORS 656.726 and 656.506.

Stat. Auth.: ORS 656.726 & 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0101, 5-1-85; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-070-0002
Purpose

The purpose of these rules is to:

(1) Prescribe the manner and intervals in which the assessment rate is to be calculated;

(2) Prescribe the manner and intervals employers are to withhold, file, and remit assessments; and

(3) Prescribe the conditions affecting the adjustment of the assessments as authorized by ORS 656.506.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0108, 5-1-85; WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-070-0003
Applicability of Rules

(1) These rules govern the Workers' Benefit Fund assessment pursuant to ORS 656.506 on or after the effective date of these rules.

(2) These rules apply to all subject employers as defined in ORS 656.005 and any otherwise non-subject employer who elects coverage pursuant to ORS 656.039.

(3) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0103, 5-1-85; WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-070-0005
Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions in the Workers' Compensation Law and as follows:

(1) "Assessments" means the funds due from employees and employers pursuant to ORS 656.506.

(2) "Employee" means a subject Oregon worker as defined in ORS 656.005 and any otherwise nonsubject worker for whom coverage is elected under ORS 656.039.

(3) "Fund" means the Workers' Benefit Fund as created in ORS 656.506.

(4) "Fund balance" means the balance of the fund after revenue and investment income has been added and expenditures have been subtracted.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0105, 5-1-85; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-070-0008
Administrative Review

(1) Contested case hearings regarding sanctions and civil penalties: Any employer as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director issued pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with 656.740.

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing will be

granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

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

(2) Hearings regarding estimation actions and orders: Under ORS 656.704(2), any employer who disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.735 & 656.740
Stats. Implemented: ORS 656.704, 656.735, 656.740 & OL 2005, Ch. 26
Hist.: WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-070-0010
Assessment Rate: Method and Manner of Determining

Prior to November 15 each year, the director will compute and notify employers of the following calendar year's assessment rate necessary to meet the needs of the fund. Factors considered in developing the rate include, but are not limited to:

(1) The estimated annual fund expenditures and revenues;

(2) The fund balance requirements;

(3) The estimated annual hours worked per employee;

(4) The estimated number of employees covered by workers' compensation insurance; and

(5) Other records relating to fund expenditures and revenues.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0120, 5-1-85; WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-070-0020
Assessments: Manner and Intervals for Filing and Payment

(1) Every employer must compute the total assessment amount due for each employee by multiplying the assessment rate determined in OAR 436-070-0010 by the number of hours or parts of an hour the employee worked in the pay period.

(a) If actual hours worked are not tracked, an employer may either calculate the assessments using a flat rate, use contract information stating the number of hours an employee works, or come up with a reasonable method for calculating hours worked. If the flat rate method is used, the calculation must be based on 40 hours per week for employees paid weekly or biweekly, or 173.33 hours per month for employees paid monthly or semi-monthly.

(b) The employer will retain from the moneys earned by each employee one half (1/2) of the amount due. In addition, the employer will be assessed an amount equal to the amount retained from each employee.

(2) Every employer must file a report of employee hours worked and remit amounts due upon a combined tax and assessment report form prescribed by the Department of Revenue. The report must be filed with the Department of Revenue:

(a) At the times and in the manner prescribed in ORS 316.168 and 316.171; or

(b) Annually as required or allowed pursuant to ORS 316.197 or 657.571.

(3) For employers required to report quarterly, reports and payments are due on or before the last day of the first month after the close of each calendar quarter. For employers that report annually, reports and payments are due on or before the last day of January following the close of each calendar year.

(4) Employers who fail to timely and accurately file and remit assessments may be charged interest on all overdue balances at the rate established by ORS 82.010 and may be assessed civil penalties in accordance with OAR 436-070-0050.

(5)(a) If an employer fails to file a report or the director determines, based on the available data, that the report filed understates assessments, the director may send to the employer a written Failure to File Notice or Notice of Audit Findings. The notice will include a warning that failure to timely and accurately resolve all issues addressed in the written notice may result in the imposition of a civil penalty. The director may coordinate with the Department of Revenue and Employment Department to provide written notice of failure to file.

(b) Within 30 days of the Failure to File Notice or the Notice of Audit Findings, the employer must file an accurate report and remit the assessments due, or otherwise resolve to the satisfaction of the director all issues identified in the written notice. If an employer fails to comply with the notice, the director may estimate the assessments due, including penalties and interest, and send to the employer a Notice of Estimation.

(c) Within 30 days of the Notice of Estimation, the employer must pay the director's estimated assessment or file and remit accurate assessment due. If the employer fails to comply with the notice, the director may send to the employer an Order of Default assessing all amounts due as calculated by the director.

(d) Within 30 days of the Order of Default, the employer must remit the estimated assessment due, unless the order is timely appealed as provided in OAR 436-070-0008.

(6) Employers or the director may initiate activity to resolve reporting errors, omissions, or discrepancies for a period not to exceed the current calendar year plus three prior calendar years. No calendar year limitation applies to cases involving fraud.

(7) When the director determines that the department has received moneys in excess of the amount legally due and payable or that it has received moneys to which it has no legal interest, the director will refund or credit the excess amount. For amounts less than $20, the director will refund to employers the excess amount only upon receipt of a written request from the employer or the employer's legal representative.

Stat. Auth.: ORS 656.506 & 82.010
Stats. Implemented: ORS 656.506 & 293.445
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0125, 5-1-85; WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 2-2006(Temp), f. & cert. ef. 1-27-06 thru 7-23-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-070-0040
Monitoring/Auditing

(1) Employers must maintain payroll and employment records which reflect the total hours worked by all employees for the current calendar year plus three prior calendar years.

(2) Pursuant to ORS 656.726, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.506
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0135, 5-1-85; WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-070-0050
Assessment of Civil Penalties

(1) The director pursuant to ORS 656.745 may assess a civil penalty against an employer.

(2) If the director finds any employer in violation of OAR 436-070 or an order of the director, the employer may be subject to penalties pursuant to ORS 656.745 of not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separate violation.

(3) An employer may be assessed a penalty for late filing or payment when received more than 10 calendar days after the due date established in OAR 436-070-0020(2). The penalty will be assessed at 10% of the outstanding balance, with a minimum of $50 for each violation up to $2,000. Penalties are in addition to interest and assessments owed.

Stat. Auth.: ORS 656.745(2)
Stats. Implemented: ORS 656.745
Hist.: WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

DIVISION 75

RETROACTIVE PROGRAM

436-075-0001
Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726 and 656.506.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.506 & 656.726
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90

436-075-0002
Purpose

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

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0003
Applicability of Rules

(1) These rules are effective January 1, 1998, and shall apply to all requests for reimbursement from the Retroactive Program involving benefits payable pursuant to:

(a) ORS 656.204 Death;

(b) ORS 656.206 Permanent Total Disability;

(c) ORS 656.208 Death During Permanent Total Disability;

(d) ORS 656.210 Temporary Total Disability for injuries prior to April 1, 1974.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.209, 656.206, 656.208, 656.210, 656.236, 656.289 & 656.506
Stats. Implemented: ORS 656.204, 656.206, 656.208, 656.210, 656.276, 656.289 & 656.506
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0005
Definitions

Except where the context requires otherwise, these rules are governed by the following definitions:

(1) "Average Weekly Wage" is that wage defined in ORS 656.005.

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

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

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

(5) "Director" means the director of the Department of Consumer and Business Services.

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

(7) "Expiration of Benefits" means the end of entitlement to a benefit because of limits set forth in the statute in effect at the time of the worker's injury.

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

(9) "Retroactive Program benefit" means that additional benefit paid to eligible claimants or beneficiaries to bring their benefits to a more current level.

(10) "Social Security Offset" means a reduction of permanent total disability benefits or fatal benefits based upon the amount of federal social security disability benefits received by a worker or surviving spouse.

(11) "Spouse" means the husband or wife of a worker. This definition also includes cohabitants as defined in ORS 656.226.

(12) "Statutory Benefit" means any benefit payable to or on behalf of the injured worker in accordance with the law in effect at the time of the worker's injury, as modified by marital/dependency status changes.

(13) "Through" means inclusion of a specific date.

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

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0006
Administration of Rules

For the purpose of administering these rules, orders of Compliance are deemed orders of the Director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90

436-075-0008
Administrative Review

(1) Any party as defined by ORS 656.005 aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

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

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

Stat. Auth.: ORS 656.740, 656.745 & 656.750
Stats. Implemented: ORS 656.704, 656.740, 656.745, 656.750 & OL 2005, Ch. 26
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-075-0010
Criteria for Eligibility

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

(2) Eligibility for Retroactive Program benefits shall be based upon the worker's injury date as follows:

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

(b) For workers receiving temporary total disability benefits, the injury must have occurred prior to July 1, l973. Workers with injuries occurring between July 1, 1973 and April 1, 1974 may qualify for benefits according to the limits defined in the Retroactive Program bulletin. Workers injured on or after April 1, 1974 are not entitled to receive Retroactive Program increases to their temporary total disability benefit.

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

(4) Costs for claims of subject workers of an employer which is noncomplying as defined in ORS 656.052 are not eligible for reimbursement from the program, but remain a cost recoverable from the employer as provided by ORS 656.054(3).

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.236, 656.289 & 656.506

Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0020
Death Benefit

(1) Death benefits shall be paid to eligible beneficiaries pursuant to ORS 656.204, and the Retroactive Program benefit schedules.

(2) Burial benefits shall be paid pursuant to ORS 656.204(1) and the Retroactive Program benefit schedules.

(3) The statutory death benefit for injuries occurring from July 1, 1973 to April 1, 1974 will be reduced by the Social Security benefit received, up to the July 1, 1973 statutory benefit level. The amount of reduction to the statutory benefit is a Retroactive Program benefit. The insurer shall request reimbursement only for the adjusted Retroactive Program benefit.

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

(5) Benefits for dependents shall be paid to the date of any status change.

(6) Remarriage allowance shall be paid pursuant to ORS 656.204 and the Retroactive Program benefit schedules.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.204
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0030
Permanent Total Disability Benefit

(1) Permanent total disability benefits shall be paid in accordance with ORS 656.206 and the benefit schedules set forth in the Retroactive Program bulletin.

(2) Benefit amounts payable for a partial month shall be calculated as set forth in 436-075-0020(4).

(3) Benefits for dependents shall be paid to the date of any status change.

(4) Any Social Security Offset determined pursuant to ORS 656.209 shall be first applied against the statutory portion of the permanent total disability benefit. Any amount of the social security offset that exceeds the statutory benefit shall be applied against the Retroactive Program benefit. The insurer shall request reimbursement only for that portion of the Retroactive Program benefit which has not been offset.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.206 & 656.209
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0040
Death During Permanent Total Disability

(1) If the injured worker dies during the period of permanent total disability, death benefits shall be paid to eligible beneficiaries pursuant to ORS 656.208 and 656.204, and the Retroactive Program benefit schedules.

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

(3) Social Security benefit for injuries occurring between July 1, 1973 and April 1, 1974 will be applied as set forth in 436-075-0020(3).

(4) Benefit amounts payable for a partial month shall be calculated as set forth in 436-075-0020(4).

(5) Burial benefits shall be paid in accordance with ORS 656.208(1) and 656.204(1) and the Retroactive Program benefit schedules; however if the injury date is prior to July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.204 & 656.208
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0050
Temporary Total Disability

(1) Temporary total disability benefits shall be paid in accordance with ORS 656.210, OAR 436-060-0150 and the benefit schedules set forth in the Retroactive Program bulletin.

(2) In no case shall the computation of benefits under these rules and the Retroactive Program bulletin cause a reduction in temporary total disability benefits currently being paid.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.210
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0065
Dispositions

(1) Any disposition of the claim by the parties pursuant to ORS 656.236, or settlement of the claim pursuant to ORS 656.289, is not eligible to receive reimbursement from the Retroactive Program unless made with the prior written approval of the director.

(2) Requests for written approval of proposed dispositions should include:

(a) A copy of the proposed disposition which specifies the amount of the proposed contribution to be made from the Retroactive Program;

(b) A statement from the insurer indicating how the amount of the contribution was calculated;

(c) Any other information as required by the director.

(3) The director will not approve the disposition for reimbursement if:

(a) The ratio of the amount requested from the program to the total amount of the disposition exceeds the percentage of current benefits due the worker from the program; or

(b) The settlement exceeds a reasonable projection of future liability.

(4) The insurer shall submit dispositions to the division in the format prescribed by the director.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.236 & 656.289
Hist.: WCD 10-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0070
Reimbursement

(1) Reimbursement from the Retroactive Program will be authorized by the Compliance Section on a quarterly basis.

(2) Requests for reimbursement must be mailed or delivered to Compliance within 30 days after the end of each quarter to be processed in that quarterly disbursement.

(3) Requests for reimbursement mailed or delivered to Compliance more than 30 days after the end of the quarter will be held over and processed with the next quarterly disbursement.

(4) A separate request for reimbursement shall be submitted for each insurer and shall include a signed certification that the payments reported on the request have been made in the amounts reported.

(5) Requests for reimbursement must be submitted in the format prescribed by the director. Each request must accurately reflect the marital/dependency status in effect and eligible for reimbursement in the period requested.

(6) Compliance will not process any request failing to meet the requirements of section (4) or (5), until such requirements are met.

(7) The department shall recover any overpayment made to an insurer as a result of an insurer error in reporting, or incorrect information submitted on a quarterly request form.

(8) In the event a denied claim is found to be compensable by a hearing referee, the Workers' Compensation Board, or the Court of Appeals, and that decision is reversed by a higher level of appeal, the insurer shall receive reimbursement for Retroactive Program benefit payments required to be made while the claim was in an accepted status.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.506
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0090
Third Party Recovery

(1) In the event of a third party recovery, previously reimbursed Retroactive Program benefits are a portion of the paying agency's lien.

(2) When the insurer learns of third party settlement negotiations on any claim for which it has received reimbursement from the Retroactive Program, the insurer should notify Compliance in accordance with the provisions set forth in ORS 656.593.

(3) Remittance on recovered Retroactive Program benefits shall be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and 656.593.

Stat. Auth.: ORS 656.506
Stats. Implemented: ORS 656.591 & 656.593
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 14-1997, f. 12-4-97, cert. ef. 1-1-98

436-075-0100
Assessment of Civil Penalties

Pursuant to ORS 656.745 the Director may assess a civil penalty against an insurer for failure to comply with these rules. Penalty orders shall be issued in accordance with ORS 656.447, and 656.704, and are subject to review under OAR 436-075-0008.

Stat. Auth.: ORS 656.625 & 656.726(4)
Stats. Implemented: ORS 656.447, 656.704, 656.726 & 656.745
Hist.: WCD 4-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 10-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90

436-075-0110
Suspension and Revocation of Authorization to Issue Guaranty Contracts

(1) Pursuant to ORS 656.447, the Director may suspend or revoke the insurer's authority to issue guaranty contracts upon a determination that the insurer has failed to comply with its obligations under such contract or that it has failed to comply with the rules or orders of the Director.

(2) For the purpose of this rule:

(a) "Suspension" and its variations means a stopping by the Director of the insurer's authority to issue new guaranty contracts for a specified period of time.

(b) "Revocation" and its variations means a permanent revocation by the Director of an insurer's authority to issue guaranty contracts.

(c) "Show-cause hearing" means an informal meeting with the Director or designee in which the insurer shall be provided an opportunity to be heard and present evidence regarding any proposed orders by the Director to suspend or revoke an insurer's authority to issue guaranty contracts.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show-cause hearing before the Director and "show cause" why it should be permitted to continue to issue guaranty contracts.

(4) A show-cause hearing may be held at any time the Director finds that an insurer has failed to comply with its obligations under a guaranty contract or that it failed to comply with rules or orders of the Director.

(5) Following a show-cause hearing, the Director may rescind the proposed order if the insurer establishes to the Director's satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy lapses or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the Division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the Director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the Director revoke the insurer's authority to issue guaranty contracts.

(8) When an insurer's authority to issue guaranty contracts has been revoked, the insurer may serve an existing account only until the policy lapses, is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer's authority to issue guaranty contracts has been in effect for five (5) years or longer, it may petition the Director to restore its authority by submitting a plan in the form prescribed by the Director, demonstrating its ability and commitment to comply with the workers' compensation law, these rules and orders of the Director.

(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-075-0008.

(11) Any order of suspension or revocation issued by a referee or other person pursuant to ORS 656.447 and this rule is a preliminary order subject to revision by the Director.

Stat. Auth.: ORS 656.506 & 656.726
Stats. Implemented: ORS 656.447
Hist.: WCD 23-1990, f. 11-29-90, cert. ef. 12-26-90

DIVISION 80

NONCOMPLYING EMPLOYERS

436-080-0001
Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726 and 656.054.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.054, 656.704 & 656.726
Hist.: WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0006, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0002
Purpose

It is the purpose of the director that under ORS 656.726(4) and 656.054 rules be established to ensure the requirements of ORS 656.017 are met. To meet that responsibility the director has delegated to the division the responsibility of ensuring the requirements of the statutes, rules, and bulletins of the department are complied with as they relate to employer coverage.

Stat. Auth.: ORS 656.054 & 656.726
Stats. Implemented: ORS 656.726
Hist.: WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0003
Applicabililty of Rules

These rules are effective January 1, 2004 and carry out the provisions of:

(1) ORS 656.017 — Employer required to pay compensation and perform other obligations and duties.

(2) ORS 656.052 — Prohibition against employment without coverage; proposed order declaring noncomplying employer; effect of failure to comply.

(3) ORS 656.054 — Claim of injured worker of noncomplying employers; notice of proposed penalty; recovery of costs from noncomplying employer.

(4) ORS 656.735 — Civil penalty for noncomplying employers; amount; liability of corporate officers; effect of final order; penalty as preferred claim; disposition of moneys collected.

(5) ORS 656.740 — Review of proposed order declaring noncomplying employer, proposed assessment or civil penalty; insurer as party; hearing.

Stat. Auth.: ORS 656.054 & 656.726
Stats. Implemented: ORS 656.726
Hist.: WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0055, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 4-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 2-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0005
Definitions

For the purpose of these rules unless the context requires otherwise:

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

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

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

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

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.054, 656.704 & 656.726
Hist.: WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0008, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0006
Administration of Rules

Any order issued by the division in carrying out the director's authority to enforce ORS Chapter 656 and the rules adopted pursuant thereto is considered an order of the director.

Stat. Auth.: ORS 656.054 & 656.726
Stats. Implemented: ORS 656.052, 656.054 & 656.726
Hist.: WCB 4-1973(Temp), f. 12-6-73, ef. 12-6-73; WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0010, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0010
Initiation of Proceedings; Issuance of Noncomplying Employer Order

If an employer has failed to comply with ORS 656.017, the division will investigate. If the division finds the employer is a subject employer that has failed to file proof of qualification in the manner required by ORS 656.407, as either a carrier-insured employer or a self-insured employer, the division will issue a Proposed and Final Order declaring the employer to be a noncomplying employer, and assess a civil penalty pursuant to ORS 656.735(1) for violation of 656.052.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.017, 656.052 & 656.735
Hist.: WCB 10-1970, f. & ef. 7-24-70; WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974, f. 2-13-84, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0015, 5-1-85; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0020
When a Hearing on the Order is Not Rquested

If the employer does not request a hearing on the order within the 60 days allowed by ORS 656.740, the division may request the Department of Justice to commence proceedings to enjoin the employer under ORS 656.052(3).

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.052, 656.735 & 656.740
Hist.: WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0020, 5-1-85; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0030
When a Hearing on the Schedule is Requested

(1) A request for hearing on an order issued under OAR 436-080-0010 or 436-080-0040 must specify the grounds upon which the employer contests the order and must be mailed or delivered to the division within 60 calendar days after the mailing of the order.

(2) When a person who is served with an order timely files a request for a hearing, the division will forward the request and other pertinent information to the Hearings Division.

(3) A division officer or employee is authorized to appear (but not make legal argument) on behalf of the director in a hearing or in a class of hearings in which the Attorney General or the Deputy Attorney General has given written consent for such representation. A copy of the list of contested case hearings for which the Attorney General or the Deputy Attorney General has given consent is maintained by the division and the Department of Justice.

(4) "Legal argument" as used in ORS 183.452 and this rule has the same meaning as in the Attorney General's Model Rule of Procedure 137-003-0008(1)(c) and (d), which is hereby adopted by reference.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.052, 656.735 & 656.740
Hist.: WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0025, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 4-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0040
Assessment of Civil Penalties Against Noncomplying Employer; Hearing on Proposed Assessment

(1) In accordance with ORS 656.735(1), the amount of penalty for a person's first violation of ORS 656.052(1) shall be the greater of $1,000 or twice the premium the employer would have paid during the non-complying period if insurance had been provided.

(a) The division may reduce the amount of the penalty due, to 105% of the amount of premium the employer would have paid during the noncomplying period if insurance had been provided if, prior to the penalty order becoming final, the employer:

(A) Agrees to not contest the penalty order;

(B) Provides evidence satisfactory to the division that it is no longer a subject employer or, if it is still a subject employer, that it has now complied with ORS 656.052(1);

(C) Provides adequate payroll information to enable the division to calculate the amount of premium the employer would have paid during the noncomplying period if insurance had been provided; and

(D) Makes arrangements satisfactory to the division for prompt payment of the reduced penalty amount.

(b) If 105% of the amount of premium the employer would have paid during the noncomplying period is less than $500, the reduced penalty will be $500.

(2) The amount of penalty, when assessed against the employer pursuant to ORS 656.735(2), shall be $250 per day for each calendar day the employer has continued to violate ORS 656.052(1), commencing with the first day of such violation:

(a) The division may reduce the amount of the penalty due to 150% of the amount of premium the employer would have paid during the non-complying period if insurance had been provided if, prior to the penalty order becoming final, the employer:

(A) Agrees to not contest the penalty order;

(B) Provides evidence satisfactory to the division that it is no longer a subject employer or, if it is still a subject employer, that is has now complied with ORS 656.052(1);

(C) Provides adequate payroll information to enable the division to calculate the amount of premium the employer would have paid during the noncomplying period if insurance had been provided; and

(D) Makes arrangements satisfactory to the division for prompt payment of the reduced penalty amount.

(b) If 150% of the amount of premium the employer would have paid during the noncomplying period is equal to or greater than $250 per calendar day of noncompliance, there will be no reduction of the penalty amount.

(c) If 150% of the amount of premium the employer would have paid during the noncomplying period is less than $1000, the reduced penalty will be $1000.

(3) For the purpose of this rule, "premium the employer would have paid during the noncomplying period" means:

(a) If payroll records are available, actual premium using the applicable occupational base rate premium applied to the payroll of the employer during the period of noncompliance; or

(b) If payroll records are not available, estimated premium based upon the number of workers employed during the noncomplying period times the average weekly wage as defined in ORS 656.005(1), using the applicable assigned risk base rated premium during the period of noncompliance.

(4) The division will mail or otherwise serve an order assessing a civil penalty, with a notice to the employer of rights under ORS 656.740.

(5) When a penalty order becomes final, the division will transfer the matter to the Business Administration Division of the department to collect the penalty.

Stat. Auth.: ORS 656.052, 656.726 & 656.735
Stats. Implemented: ORS 656.052, 656.735 & 656.740
Hist.: WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0030, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 8-1995(Temp), f. & cert. ef. 7-26-95; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0060
When a Worker Files a Claim for an Injury

(1) When the division issues an order under OAR 436-080-0010 declaring an employer a noncomplying employer, and a subject worker has filed a claim for an injury sustained during the period of noncompliance while the worker was employed by such employer, the division will:

(a) Refer the claim with a copy of the order and the results of its investigation to the assigned claims agent for processing as required by ORS 656.054; and

(b) Inform the worker, the worker's representative, if represented, and the employer that the claim has been referred to the assigned claims agent;

(2) The notice to the employer will inform the employer of the right to object to the claim.

(3) If the employer wishes to object to the claim, the employer shall request a hearing. The request for hearing must be filed within 60 days from the date of the mailing of the Notice of Referral.

(4) When the assigned claims agent accepts or denies the claim, it shall notify the worker, employer, and the division of its action within the time provided by ORS 656.262.

(5) When the division finds that at the time of the injury, either the worker was not a subject worker or the employer was not a subject employer, the worker and employer shall be notified of such determination. The worker may request a hearing by filing a hearing request within 60 days after the mailing of the determination. The hearing request must be sent to the Workers' Compensation Division administrator. The worker and employer shall be parties to any such hearing, and will be notified by the Hearings Division of the time and place set for hearing.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.054
Hist.: WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974 f. 2-13-74, ef. 3-11-74; WCB 15-1979(Admin), f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0040, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 26-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 8-1992(Temp), f. & cert. ef. 4-15-92; WCD 14-1992, f. & cert. ef. 10-13-92; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 9-1997(Temp), f. & cert. ef. 8-1-97; WCD 2-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0065
Determination Of Assigned Claims Agent

(1) When selecting an assigned claims agent, the director will consider claims processing performance data collected by the division. That data and data provided by potential assigned claims agents will be used to determine which claims agent can deliver the most timely and appropriate benefits to injured workers and can best control claim costs and administrative costs. In addition, the director may use any other factors the director considers appropriate.

(2) If no qualified entity agrees to be an assigned claims agent, the director may require one or more of the three highest premium producing insurers to be assigned claims agents. In addition to the premium consideration, the criteria described in section (1) of this rule will be used to make that determination.

Stat. Auth.: ORS 656.054 & 656.726
Stats. Implemented: ORS 656.054
Hist.: WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-080-0070
Reimbursement of Assigned Claims Agent for Claims Costs for Injured Workers of Noncomplying Employers

(1) When an assigned claims agent pays compensation to a claimant or incurs other costs on a claim referred to it under ORS 656.054, the assigned claims agent shall report the payment to the department as established by contract with the assigned claims agent. Any amounts received by the assigned claims agent and reported to the department under subsections (5) and (6) of this rule will be offset against such expenditures. Subject to section (3) of this rule, costs incurred by the assigned claims agent for which reimbursement will be allowed include:

(a) All compensation paid claimant.

(b) All expenses incurred for medical services.

(c) Attorney fees paid to the claimant in addition to any compensation, and sums assessed under ORS 656.382(3) and paid by the assigned claims agent, but not fees and sums paid under ORS 656.262(11) and 656.382(1).

(d) A reasonable amount for administrative costs at a rate proposed by the assigned claims agent and approved by the director prior to June 30 of each year. Late requests for increase on the rate of reimbursement, if approved, shall be effective on the date the request was received by the director.

(2) The department will review the request and issue the reimbursement out of the Workers' Benefit Fund.

(3) The department will conduct an annual audit of the noncomplying employer claim files processed by the assigned claims agent to validate the amount reimbursed pursuant to section (1) of this rule. Reimbursement shall not be allowed, if, upon such audit, any of the following are found to apply:

(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

(b) Compensation has been paid negligently for treatment of any condition unrelated to the compensable condition;

(c) The compensability of an accepted claim is questionable and the rationale for acceptance has not been reasonably documented in accordance with generally accepted claims management procedures;

(d) The separate payments of compensation have not been documented in accordance with generally accepted accounting procedures; or

(e) The payments were made pursuant to a disposition agreement as provided by ORS 656.236 without the prior approval of the department.

(4) Under ORS 656.054 and 656.704(2), the assigned claims agent may appeal any disapproval of reimbursement made by the department under this rule as provided in OAR 436-001.

(5) When a damage action is brought against a noncomplying employer or an action is brought against a third party by an employee of a noncomplying employer or the employee's beneficiaries, or by the assigned claims agent as the paying agency for such an employee, as authorized by ORS 656.576 to 656.595, the assigned claims agent shall report the commencement and termination of such action to the department. Thereafter, at the end of each calendar year, the assigned claims agent shall report the status of all such actions that are pending.

(6) When an action against an employer, or third party is settled or if damages are recovered, the assigned claims agent shall report within (30) days to the department the amount of the recovery retained by the assigned claims agent under ORS 656.593(1)(c).

(7) The Business Administration Division of the department is responsible for collecting from noncomplying employers those costs incurred by the Workers' Benefit Fund for which the assigned claims agent is entitled to reimbursement from the department under this rule. The Business Administration Division will inform each noncomplying employer of the liability under ORS 656.054(3) and keep the employer advised of costs incurred by the assigned claims agent.

Stat. Auth.: ORS 656.054 & 656.726
Stats. Implemented: ORS 656.054, 656.704 & OL 2005, Ch. 26
Hist.: WCB 10-1970, f. & ef. 7-24-70; WCB 4-1973(Temp), f. & ef. 12-6-73; WCB 4-1974, f. 2-13-74, ef. 3-11-74; WCB 15-1975, f. 9-22-75, ef. 10-11-75; WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0050, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 4-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-080-0080
Collection of Subject Worker's Payment

(1) When the division finds the noncomplying employer has withheld monies from subject workers pursuant to ORS 656.506, it will collect such money from the noncomplying employer.

(2) The Business Administration Division is responsible for collecting from noncomplying employers those workers' payments not collected by the Workers' Compensation Division and referred to it by the Workers' Compensation Division.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.506
Hist.: WCD 5-1978(Admin), f. 3-31-78, ef. 4-1-78; Renumbered from 436-052-0051, 5-1-85; WCD 7-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 1-1996, f. 1-3-96, cert. ef. 1-5-96; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

DIVISION 85

PREMIUM ASSESSMENT

436-085-0001
Authority for Rules

These rules are adopted under the director's authority contained in ORS 656.726.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.612, 656.614 & 656.726
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0002
Purpose

The purpose of these rules is to establish guidelines to assure accurate and timely reporting and remittance of premium assessment moneys due the director.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.612 & 656.614
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0003
Applicability of Rules

(1) These rules are effective April 1, 2005, to carry out the provisions of:

(a) ORS 656.612 — Consumer and Business Services Fund; purpose, administration, assessments, and collections.

(b) ORS 656.614 — Self-Insured Employers Adjustment Reserve; Self-Insured Employer Group Adjustment Reserve.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.612, 656.614 & 656.726(4)
Stats. Implemented: ORS 656.612 & 656.614
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 5-1987, f. 12-18-87, ef. 1-1-88; WCD 24-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-1991, f. 12-13-91, cert. ef. 1-1-92; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0005
Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions in the Workers' Compensation Law and as follows:

(1) "Assessable earned premium" means the amount of earned premium, minus exempted earned premium, plus large deductible premium credits or modifications that are subject to the premium assessment.

(2) "Direct earned premium" for the purposes of these rules means "assessable earned premium."

(3) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter.

(4) "Earned premium" means the amount reported to the Oregon Insurance Division in the insurer's Annual Statement, Exhibit of Premiums and Losses (Statutory Page 14), Business in the State of Oregon, Column 2 Direct Premiums Earned, Line 16 Workers' Compensation. These premiums:

(a) Exclude reinsurance accepted and are without deduction of reinsurance ceded;

(b) Are before application of any large deductible credits or modification; and

(c) Are after application of experience rating, premium discounts, retrospective rating, audit premiums, foreign terrorism premiums, domestic terrorism and catastrophic premiums, or other individual risk rating adjustments, and are exclusive of deposit premiums.

(5) "Exempted earned premium" means premium earned on insurance under jurisdiction of the federal government (e.g. U.S. Longshore and Harbor Workers' Compensation Act, Federal Employer's Liability Act, and Jones Act), employer liability increased limits premium, and excess coverage premium. All exempted earned premium must be stated on a direct basis prior to reinsurance transactions.

(6) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state.

(7) "Premium Assessments" means moneys due the director under ORS 656.612 and 656.614.

(8) "Self-Insured Employer" means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(9) "Self-Insured Employer Group" means five (5) or more employers in the same industry certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 5-1987, f. 12-18-87, ef. 1-1-88; WCD 24-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0008
Administrative Review

(1) Any insurer or self-insured employer aggrieved by a proposed order or proposed assessment of civil penalty of the director issued pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

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

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

Stat. Auth.: ORS 656.612, 656.614, 656.726(4) & 656.740
Stats. Implemented: ORS 656.704, 656.735, 656.740, 656.745 & OL 2005, Ch. 26
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 5-1987, f. 12-18-87, ef. 1-1-88; WCD 24-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-1991, f. 12-13-91, cert. ef. 1-1-92; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-085-0025
Premium Assessment; Manner and Intervals for Payments: Insurers

Insurers must report and remit premium assessment moneys to the director using a completed Form 440-910, or its electronic equivalent, as follows:

(1) No later than the 15th day of the second month following the last day of a calendar quarter, the insurer must report and remit premium assessment based upon the insurer's assessable earned premium for that quarter.

(2) Upon written request from the insurer, the director may allow an insurer to report and remit premium assessments annually when the annual premium assessment is less than $1,000.

(3) The director may waive an insurer's reporting liability after confirming that the insurer has no earned premium for at least four consecutive quarters. The waiver will remain in effect until premium is earned.

(4) Assessable earned premium reported by insurers will be final except for corrections made as a result of audits by the director, examinations by the Insurance Division or insurance regulator of the insurer's state of domicile, or detection by the insurer of clerical error. All such corrections will be made at the premium assessment rate in effect for the year being corrected.

(5) A separate report using Form 440-910 or its electronic equivalent, and remittance check must be submitted for each insurer, including each insurer operating within a group of insurance companies.

(6) The insurer must maintain sufficient documentation to support the assessable earned premium reported to the director and any adjustments or corrections thereto. The documentation must be sufficient for the director to verify the amount reported, adjusted, or corrected.

Stat. Auth.: 656.612, 656.614 & 656.726(4)
Stats. Implemented: ORS 656.612 & 656.614
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 5-1987, f. 12-18-87, ef. 1-1-88; WCD 24-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 10-1991, f. 12-13-91, cert. ef. 1-1-92; WCD 7-1995, f. 7-20-95, cert. ef. 10-1-95; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0030
Premium Assessment; Manner and Intervals for Payments: Self-Insured Employers and Self-Insured Employer Groups

(1) As used in this rule the term "self-insured employers" includes self-insured employer groups.

(2) For premium assessment purposes the premium of all self-insured employers will be determined by using those rates filed with the Insurance Division by a single insurer effective and filed by April

1, which the director has determined will provide the lowest overall rates to all self-insured employers.

(3) Self-insured employers may elect to have their premium calculated either by using:

(a) The normal method of calculation which is manual premium modified by experience rating and premium discount; or

(b) A one-year retrospective rating plan developed and approved by the director. However, any employer becoming self-insured after July 1, may not elect a retrospective rating plan for that fiscal year.

(4) Self-insured employers are required to calculate and remit premium assessments based on the normal method of premium calculation unless the current method elected is to use the one-year retrospective rating plan.

(5) On or before May 31 of each year, the director will issue a bulletin notifying all self-insured employers of the premium rates and the retrospective rating plans developed pursuant to sections (2) and (3) of this rule.

(6) On or before July 1 of each year, every self-insured employer electing to change their current method of premium calculation must submit written notification of the election to the director. Once elected, the method may not be changed for that fiscal year and remains in effect until the self-insured employer timely elects to change the method.

(7) No later than the last calendar day of the month that follows the last day of a calendar quarter, the self-insured employer must report and remit premium assessment using Form 440-900 or Form 440-937 or its electronic equivalent. The premium assessment must be based upon the self-insured employer's premium for that quarter and the premium assessment rate in effect for that quarter as prescribed in OAR 440-045. For retrospective rating plans the premium assessment must be based upon 80 percent of the self-insured employer's standard premium until adjusted by retrospective rating. The director may waive the self-insured reporting requirement after confirming that the self-insured employer has no Oregon payroll for four consecutive quarters.

(8) Notwithstanding section (7) of this rule all premium adjustments resulting from retrospective rating plans or payroll audits must be made by using the premium assessment rate or rates in effect for the period being adjusted.

(9) Retrospective rating adjustments covering periods where more than one assessment rate applied will have the adjusted premium prorated in direct proportion to the self-insured employer's standard premium for each of the periods the assessment rates differed. Total premium assessment due for the entire period will be adjusted on the same basis.

(10) An experience rating modification will be determined individually for each self-insurance plan. The director will use the same method as that used by the Oregon Council on Compensation Insurance, except that the director will use only Oregon claims and payroll exposure and will assign a policy period of July 1 through the following June 30. Loss information necessary to calculate the experience rating modification must be provided to the director by the authorized claims processing location(s). If sufficient experience is not available to promulgate an experience modification based on Oregon experience only, the self-insured employer will be assigned an experience rating modification of 1.00.

(11) When the director orders an adjustment in the experience rating modification applicable for a particular policy period, the adjustment will be applied retroactively to the beginning of the period. Any resulting increase in the assessment is payable on demand. Any resulting decrease may be applied against the next quarterly assessment payment.

(12) When payroll information submitted for use in calculating the experience rating modification has been determined to be inaccurate, the director or the self-insured employer may request a revision of the experience rating modification. A payroll revision may be made only for the three most current years. Any experience modification using that revised payroll information will be recalculated by the director.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.612 & 656.614
Hist.: WCB 2-1976(Admin)(Temp), f. & ef. 4-12-76; WCD 3-1976(Admin), f. & ef. 6-15-76; WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 3-1981(Admin)(Temp), f. 10-30-81, ef. 11-1-81; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1982(Admin), f. & ef. 4-1-82; WCD 8-1982(Admin), f. & ef. 5-17-82; WCD 10-1982(Admin), f. 9-30-82, ef. 10-1-82; WCD 1-1983(Admin)(Temp), f. 6-30-83, ef. 7-1-83; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from OAR 436-051-0020 & 0025; WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 5-1987, f. 12-18-87, ef. 1-1-88; WCD 24-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0035
Audits

To ensure compliance with these rules, insurers, self-insured employers and self-insured employer groups will be subject to periodic audits as authorized by ORS 656.726 and 656.745.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.726 & 656.745
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

436-085-0060
Assessment of Civil Penalties

(1) The director pursuant to ORS 656.745 may assess a civil penalty against an insurer, self-insured employer, or self-insured employer group.

(2) An insurer, self-insured employer or self-insured employer group in violation of OAR 436-085, may be assessed a civil penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation or each day a violation continues, will be considered a separate violation.

Stat. Auth.: ORS 656.612, 656.614 & 656.726(4)
Stats. Implemented: ORS 656.735, 656.740 & 656.745
Hist.: WCD 5-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 10-1991, f. 12-13-91, cert. ef. 1-1-92; Administrative correction; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05

DIVISION 100

WORKERS' COMPENSATION BENEFITS OFFSET

436-100-0001
Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726 and 656.727.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209, 656.726 & ORS 656.727
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983 (Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0001, 5-1-85

436-100-0002
Purpose of Rules

The purpose of these rules is to establish requirements and procedures for the administration of offsetting permanent total disability benefits against social security disability benefits.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209 & 656.727
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983 (Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered to 436-057-0004, 5-1-85

436-100-0003
Applicability of Rules

(1) These rules are effective January 1, 1998, to carry out the provisions of ORS 656.209 and 656.727.

(2) These rules apply to:

(a) Those workers receiving awards for permanent total disability and are eligible for and receiving federal social security disability benefits; and

(b) Injured workers whose period of disability under the Social Security Administration began on or after June 1, 1965.

(3) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.209 & 656.727
Stats. Implemented: ORS 656.209
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0003, 5-1-85; WCD 15-1997, f. 12-4-97, cert. ef. 1-1-98

436-100-0005
Definitions

(1) "Authorization" means an order issued by the Workers' Compensation Division directing the paying agent to offset the worker's permanent total disability benefits by the amount specified in the order.

(2) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under ORS 656.001 through 656.794.

(3) "Compliance Section" means the Compliance Section of the Workers' Compensation Division.

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

(5) "Division" means the Workers' Compensation Division.

(6) "Federal Disability Benefit Limitation" means the amount determined pursuant to 42 USC 224(a) and Social Security Administration rules.

(7) "Offset" means a reduction of permanent total disability benefits based upon the amount of federal social security disability benefits received by a worker.

(8) "Paying agency or paying agent" means the self-insured employer or insurer paying benefits to the worker or beneficiaries.

(9) "Permanent total disability benefits" means compensation to an injured worker awarded permanent total disability compensation under ORS 656.206.

(10) "Worker" means any worker receiving permanent total disability benefits.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.209
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin). f. & ef. 2-22-84; Renumbered from 436-057-0005, 5-1-85; WCD 15-1997, f. 12-4-97, cert. ef. 1-1-98

436-100-0006
Administration of Rules

For the purpose of administration of these rules, orders of the Compliance Division are deemed orders of the Director.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209 & 656.726
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0007, 5-1-85

436-100-0008
Administrative Review

(1) Any worker aggrieved by any offset authorization of the division may apply to the Workers' Compensation Division for a reconsideration of that authorization prior to requesting a hearing.

(2) Any party aggrieved may request a hearing pursuant to the provisions of ORS 656.283.

Stat. Auth.: ORS 656.726 & 656.727
Stats. Implemented: ORS 656.209
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0998, 5-1-85; WCD 15-1997, f. 12-4-97, cert. ef. 1-1-98

436-100-0010
Criteria for Eligibility

(1) Permanent total disability benefits shall be offset by the workers' social security disability benefits. However, the total combined benefit, permanent total disability benefits plus social security disability benefits, shall not be offset to an amount less than the greater of:

(a) The amount the worker would have received pursuant to ORS 656; or

(b) The federal benefit limitation.

(2) Permanent total disability benefits shall not be paid by the paying agent in an amount greater than authorized by ORS Chapter 656.

(3) Offset of permanent total disability benefits shall be made by a paying agent only in an amount and as authorized by the Director.

(4) Offset of permanent total disability benefits shall be authorized by the Director only upon actual receipt of federal social security disability benefits by the injured worker.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209 & 656.727
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0100, 5-1-85

436-100-0020
Requirements of Workers

(1) Workers entitled to receive permanent total disability benefits shall make application for federal social security disability benefits.

(2) Workers and eligible beneficiaries shall, upon Department request, execute a release form authorizing the Social Security Administration to make disclosure to the Department of such information regarding the injured workers as will enable the Department to carry out the provisions of ORS 656.209 and these rules.

(3) Whenever there is a change in the federal social security beneficiary eligibility, the worker shall notify the Compliance Division.

(4) Upon request of the Department, the worker may be required at any time to furnish additional information regarding social security disability benefits.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209 & 656.727
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0115, 5-1-85

436-100-0030
Authorization of Offset; Effective Date

(1) Authorization issued by the Department shall be directed to the paying agent with a copy to the injured worker.

(2) A paying agent making payment of permanent total disability benefits shall be entitled to social security disability offset only as authorized by the Department.

(3) The Department shall review the social security offset calculation when notified of a change in the status of a worker subject to social security offset. An amended authorization will be issued, if necessary.

(4) Whenever there is a change in eligibility status of the worker or any one of his/her beneficiaries receiving benefits for permanent total disability subject to offset, the paying agent shall notify the Compliance Division.

(5) The paying agent will, immediately upon the death of a worker, terminate payment of previously authorized permanent total disability benefits offset and commence payment of other compensation due under ORS Chapter 656, if any.

(6) The effective date of offset will be the effective date established in the authorization.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209 & 656.727
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0130, 5-1-85

436-100-0040
Sanctions Against Worker for Failure to Cooperate with the Department

(1) Any worker entitled to receive permanent total disability benefits who fails to comply with these rules shall be subject to suspension of benefits until the worker has complied.

(2) If a worker fails to comply with these rules, a written demand shall be made upon him by personal service or registered mail. If the worker fails to comply within 20 days of receipt of the demand, the Director may authorize suspension of benefits until the worker complies.

(3) An Order of Suspension of benefits shall continue in force from the date issued until the date the worker actually complies with these rules.

(4) No compensation shall become due or shall be payable during a period of suspension of benefits.

Stat. Auth.: ORS 656
Stats. Implemented: ORS 656.209 & 656.727
Hist.: WCB 7-1978, f. 6-5-78, ef. 6-6-78; WCD 4-1983(Admin)(Temp), f. & ef. 9-1-83; WCD 2-1984(Admin), f. & ef. 2-22-84; Renumbered from 436-057-0150, 5-1-85

DIVISION 105

EMPLOYER-AT-INJURY PROGRAM

436-105-0001
Authority for Rules

The director has adopted OAR chapter 436, division 105 under the authority of ORS 656.622 and 656.726.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01

436-105-0002
Purpose of Rules

(1) The Employer-at-Injury Program encourages the early return to work of injured workers by providing incentives to employers.

(2) The Employer-at-Injury Program is activated by the employer and administered by the insurer.

(3) The program consists of Wage Subsidy, Worksite Modification, and Employer-at-Injury Program Purchases.

(4) These rules explain:

(a) The assistance and reimbursements available from the Employer-at-Injury Program;

(b) Who is qualified for the assistance and reimbursement; and

(c) How to receive assistance and reimbursements.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0041, 436-110-0042 & 436-110-0045; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0510; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0003
Applicability of Rules

(1) These rules apply to:

(a) All individual Employer-at-Injury Programs begun on or after December 1, 2007; and

(b) All reimbursement requests made to the division in accordance with OAR 436-105-0540(4) on or after December 1, 2007 regardless of the date an Employer-at-Injury Program began, unless the insurer requests that reimbursement be based on the rules in effect on the date an individual Employer-at-Injury Program began.

(2) The director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 9-27-04; WCD 8-2004, f. 7-15-04, cert. ef. 8-1-04; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0005
Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "Administrator" means the Administrator of the Workers' Compensation Division, or the administrator's delegate for the matter.

(2) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(3) "Director" means the Director of the Department of Consumer and Business Services, or the director's delegate for the matter.

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

(5) "Employer-at-Injury" means the organization that employed the worker when the worker:

(a) Sustained the injury or occupational disease;

(b) Made the claim for aggravation; or

(c) Requested an Own Motion opening under ORS 656.278.

(6) "Fund" means the Workers' Benefit Fund.

(7) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(8) "Premium" means the monies paid to an insurer for the purpose of purchasing workers' compensation insurance.

(9) "Regular employment" means the employment the worker held at the time of:

(a) Injury;

(b) The claim for aggravation; or

(c) Own Motion opening under ORS 656.278.

(10) "Reimbursable wages" means the worker's gross wages for the Wage Subsidy period.

(11) "Skills building" means a class or course of instruction taken by the worker for the purpose of enhancing an existing skill or developing a new skill. When skills building is the transitional work, the worker must agree in writing to take the class or course of instruction.

(12) "Transitional Work" means temporary work with the employer-at-injury which is not the worker's full duty regular work and is assigned because the worker cannot perform full duty regular work. Transitional work must be within the worker's injury-caused limitations and may be created through modification of the worker's regular work, job restructuring, assistive devices, worksite modification(s), reduced hours, or reassignment to another job. Transitional work must be within the employer's course and scope of trade or profession, unless the work is "skills building."

(13) "Worker Leasing Company" means the person which provides workers, by contract and for a fee, as prescribed in ORS 656.850.

(14) "Work site" means a primary work area available for a worker to use to perform the required job duties. The work site may be the employer's, client's, or worker's premises, property, and equipment used to conduct business under the employer's or client's direction and control. A work site may include a worker's personal property or vehicle if required to perform the job.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0006
Administration of Rules

(1) Orders issued by the division to enforce ORS 656.622 or these rules are orders of the director.

(2) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has the final authority to determine how the funds will be disbursed.

(3) The director may use monies from the fund for activities to provide information about and encourage the reemployment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of reemployment assistance programs and associated production costs; and

(b) Public reemployment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01

436-105-0008
Reconsideration/Appeal to the Director

(1) The division will deny any reimbursement for Employer-at-Injury Program assistance it finds in violation of these rules. The division has the discretion to deny any reimbursement of Employer-at-Injury Program assistance it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Parties directly affected by a division Employer-at-Injury Program decision may request a reconsideration by sending a written request for reconsideration to the administrator no later than 60 days after the date the decision is issued. Facsimiles that are legible and complete are acceptable and will be processed the same as originals. Reconsideration must precede a director's review.

(3) The request for reconsideration must specify the reasons why the decision is appealed and may include additional documentation. No reconsideration will be granted unless the request meets the requirements of this rule.

(4) The division will reconsider the decision and notify all directly affected parties of its decision in writing. The affected parties may request a director's review by sending a written request no later than 60 days after the date the reconsideration was issued. The request must specify the reasons why the decision is appealed and may include additional documentation.

(5) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(6) The director's review decision will be issued in writing and all directly affected parties will be notified. The director's review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0500
Insurer Participation in the Employer-At-Injury Program

(1) An insurer must be an active participant in providing reemployment assistance with the employer's consent. Participation

includes issuing notices of the available assistance and administering the Employer-at-Injury Program as specified in these rules.

(2) The insurer will notify the worker and employer-at-injury in writing of the assistance available from the Employer-at-Injury Program. A notice must be issued:

(a) Upon acceptance or reopening of a claim; and

(b) Within five days of a worker's first release for work after claim opening unless the release is for regular work.

(3) The notices of Employer-at-Injury Program assistance must contain the following language:

(a) The notice to the worker must appear in bold type as follows:

The Reemployment Assistance Program provides Oregon's qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through the Employer-at-Injury Program while your claim is open. Your employer may contact

(b) The notice to the employer-at-injury must appear in bold type as follows:

Because of your worker's injury, you may be eligible for assistance through the Employer-at-Injury Program to return the worker to transitional work while the worker's claim is open. To learn more about the assistance available from the program, please call.

(4) The insurer will administer the Employer-at-Injury Program according to these rules. The insurer will assist an employer to:

(a) Obtain a qualifying medical release, pursuant to section (5) of this rule, from the medical service provider;

(b) Identify a transitional work position;

(c) Process employer Wage Subsidy requests as specified in OAR 436-105-0520(1);

(d) Make Worksite Modification purchases as specified in OAR 436-105-0520(2);

(e) Make Employer-at-Injury Program Purchases as specified in OAR 436-105-0520(3); and

(f) Request Employer-at-Injury Program reimbursement from the division as specified in OAR 436-105-0540.

(5) For purposes of the Employer-at-Injury Program, medical releases must meet the following criteria:

(a) All medical releases must be dated and related to the accepted or deferred conditions of the claim. The date the medical release is issued by the worker's medical service provider is considered the effective date if an effective date is not otherwise specified;

(b) Two types of medical release qualify under these rules:

(A) A medical release that states the worker's specific restrictions; or

(B) A statement by the medical service provider that indicates the worker is not released to regular employment accompanied by an approval of a job description which includes the job duties and physical demands required for the transitional work.

(c) A medical release must cover any period of time for which benefits are requested.

(6) For the purposes of the Employer-at-Injury Program, a medical release, and any restrictions it contains, remains in effect until another medical release is issued by the worker's medical service provider. An employer or insurer may get clarification about a medical release from the medical service provider who issued the release any time prior to submitting the reimbursement request.

(7) The insurer must maintain all records of the Employer-at-Injury Program for a period of three years from the date of the last Employer-at-Injury Program Reimbursement Request. The insurer will maintain the following information at the authorized claim processing location(s):

(a) The worker's claim file;

(b) Documentation from the worker's medical service provider that the worker is unable to perform regular employment due to the injury and dated copies of all work releases from the worker's medical service provider;

(c) A legible copy of the worker's payroll records for the Wage Subsidy period as follows:

(A) Payroll records must state the payroll period, wage rate(s), and the worker's gross wages for the Wage Subsidy period. The payroll record must also include the dates and hours worked each day if the worker has hourly restrictions;

(B) Insurers and employers may supplement payroll records with documentation of how the worker's earnings were calculated for the Wage Subsidy. Supplemental documentation may be used to determine a worker's work schedule, wages earned on a particular day, dates of paid leave, or to clarify any other necessary information not fully explained by the payroll record;

(C) If neither the payroll record(s) nor supplemental documentation show the amount of wages earned by the worker for reimbursable partial payroll periods, the allowable reimbursement amount may be calculated as follows:

(i) Divide the gross wages by the number of days in the payroll period for the daily rate; and

(ii) Multiply the daily rate by the number of eligible days; and

(D) If a partial day's reimbursement is requested after a worker is released for transitional work, or prior to returning from a medical appointment with a regular work release, documentation of the time of the medical appointment and hours and wages of transitional work must be provided for those days.

(d) A legible copy of invoices, proof of payment, and proof of the delivery date of the item(s) for Worksite Modification purchases and Employer-at-Injury Program Purchases;

(e) Written documentation of the insurer's decision to approve Worksite Modifications;

(f) Documentation of the transitional work, which must include the start date, wage and hours, and a description of the job duties;

(g) Documentation that payments for a home care worker were made to the Oregon Department of Human Services, if applicable;

(h) The written acceptance by the worker when skills building is the transitional work; and

(i) Documentation, including course title and curriculum for a class or course of instruction when Employer-at Injury Program Purchases are requested.

Stat. Auth.: ORS 656.340, 656.622 & 656.726(4)
Stats. Implemented: ORS 656.340 & 656.622
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0090; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0360; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0540; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 9-27-04; WCD 8-2004, f. 7-15-04, cert. ef. 8-1-04; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0510
Employer Eligibility

(1) The employer must maintain Oregon workers' compensation insurance coverage.

(2) The employer must be the employer at injury as defined in OAR 436-105-0005.

(3) The employer must be re-employing an eligible worker while the worker's claim is open.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered to 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0520; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0511
Worker Eligibility

(1) The worker must have an accepted or deferred Oregon workers' compensation injury or occupational disease claim at the time of the Employer-at-Injury Program.

(2) The worker must not be covered by the Injured Inmate Law.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered to 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0520; WCD 12-2002(Temp), f. & cert. ef. 12-11-

02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05
436-105-0512; Renumbered from 436-105-0510, WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0512
End of Eligibility

The Employer-at-Injury Program will end when:

(1) The worker or employer no longer meets the eligibility provisions stated in OAR 436-105-0510 and 436-105-0511;

(2) The worker's claim is closed;

(3) Sanctions under OAR 436-105-0560 preclude eligibility; or

(4) The insurer ends the Employer-at-Injury Program at any time while the worker's claim is open.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered to 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0520; WCD 12-2002(Temp), f. & cert. ef. 12-11-02 thru 6-8-03; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05
436-105-0512; Renumbered from 436-105-0510, WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0520
Assistance Available from the Employer-at-Injury Program

The Employer-at-Injury Program may be used only once per worker per claim opening, for a non-disabling claim or a disabling claim. If a non-disabling claim becomes a disabling claim after one year from the date of acceptance, the disabling claim is considered a new opening and the Employer-at-Injury Program may be used again. Assistance available includes:

(1) Wage Subsidy provides 50 percent reimbursement of the worker's gross wages for the Wage Subsidy period. Wage Subsidy benefits are subject to the following conditions:

(a) A Wage Subsidy may not exceed 66 work days and must be completed within a 24 consecutive month period;

(b) A Wage Subsidy may not start or end with paid leave;

(c) If the worker has hourly restrictions, reimbursable paid leave must be limited up to the maximum number of hours of the worker's hourly restrictions. Paid leave exceeding the worker's hourly restrictions is not subject to reimbursement;

(d) Any day during which the worker exceeds his or her injury-caused limitations will not be reimbursed. If, however, an employer uses a time clock, a reasonable time not to exceed 30 minutes per day will be allowed for the worker to get to and from the time clock and the worksite without exceeding the worker's hourly restrictions.

(2) Worksite Modification means altering a work site by renting, purchasing, modifying, or supplementing equipment to enable a worker to perform the transitional work within the worker's limitations. Maximum reimbursement is $2,500. Worksite Modification assistance is subject to the following conditions:

(a) The insurer determines the appropriate Worksite Modification(s) for the worker;

(b) The insurer documents its reason(s) for approving the modification(s);

(c) The Worksite Modification(s) must be ordered during the Employer-at-Injury Program;

(d) Modifications purchased by the employer in good faith are reimbursable if the worker refuses to return to work;

(e) Worksite Modification items become the employer's property upon the end of the Employer-at-Injury Program.

(3) Employer-at-Injury Program Purchases are limited to:

(a) Tuition, books, fees, and materials required for a class or course of instruction to enhance an existing skill or develop a new skill when skills building is used as transitional work or when required to meet the requirements of the transitional work position. Maximum expenditure is $1,000. Tuition, books, fees, and required materials will be provided under the following conditions:

(A) The insurer determines the instruction will help the worker enhance an existing skill or develop a new skill, and documents its decision;

(B) Costs for tuition, books, fees, and required materials may be fully reimbursed if the worker began participation in the class or course while eligible for the Employer-at-Injury Program; or

(C) The employer in good faith paid for the costs of the class or course after the worker agreed to take part in the training and then the worker refused to attend.

(b) Tools and equipment required for the worker to perform transitional work. Maximum expenditure is $2,500, and these purchases will be the employer's property.

(c) Clothing required for the job, except clothing the employer normally provides. Clothing becomes the worker's property. Maximum expenditure is $400.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0041, 436-110-0042 & 436-110-0045; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0510; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0530
Employer-at-Injury Program Procedures for Concurrent Injuries

(1) A worker is eligible for only one Employer-At-Injury Program at a time.

(2) When a worker in an Employer-at-Injury Program incurs a new compensable injury, transitional work for the first Employer-At-Injury is considered regular work for the second Employer-at-Injury Program.

(3) If the new injury makes the first Employer-at-Injury Program unsuitable, the worker may be eligible for a second Employer-at-Injury Program under the new injury.

(4) When the worker is no longer eligible for the second Employer-At-Injury Program, the first Employer-At-Injury Program may be resumed if the employer and worker still meet eligibility criteria under that claim.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 5-2003, f. 5-16-03, cert. ef. 6-8-03

436-105-0540
Employer-at-Injury Program Reimbursement Procedures

(1) Reimbursements may include Wage Subsidy, Employer-at-Injury Program Purchases, and Worksite Modification.

(2) The insurer is entitled to a program administrative cost of $120.00 for the first reimbursement request of an Employer-at-Injury Program. A subsequent request for reimbursement for the same Employer-at-Injury Program is not entitled to an additional program administrative cost.

(3) The insurer must receive all required documentation for reimbursement within one year from the end of the Employer-at-Injury Program in order to qualify for reimbursement. The insurer must date stamp each reimbursement request document with the receipt date.

(4) The insurer must submit the request for reimbursement (Form 2360) to the division within one year and 30 days from the end of the Employer-at-Injury Program.

(5) An Employer-at-Injury Reimbursement Request must be a minimum of $100, not including the administrative cost, to be subject to reimbursement.

(6) When the division finds the insurer has submitted an Employer-at-Injury Program Reimbursement Request which is incomplete or contains an error, the division may return the form to the insurer for correction. The insurer has 60 days from the date the insurer receives the reimbursement request, or one year and 30 days from the end of Employer-at-Injury Program eligibility, whichever is greater, to make the corrections and return the corrected form to the division.

(7) The insurer may send an Employer-at-Injury Program Reimbursement Request to the division when a claim was initially denied and was subsequently accepted after the Employer-at-Injury Program eligibility ended and more than one year and 30 days have passed. In that case, the insurer must send a completed Employer-at-Injury Program Reimbursement Request to the division within 60 days of the first Order or Stipulation and Order accepting the claim. A copy of the Order accepting the claim, or Stipulation and Order accepting the claim must be attached.

(8) The insurer may request reimbursement for a qualifying Employer-at-Injury Program that took place while the claim was in accepted or deferred status even if the claim is denied at the time the reimbursement request is sent to the division.

(9) Amended reimbursement requests must be sent to the division within one year and 30 days from the end of the Employer-at-Injury Program eligibility except as provided in section (6) of this rule. The insurer may not request additional administrative cost reimbursement for filing an amended reimbursement request.

(10) Amendments are to be made on a completed Employer-at-Injury Program Reimbursement Request, Form 2360. The amended reimbursement request must cite the corrected information with the statement "Amendment" written across the top of the form. The corrected information should be highlighted.

(11) The insurer will not use Employer-at-Injury Program costs subject to reimbursement for rate making, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that Employer-at-Injury Program costs do not affect the employer's rates or dividend.

(12) If a Preferred Worker employed by an eligible employer with active Premium Exemption incurs a new injury, the claim is subject to Claim Cost Reimbursement under OAR 436-110. If the worker subsequently enters an Employer-at-Injury Program, program costs are to be separated from claim costs and will not be reimbursed as claim costs.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0090; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0360; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-0, Renumbered from 436-110-0540; WCD 4-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 9-27-04; WCD 8-2004, f. 7-15-04, cert. ef. 8-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0550
Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the division. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements must be repaid to the department.

(2) The audit may include but not be limited to a review of the records required in OAR 436-105-0500(6).

(3) When conflicting documentation exists, the division will utilize a preponderance of evidence standard to decide eligibility for reimbursement and if there is no clear preponderance, reimbursement will be allowed.

(4) The division reserves the right to visit the work site to determine compliance with these rules.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4) & 731.475

Stats. Implemented: ORS 656.455, 656.622 & 731.475

Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-105-0560
Sanctions

(1) Any person who knowingly makes a false statement or misrepresentation to the director or an employee of the director for the purpose of obtaining any benefits or reimbursement from the Employer-at-Injury Program or who knowingly misrepresents the amount of a payroll, or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for the director to sanction an insurer, self-insured employer, employer or their representative include, but are not limited to:

(a) Misrepresenting information in order to receive Employer-at-Injury Program assistance;

(b) Making a serious error or omission which resulted in the division approving reimbursement in error;

(c) Failing to respond to employer requests for assistance or failing to administer Employer-at-Injury Program assistance; or

(d) Failure to comply with any condition of these rules.

(3) Sanctions by the director may include one or more of the following:

(a) Ordering the person to take corrective action within a specific period of time;

(b) Ordering the person being sanctioned to repay the department all, or part, of the monies reimbursed, with or without interest at a rate set by the department. The order may include the department's legal costs;

(c) Ending the employer's eligibility to use the Employer-at-Injury Program for a specific period of time; and

(d) Pursuing civil penalties under ORS 656.745 or criminal action against the party.

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622, 656.745 & 656.990

Hist.: WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01

DIVISION 110

PREFERRED WORKER PROGRAM

436-110-0001
Authority for Rules

The director has adopted OAR chapter 436, division 110 under authority of ORS 656.622 and 656.726.

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973(Admin), f. 1-2-73, ef. 1-15-73; WCB 3-1973(Admin), f. 3-14-73, ef. 4-1-73; WCD 2-1977 (Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0001, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01

436-110-0002
Purpose of Rules

(1) These rules explain what assistance and reimbursements are available from the Preferred Worker Program, who is qualified, and how to receive assistance and reimbursements.

(2) The Preferred Worker Program encourages the reemployment of workers whose on-the-job injuries result in disability which may be a substantial obstacle to employment by providing assistance from the Workers' Benefit Fund to eligible injured workers and to the employers who employ them.

(3) The Preferred Worker Program is a worker and employer-at-injury-activated program.

Stat. Auth.: ORS 656.622 & 656.726(4)

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0041, 436-110-0042 & 436-110-0045; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-110-0003
Applicability of Rules

(1) These rules apply to all requests for Preferred Worker Program reemployment assistance received by the division on or after the effective date of these rules.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0005, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef.1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0005
Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "Administrator" means the Administrator of the Workers' Compensation Division, or the administrator's delegate for the matter.

(2) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.

(3) "Date of hire" means the date the worker started work for the employer in the job for which benefits are requested.

(4) "Director" means the Director of the Department of Consumer and Business Services, or the director's delegate for the matter.

(5) "Disability" means permanent physical or mental restriction(s) or limitation(s) caused by an accepted disabling Oregon workers' compensation claim which limits the worker from performing one or more of the worker's regular job duties.

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

(7) "Division approval" means a Preferred Worker agreement signed by an authorized division representative.

(8) "Employer at injury" means the organization in whose employ the worker sustained the injury or occupational disease.

(9) "Exceptional disability" means a disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury which results in impairment equal to or greater than a Class III as defined in OAR 436-035. The division will determine whether a worker has an exceptional disability based upon the combined effects of all of the worker's Oregon compensable injuries resulting in permanent disability.

(10) "Fund" means the Workers' Benefit Fund.

(11) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.

(12) "Premium" means premium which results from a calculation which takes payroll multiplied by applicable rates of the employer's individual insurer multiplied by the employer's experience rating modification less any discounts, assessments, surcharges, or taxes.

(13) "Regular employment" means the job the worker held at the time of the injury, claim for aggravation, or own motion opening.

(14) "Reimbursable wages" means the gross taxable wages paid a worker for services performed.

(15) "Worksite" means a primary work area which is in Oregon, already constructed and available for a worker to use to perform the required job duties. The worksite may be the employer's, worker's, or worker leasing company's client's premises, property, and equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job. If the "worksite" is mobile, it must be available in Oregon for inspection and modification.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0010, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0006
Administration of Rules

(1) Orders issued by the division to enforce ORS 656.622 or these rules are orders of the director.

(2) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has final authority to determine how the funds will be disbursed.

(3) The director may use moneys from the fund for activities to provide information about and encourage reemployment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of reemployment assistance programs and associated production costs; and

(b) Public reemployment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0015; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01

436-110-0007
Reconsideration/Appeal to the Director

(1) The division will deny any request for Preferred Worker Program assistance it finds is in violation of these rules. The division has the discretion to deny a request it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Parties directly affected by a division reemployment assistance decision may request a reconsideration by sending a written request for reconsideration to the administrator no later than 60 days after the date the decision is issued. Facsimiles that are legible and complete are acceptable and will be processed the same as originals. Reconsideration must precede a director's review.

(3) The request for reconsideration must specify the reasons why the decision is appealed. No reconsideration will be granted unless the request meets the requirements of this subsection.

(4) The division will reconsider the decision prior to a director's review and will notify all affected parties of its decision upon reconsideration.

(5) If, upon reconsideration, the division upholds the original decision, the director's review will begin.

(6) The director may require any affected party to provide information or to participate in the director's review. If the party requesting the director's review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(7) The director's review decision will be issued in writing. The director's review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0080 & 436-110-0090; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0360; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0540; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0240
Insurer Participation in the Preferred Worker Program

(1) The insurer of the employer at injury must be an active participant in providing reemployment assistance. Participation includes issuing notices of the assistance available from the Preferred Worker Program.

(2) The insurer must notify the worker and employer at injury in writing of the reemployment assistance available from the fund. A notice must be issued:

(a) Within five days of a worker's release for work after the worker has been declared medically stationary by the attending physician;

(b) Upon determination of eligibility or ineligibility of the worker for vocational assistance under OAR 436-120; and

(c) Upon approval of a Claim Disposition Agreement.

(3) Pursuant to section (2) of this rule, the Notice to the Worker must appear in bold type and contain the following language:

The Preferred Worker Program helps Oregon's injured workers get back to work. To find out whether you qualify, contact the Preferred Worker Program at one of the telephone numbers, fax numbers, or addresses listed below.
For the Salem office call: (503) 947-7588, 1-800-445-3948, (503) 947-7993 (TTY), or FAX (503) 947-7581.

For the Medford office call: (541) 776-6032, 1-800-696-7161, or FAX (541) 776-6022.
Or write the Preferred Worker Program at: 350 Winter Street NE, P.O. Box 14480, Salem, Oregon 97309-0405; or 1840 Barnett Road, Suite C, Medford, Oregon 97504-8293.

(4) Under section (2) of this rule, the Notice to the Employer must appear in bold type and contain the following language:

If your worker is unable to return to regular work because of injury-caused limitations, you may be eligible for the Preferred Worker Program incentives including Premium Exemption, Claim Cost Reimbursement, Wage Subsidy, and Worksite Modification, which you may use to re-employ your worker. You must request Preferred Worker Program assistance from the Workers' Compensation Division within 180 days of the worker's claim closure date. To find out about the Preferred Worker Program, contact the program at one of the telephone numbers, fax numbers, or addresses listed below.
For the Salem office call: (503) 947-7588, 1-800-445-3948, (503) 947-7993 (TTY), or FAX (503) 947-7581.
For the Medford office call: (541) 776-6032, 1-800-696-7161, or FAX (541) 776-6022.
Or write the Preferred Worker Program at: 350 Winter Street NE, P.O. Box 14480, Salem, Oregon 97309-0405; or 1840 Barnett Road, Suite C, Medford, Oregon 97504-8293.

(5) The insurer must provide the division with Preferred Worker information in the form and format the director prescribes in OAR 436-030, upon the following:

(a) Claim closure according to ORS 656.268;

(b) Within 30 calendar days from the insurer's receipt of the earliest Opinion and Order of an Administrative Law Judge, Order on Reconsideration, Order on Review by the Board, decision of the Court of Appeals, or stipulation which grants initial permanent disability after the latest opening of the worker's claim; and

(c) Approval of a Claim Disposition Agreement according to ORS 656.236 and documented medical evidence indicates permanent disability exists as a result of the injury or disease, and the worker is unable to return to regular employment.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.340, 656.622 & 656.726(4)
Stats. Implemented: ORS 656.340(1), (2), (3), 656.622 & 656.726(4)
Hist.: WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0017; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0290
Employer at Injury Use of the Preferred Worker Program

The conditions for the employer at injury to activate the Preferred Worker Program include:

(1) The employer at injury must request Preferred Worker Program assistance from the division within 180 days of the worker's claim closure date, with the following exception. When Worksite Modifications are provided, and the modifications are completed and verified by the division more than 150 days after the worker's claim-closure date, the employer at injury will have 30 calendar days from the verification date to request other assistance.

(2) In calculating the 180-day period under this rule, the claim closure date will not be included, and if the 180th day falls on a Saturday, Sunday, or legal holiday, the next business day will be considered the end of the 180-day period.

(3) The worker must agree to accept the new or modified regular job in writing. The job offer must include:

(a) The start date. If the job starts after the modifications are in place, so note;

(b) Wage and hours;

(c) Job site location; and

(d) Description of job duties.

(4) If the employer at injury uses Worksite Modification assistance and the employer or worker later requests additional modifications for the same job, the employer's Worksite Modification benefit will be exhausted before using the worker's Worksite Modification benefits.

(5) All other provisions under OAR 436-110 apply unless otherwise indicated.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0310
Eligibility and End of Eligibility for the Preferred Worker Program

(1) The eligibility requirements for an employer, except as provided in OAR 436-110-0345(1) for Employment Purchases, are:

(a) The employer has and maintains Oregon workers' compensation insurance coverage;

(b) The employer complies with the Oregon Workers' Compensation Law;

(c) The employer must offer or provide employment to an eligible Preferred Worker who is a subject Oregon worker according to ORS 656.027;

(d) If the employer is a worker leasing company, it must be licensed with the division; and

(e) The employer is not currently ineligible for Preferred Worker benefits under OAR 436-110-0900.

(2) The eligibility requirements for a worker are:

(a) The worker has an accepted disabling Oregon compensable injury or occupational disease. Injuries covered by the Injured Inmate Law do not qualify;

(b) Because of injury-caused limitations, medical evidence indicates the worker will not be able to return to regular employment as defined in OAR 436-110-0005 under the most recent disabling claim or claim opening. If the worker is not eligible under the most recent disabling claim or claim opening, eligibility may be based on the most recent disabling claim closure where injury-caused permanent restrictions prevented the worker from return to regular employment;

(c) Medical documentation indicates permanent disability exists as a result of the injury or disease, whether or not an order has been issued awarding permanent disability; and

(d) The worker is authorized to work in the United States.

(3) A worker may not use Preferred Worker benefits for self-employment unless the injury which gave rise to the worker's eligibility for the Preferred Worker Program occurred in the course and scope of self-employment. In that case, the worker may use the benefits to return to the same self-employment or for employment other than self-employment.

(4) Reasons for ending Preferred Worker Program eligibility include, but are not limited to, the following:

(a) Misrepresentation or omission of information by a worker or employer to obtain assistance;

(b) Failure of a worker or employer to provide requested information or cooperate;

(c) Falsification or alteration of a Preferred Worker card or a Preferred Worker Program Agreement;

(d) Conviction of fraud in obtaining workers' compensation benefits;

(e) The worker no longer meets the eligibility requirements under section (2) of this rule;

(f) The worker or employer is sanctioned from receiving reemployment assistance in accordance with OAR 436-110-0900;

(g) The employer does not maintain Oregon workers' compensation insurance coverage, except as provided in OAR 436-110-0345(1) for Employment Purchases;

(5) The division retains the right to reinstate Preferred Worker Program eligibility if eligibility was ended prematurely or in error, or the employer has reinstated or obtained workers' compensation insurance coverage.

(6) A worker found ineligible because he/she was not authorized to work in the United States may request a redetermination of eligibility after providing the division with documentation that he/she is authorized to work in the United States.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78, WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0020, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0020; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0280; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0320
Preferred Worker Identification Card

(1) The division issues a Preferred Worker Identification card to eligible workers. The card identifies the worker as being eligible to offer an employer Preferred Worker Program assistance. If a Preferred Worker loses the card, the division will issue a replacement card.

(2) The division issues this card as follows:

(a) Automatically at the time of claim closure based upon insurer submission of Preferred Worker information as specified in OAR 436-110-0240(5);

(b) Prior to claim closure when the worker has available, immediate employment with an employer who meets the eligibility criteria under OAR 436-110-0310(1); or

(c) Upon request by the worker or their representative any time after claim closure.

(3) The division may inactivate a Preferred Worker card if:

(a) The Preferred Worker card was issued in error; or

(b) Any reason for ending Preferred Worker Program eligibility as specified in OAR 436-110-0310(4) applies.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0022; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0325
Premium Exemption General Provisions

(1) Premium Exemption begins automatically when an employer hires a Preferred Worker, and is in effect for 3 years from the date of hire as defined in OAR 436-110-0005(3).

(2) If a worker is not a Preferred Worker on the date of hire, the division will determine when the worker is eligible. Premium Exemption will be effective for 3 years from that eligibility date.

(3) Premium Exemption releases an employer from paying workers' compensation insurance premiums and premium assessments on a Preferred Worker during the time Premium Exemption is in effect. While actively using Premium Exemption, the employer does not report, and the insurer cannot use, the Preferred Worker's payroll for the calculation of insurance premiums or premium assessments. However, the employer is required to report and pay workers' compensation employer assessments and withhold employee contributions as required by OAR 436-070. The employer must start paying insurance premiums and premium assessments when Premium Exemption ends.

(4) If a worker covered under Premium Exemption incurs a compensable injury or occupational disease during the Premium Exemption period, the employer must notify its insurer of the injury. If the employer fails to note the Preferred Worker status when the Form 801 was filed with the insurer, the employer must notify the insurer as soon as possible that the injury or disease was incurred by a Preferred Worker.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 4367-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0330
Claim Cost Reimbursement

(1) Claim Cost Reimbursement provides reimbursement to the insurer for claim costs when a Preferred Worker files a claim for injury or occupational disease while employed under Premium Exemption as follows:

(a) Reimbursements will be made for the life of the claim;

(b) Reimbursable claim costs include disability benefits, medical benefits, vocational costs in accordance with OAR 436-120-0720, Claim Disposition Agreements in accordance with ORS 656.236, Disputed Claim Settlements in accordance with ORS 656.289, stipulations, as well as attorney fees awarded the worker or the worker's beneficiaries, and administrative costs;

(c) Reimbursable claims costs for denied claims include costs incurred up to the date of denial, but are limited to benefits the insurer is obligated to pay under ORS 656 and diagnostic tests, including insurer medical examinations necessary to determine compensability of the claim;

(d) The administrative cost factor to be applied to claim costs will be as published in Bulletin 316; and

(e) The claim must not be used for ratemaking, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that claim data will not affect the employer's rates or dividend.

(2) The insurer must request Claim Cost Reimbursement as follows:

(a) All requests for reimbursement must be made within one year of the quarter within which payment was made;

(b) Quarterly reimbursement requests must be in the format the director prescribes by bulletin; and

(c) Reimbursement documentation must include, but not be limited to:

(A) Net amounts paid. "Net amounts" means the total compensation paid less any recoveries including, but not limited to, third party recovery or reimbursement from the Retroactive Program, Reopened Claims Program, or the fund;

(B) Payment certification statement; and

(C) Any other information the division deems necessary.

(3) Requests for reimbursement must not include:

(a) Claim costs for any injury which did not occur while the worker was employed with Premium Exemption;

(b) Costs incurred for conditions completely unrelated to the compensable claim;

(c) Costs incurred due to inaccurate, untimely, unreasonable, or improper processing of the claim;

(d) Penalties, fines or filing fees;

(e) Disposition amounts in accordance with ORS 656.236 (CDA) and 656.289 (DCS) not previously approved by the division;

(f) Costs reimbursed or outstanding requests for reimbursement from the Reopened Claims Program, Retroactive Program, or the fund; or

(g) Reimbursable Employer-at-Injury Program costs.

(4) Periodically, the division will audit the physical file of the insurer to validate the amount reimbursed. Reimbursed amounts must be refunded to the division and, as applicable, future reimbursements denied if, upon audit, any of the following is found to apply:

(a) Reimbursement has been made for any of the items specified in section (3) of this rule;

(b) If claim acceptance as a new injury rather than an aggravation is questionable and the rationale for acceptance has not been reasonably documented;

(c) The separate payments of compensation have not been documented;

(d) The insurer included claim costs in any dividend or retrospective rating or experience rating calculations;

(e) The insurer is unable to provide applicable records relating to experience rating, retrospective rating, or dividend calculations at the time of audit or within 14 working days thereafter.

(5) If the conditions described in subsections (4)(a) through (e) of this rule are corrected and all other criteria of the rules are met, eligibility for reimbursement may be reinstated. If reimbursement eligibility is reinstated, any moneys previously reimbursed and then recovered will be reimbursed again according to these rules.

(6) If an employer fails to notify its insurer of the "Preferred Worker" status when the Form 801 is submitted or fails to send its insurer a copy of the Preferred Worker Identification Card, and later notifies its insurer that the injury or disease was incurred by a Preferred Worker, the insurer must correct all records previously filed which include claim costs in any dividend, retrospective rating, or any claim valuation for experience rating performed.

(7) A Claim Disposition Agreement according to ORS 656.236, a Disputed Claim Settlement according to ORS 656.289, or any stip-

ulation or agreement of a claim subject to claim cost reimbursement from the fund must meet the following requirements for reimbursement:

(a) The insurer must obtain prior written approval of the disposition from the division. The proposed disposition must be submitted to the division prior to submitting the disposition to the Workers' Compensation Board or administrative law judge for approval;

(b) A claim's future liability and the proposed contribution from the fund must be a reasonable projection, as determined by the division, in order to be approved for reimbursement from the fund; and

(c) A request for approval of the proposed disposition must include:

(A) The original proposed disposition, containing appropriate signatures and appropriate signature lines for division and Workers' Compensation Board or administrative law judge approval, which specifies the proposed assistance from the fund;

(B) A written explanation of how the calculations for the amount of assistance from the fund were made; and

(C) Other information as required by the division.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978(Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015, 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0260 & 436-110-0300; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0335
Wage Subsidy General Provisions

Wage Subsidy provides an employer with partial reimbursement of a worker's gross wages for a specified period. Wage Subsidy benefits are subject to the following conditions:

(1) The effective date of a Wage Subsidy is mutually agreed to by the division, employer, and worker if applicable;

(2) A Wage Subsidy is limited to a duration of 183 calendar days and a monthly reimbursement rate of 50 percent, except for a worker with an exceptional disability as defined in OAR 436-110-0005(9). For a worker with an exceptional disability, the Wage Subsidy duration is limited to 365 calendar days and a monthly reimbursement rate of 75 percent;

(3) A Wage Subsidy Agreement may be interrupted once for reasonable cause and extended to complete the Wage Subsidy Agreement on a whole workday basis. Reasonable cause includes, but is not limited to, personal or family illness, death in the worker's family, pregnancy of the worker or worker's spouse, a compensable injury to the worker, participation in an Employer-at-Injury Program, or layoff. A layoff must be a minimum of 10 consecutive work days. A period of time during which the employer is without workers' compensation insurance coverage is not "reasonable cause," and no extension will be granted;

(4) A Preferred Worker's pay structure must be the same as the pay structure for other workers employed in similar jobs by the employer;

(5) Wages subject to reimbursement must be within the prevailing wage range for that occupation. The prevailing wage range is determined by the following method:

(a) First, examine the wages paid by the employer for other workers doing the same job;

(b) If no other workers are doing the same job, a labor market survey of the local labor market may be conducted; and

(c) If the labor market survey does not support the wage rate requested, the division will determine the wage subject to reimbursement;

(6) Preferred Worker Program Wage Subsidies may not be combined with a wage subsidy for a training plan under OAR 436-120;

(7) A worker-activated and employer at injury-activated wage subsidy can not be used for the same job with the employer at injury;

(8) If the worker's employer changes during the Wage Subsidy Agreement period due to a sale of the business, incorporation, or merger, the agreement can be transferred to the new employer by an addendum to the agreement approved by the division as long as the worker's job remains the same and the new employer is eligible under OAR 436-110-0310(1);

(9) A completed and signed Wage Subsidy Reimbursement Request form must be submitted to the division with a copy of the worker's payroll records. The payroll record must state the dates (daily or weekly), hours, wage rate, and the worker's gross wage. Payroll records must be a legible copy and compiled in accordance with generally accepted accounting procedures; and

(10) All requests for reimbursement must be made within one year of the Wage Subsidy Agreement end date.

(11) Wage Subsidy cannot be used for "regular employment" as defined in OAR 436-110-0005(13) unless the job has been modified to overcome the worker's injury-caused permanent restrictions.

[ED. NOTE: Forms referenced available from the agency.]

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025,436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0336
Wage Subsidy — Employer at Injury Activated

Wage Subsidy is activated by the employer at injury as follows:

(1) The job must be within the worker's injury-caused restrictions. If a worksite modification is necessary to meet this requirement, Wage Subsidy will not be approved until the modification is complete, and verified by a representative of the division.

(2) The employer must complete and sign a Wage Subsidy Agreement, and send it to the division in the timeframes allowed in OAR 436-110-0290.

(3) The completed and signed job offer must accompany the request as required in OAR 436-110-0290(3), unless it was already submitted with another request.

(4) The employer at injury may use Wage Subsidy once during an eligibility period.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0337
Wage Subsidy — Worker Activated

A Wage Subsidy may be requested by a worker as follows:

(1) A Wage Subsidy Agreement must be completed and signed by the worker and employer and submitted to the division within three years of the date of hire.

(2) A Preferred Worker may use Wage Subsidy twice, once each for two different jobs. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(3) If the employer at injury uses Wage Subsidy for a job, the worker cannot use Wage Subsidy for the same job.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0345
Employment Purchases – General Provisions

(1) An Employment Purchase is assistance necessary for a worker to find, accept, or retain employment. These purchases may be provided for a job with a non-subject employer in Oregon, as long as that employer complies with the appropriate workers' compensation law.

Except as provided in subsection 2(h) of this rule, all purchases become the worker's property.

(2) Employment Purchases are limited to:

(a) Tuition, books, and fees for instruction provided by an educational entity accredited or licensed by an appropriate body in order to update existing skills or to meet the requirements of an obtained job. Maximum expenditure per use is $1,000;

(b) Temporary lodging, meals, and mileage to attend instruction when overnight travel is required. The cost of meals, lodging, public transportation, and use of a personal vehicle will be reimbursed at the rate of reimbursement for State of Oregon classified employees as published in Bulletin 112. Lodging, meals, and mileage are limited to a combined period of one month, and the total maximum expenditure per use is $500;

(c) Tools and equipment mandatory for employment. Purchases must not include items the worker possesses, duplicate Worksite Modification items, vehicles, or items needed for worksite creation. Maximum expenditure per use is $2,500;

(d) Clothing required for the job. Maximum expenditure per use is $400;

(e) Moving expenses for a job if the new worksite is in Oregon and more than 50 miles from the worker's primary residence. When the worker's permanent disability from the injury precludes the worker from commuting the required distance, moving expenses may be provided to move within 50 miles of the worker's primary residence or within the distance the worker commuted for work at claim opening. Moving expenses are limited to one use. Expenditure is limited to:

(A) The cost of moving household goods weighing not more than 10,000 pounds and reasonable costs of meals and lodging for the worker. The cost of meals, lodging, public transportation, and use of a personal vehicle will be paid at the rate of reimbursement for State of Oregon classified employees as published in Bulletin 112. Lodging and meals are limited to a maximum period of two weeks. Mileage for one personal vehicle is limited to a single one-way trip; and

(B) Rental allowance for the worker's primary residence limited to first month's rent as specified in the rental agreement, non-refundable deposit in an amount not to exceed the first month's rent, and a required credit check for that residence;

(f) Initiation fees, or back dues and one month's current dues, required by a labor union; and

(g) Occupational certification, licenses, and related testing costs, drug screen testing, physical examinations, or membership fees required for the job. Maximum expenditure is $500.

(h) Worksite creation costs which are limited to equipment, furnishings or other things the employer needs to create a new job for the worker. All items purchased are the property of the employer. Maximum expenditure per use is $5,000.

(i) Miscellaneous purchases which do not fit into subsections (a) through (h) of this section. This category may be used to help a worker to find, accept, or retain employment, but does not include a vehicle purchase. Finding employment is limited to necessary purchases to go to an interview in Oregon. This category can be used as often as necessary up to a maximum of $2,500 per claim opening.

(j) Employment Purchases cannot be used for "regular employment" as defined in OAR 436-110-0005(13) unless the job has been modified to overcome the worker's injury-caused permanent restrictions.

(3) The person or entity that purchased the item(s) may request reimbursement by submitting to the division a legible copy of an invoice or receipt showing payment has been made for the item(s) purchased. Reimbursement will be made for only those items and costs approved and paid.

(4) Costs of Employment Purchases will be paid by reimbursement, by an Authorization for Payment, or by other instrument of payment approved by the director.

(5) The division will not purchase directly or otherwise assume responsibility for Employment Purchases.

(6) Reimbursed costs will not be charged by the insurer to the employer as claim costs or by any other means.

(7) All requests for reimbursement must be made within one year of the Employment Purchase Agreement end date.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025,436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0346
Employment Purchases – Employer at Injury Activated

Conditions for use of Employment Purchases by the employer at injury are as follows:

(1) The employer must submit a completed Employment Purchase Agreement listing item(s) that are required of the worker to perform the job for which the worker is employed.

(2) The employer at injury may use each Employment Purchase category once.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0347
Employment Purchases — Worker Activated

Conditions for use of Employment Purchases by a worker are as follows:

(1) Except for moving expenses, and miscellaneous purchases needed to find a job, the worker and employer must submit a completed Employment Purchase Agreement listing item(s) that are required of the worker to perform the job.

(2) If Employment Purchases are to be used with a non-subject employer in Oregon, Premium Exemption is not activated.

(3) Except as otherwise provided in these rules, a Preferred Worker may use each Employment Purchase category twice, once each for two different jobs. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(4) A Preferred Worker may request Employment Purchases as follows:

(a) The worker must contact the division directly for assistance in receiving Employment Purchases. The worker may make the request prior to employment, but not more than three years afterthe date of hire.

(b) The Employment Purchase Agreement form must be completed and signed by the worker and employer and submitted to the division. If the request is for moving expenses, or the miscellaneous category, only the worker's signature is required.

Stat. Auth.: ORS 656.726(4) & 656.622

Stats. Implemented: ORS 656.622

Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0350
Worksite Modification — General Provisions

(1) Worksite Modification means altering a worksite in Oregon, or available for inspection and modification in Oregon, by purchasing, modifying, or supplementing equipment, or changing the work process, to enable a worker to work within the limitations imposed by compensable injuries or occupational diseases. Worksite Modification may also include the means to protect modifications purchased by the Preferred Worker Program in an amount not to exceed $2,500.

(2) Conditions for the use of Worksite Modification assistance are as follows:

(a) Modifications will be provided to allow the worker to perform the job duties within the worker's injury-caused permanent limitations. In order to determine appropriate Worksite Modifications, the Reemployment Assistance Unit consultants have discretion to use reports by a medical service provider specific to the worker, specific documented "best practices" described by a medical service provider or authority, and their own professional judgement and experience;

(b) A job analysis which includes the duties and physical demands of the job before and after modification may be required to show how the modification will overcome the worker's limitations. The job analysis may be submitted to the attending physician for approval before the modification is performed;

(c) Modifications are limited to a maximum of $25,000 for one job. A modification over $25,000 may be provided if the worker has an exceptional disability as defined in OAR 436-110-0005(9);

(d) Modifications not to exceed $1,000 may be provided which would reasonably be expected to prevent further injury or exacerbation of the worker's accepted condition. Appropriateness of this type of modification will be determined by a Reemployment Assistance Consultant based upon his or her professional judgment and experience, reports by a medical service provider specific to the worker, or specific documented "best practices" described by a medical service provider or authority. Costs of the modification(s) are included in the calculation of the total Worksite Modification costs;

(e) Modifications are limited to $2,500 for on-the-job training under OAR 436-120 or other similar on-the-job training programs when the trainer is not the employer-at-injury. A modification will not be approved for any other type of training;

(f) Modifications limited to $2,500 may be provided to protect the items approved in the Worksite Modification Agreement from theft, or damage from the weather. Insurance policy premiums will not be paid;

(g) When a vehicle is being modified, the vehicle owner must provide proof of ownership and insurance coverage. The worker must have a valid driver license;

(h) Rented or leased vehicles and other equipment will not be modified;

(i) Modifications must be reasonable, practical, and feasible, as determined by the division;

(j) When the division determines the appropriate form of modification and the worker or employer requests a form of modification equally appropriate but with a greater cost, upon division approval, funds equal to the cost of the form of modification identified by the division may be applied toward the cost of the modification desired by the worker or employer;

(k) A modification may include rental of tools, equipment, fixtures, or furnishings to determine the feasibility of a modification. It may also include consultative services necessary to determine the feasibility of a modification, or to recommendor design a Worksite Modification;

(l) Rental of Worksite Modification items and consultative services require division approval and are limited to a cost of up to $3,500 each. The cost for rental of Worksite Modification items and consultative services does not apply toward the total cost of a Worksite Modification;

(m) Modification equipment will become the property of the employer, worker, or worker leasing company's client on the "end date" of a Worksite Modification Agreement or when the worker's employment ends, whichever occurs first. The division will determine ownership of Worksite Modification equipment prior to approving an agreement and has the final authority to assign property.

(n) The division may request a physical capacities evaluation, work tolerance screening, or review of a job analysis to quantify the worker's injury-caused permanent limitations. The cost of temporary lodging, meals, public transportation, and use of a personal vehicle necessary for a worker to participate in one or more of these required activities will be reimbursed at the rate of reimbursement for State of Oregon classified employees as published in Bulletin 112. The cost of the services described in this subsection does not apply toward the total cost of a Worksite Modification;

(o) If the property provided for the modification is damaged, in need of repair, or lost, the division will not repair or replace the property;

(p) The employer must not dispose of the property provided for the modification or reassign it to another worker while the worker is employed in work for which the modification is necessary or prior to the end of the agreement without division and worker approval. Failure to repair or replace the property, or inappropriate disposal or reassignment of the property, may result in sanctions under OAR 436-110-0900; and

(q) The worker must not dispose of the property provided for the modification while employed in work for which the modification is necessary or prior to the end of the agreement without division approval. Failure to repair or replace the property, or inappropriate disposal of the property, may result in sanctions under OAR 436-110-0900.

(3) A worker, employer or their representative may request Worksite Modification assistance.

(4) The person or entity that purchased the item(s) may request reimbursement by submitting to the division proof of payment for the items purchased. Reimbursement will be made for only those items and costs approved and paid; and

(5) Costs of approved Worksite Modifications are paid by reimbursement, an Authorization for Payment, or by other instrument of payment approved by the director.

(6) The division will not purchase directly or otherwise assume responsibility for Worksite Modifications.

(7) Reimbursed costs will not be charged by the insurer to the employer as claims costs or by any other means.

(8) A division Worksite Modification Consultant will determine if competitive quotes are required.

(9) All requests for reimbursement must be made within one year of the Worksite Modification Agreement end date.

[Publications: Publications referenced are available from the agency]
Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCB 1-1973, f. 1-2-73, ef. 1-15-73; WCB 3-1973, f. 3-14-73, ef. 4-1-73; WCD 2-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 2-1978 (Admin), f. & ef. 2-1-78; WCD 7-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-063-0015 & 436-063-0045, 5-1-85; WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0010, 436-110-0020, 436-110-0025, 436-110-0031, 436-110-0032, 436-110-0035, 436-110-0037, 436-110-0041, 436-110-0042, 436-110-0045, 436-110-0047, 436-110-0051, 436-110-0052 & 436-110-0060; WCD 15-1995(Temp), f. 10-9-95, cert. ef. 10-11-95; WCD 20-1995(Temp), f. 12-8-95, cert. ef. 1-1-96; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 4-1997(Temp), f. 3-13-97, cert. ef. 3-17-97; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0200 & 436-110-0400; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01, Renumbered from 436-110-0300 & 436-110-0340; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0351
Worksite Modification — Employer at Injury Activated

Conditions for use of Worksite Modifications by the employer at injury are as follows:

(1) The employer at injury may use Worksite Modification assistance once for a job provided for their injured worker, or a second time if the worker changes to another job with the employer at injury within the timeframes allowed in OAR 436-110-0290(1).

(2) Modifications are limited to a maximum of $25,000 on the claim which qualified the worker for assistance. A modification over $25,000 may be provided if the worker has an exceptional disability as defined in OAR 436-110-0005(9).

(3) The division must approve, by authorized signature, a completed and signed Worksite Modification Agreement prior to any reimbursement or Authorization for Payment.

(4) Modifications may be provided for requests received within 180 days from the worker's claim closure date. Additional modifications may be provided under an approved agreement by addendum for requests received within three years from the date the worker started work for the employer in employment for which the Worksite Modification request was made.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0352
Worksite Modification — Worker Activated

Conditions for use of Worksite Modification assistance by the worker are as follows:

(1) The division must approve, by authorized signature, a completed and signed Worksite Modification Agreement form, prior to any reimbursement or Authorization for Payment.

(2) Modifications may be provided for requests received within three years from the date of hire.

(3) A worker may use Worksite Modification assistance once with one employer and once with a second employer, or twice with the

same employer if there is a job change. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(4) Modifications after June 30, 1990, are limited to a maximum of $25,000 on the claim which qualified the worker for assistance. A modification over $25,000 may be provided for a worker with an exceptional disability as defined in OAR 436-110-0005(9). This maximum is not reduced by the use of Worksite Modifications by the employer at injury.

Stat. Auth.: ORS 656.726(4) & 656.622
Stats. Implemented: ORS 656.622
Hist.: WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0850
Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the division. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the division directly or from future reimbursements by way of offset. If the division finds upon audit that procedures which led to disallowed reimbursements are still being used, the division may withhold further reimbursements until corrections satisfactory to the division are made.

(2) An insurer or employer must maintain claim records, notices, worker payroll records, reports, receipts, and documentation of payment supporting reemployment assistance costs for which reimbursement has been requested or expenditure by Authorization for Payment has been made. These records must be maintained for a period of three years after the last reimbursement request or expenditure by Authorization for Payment.

(3) The division reserves the right to visit the worksite to determine compliance with the agreement under which reemployment assistance has been provided.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4) & 731.475
Stats. Implemented: ORS 656.455, 656.622 & 731.475
Hist.: WCD 1-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0100; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0450; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-110-0900
Sanctions

(1) Any person who knowingly makes any false statement or representation to the director or an employee of the director for the purpose of obtaining any benefit or payment from the Preferred Worker Program or who knowingly misrepresents the amount of a payroll, or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for the director to sanction an individual certified under OAR 436-120, a vocational assistance provider authorized under OAR 436-120, an agency of the State of Oregon, an insurer, an employer, or a Preferred Worker include, but are not limited to, the following:

(a) Misrepresenting information in order to obtain reemployment assistance. Two examples of misrepresentation are:

(A) Changing a job description or job title where there are not corresponding job duty changes in order to obtain benefits; and

(B) Obtaining a worker's signature on incomplete, incorrect, or blank agreements or reimbursement requests.

(b) Making a serious error or omission which resulted in the division approving a *Preferred Worker Program Agreement*, issuing a Preferred Worker card, or reimbursing claim costs in error;

(c) Failing to abide by the terms and conditions of a *Preferred Worker Program Agreement*;

(d) Failing to abide by the provisions of these rules or ORS 656.990;

(e) Failing to return required receipts or invoices;

(f) Submitting false reimbursement requests or job analyses;

(g) Altering an *Authorization for Payment* form or purchasing unauthorized items; or

(h) Failing to return a Preferred Worker card if requested by the division.

(3) Sanctions by the director may include one or more of the following:

(a) Ordering the person being sanctioned to repay the department for reemployment assistance costs incurred, including the department's legal costs;

(b) Prohibiting the person being sanctioned from negotiating or arranging reemployment assistance for such period of time as the director deems appropriate;

(c) Decertifying an individual or vocational assistance provider under the authority of OAR 436-120;

(d) Ordering an employer or worker ineligible for reemployment assistance for a specific period of time; and

(e) Pursuing civil or criminal action against the party.

Stat. Auth.: ORS 656.622 & 656.726(4)
Stats. Implemented: ORS 656.622 & 656.990
Hist.: WCD 12-1987, f. 12-17-87, ef. 1-1-88; WCD 13-1990(Temp), f. 6-21-90, cert. ef. 7-1-90; WCD 32-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 1-1993, f. 1-21-93, cert. ef. 3-1-93, Renumbered from 436-110-0110; WCD 10-1996, f. 3-12-96, cert. ef. 4-5-96; WCD 11-1997, f. 8-28-97, cert. ef. 9-12-97, Renumbered from 436-110-0500; WCD 7-2001, f. 8-14-01, cert. ef. 10-1-01; WCD 4-2005, f. 5-26-05, cert. ef. 7-1-05

DIVISION 120

VOCATIONAL ASSISTANCE TO INJURED WORKERS

436-120-0001
Authority for Rules

The director has adopted OAR 436-120 by the director's authority under ORS 656.283(2), 656.340, and 656.726(4).

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.262(6), 656.268, 656.283(2), 656.313, 656.331(1)(b), 656.340, 656.447, 656.740, 656.745, 183 & Sec. 15, Ch. 600, OL 1985
Hist.: WCB 6-1973, f. 12-20-73, ef. 1-11-74; WCB 45-1974(Temp), f. & ef. 11-5-74; WCD 4-1975(Admin), f. 2-6-75, ef. 2-25-75; WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0003, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01

436-120-0002
Purpose of Rules

The purpose of these rules is to prescribe uniform standards for determining eligibility, delivery and payment for vocational services to injured workers, procedures for resolving disputes, and to establish standards for the certification of vocational counselors and providers.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.012(2)(c), 656.258, 656.268(1), 656.283, 656.340 & Sec. 15, Ch. 600, OL 1985
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0008, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00

436-120-0003
Applicability of Rules

(1) These rules govern vocational assistance pursuant to the Workers' Compensation Law on or after the effective date of these rules except as OAR 436-120 otherwise provides.

(2) The director's decisions under OAR 436-120-0008 regarding eligibility will be based on the rules in effect on the date the insurer issued the notice. The director's decisions regarding the nature and extent of assistance will be based on the rules in effect at the time the assistance was provided. If the director orders future assistance, such assistance must be provided in accordance with the rules in effect at the time assistance is provided.

(3) Under these rules a claim for aggravation or reopening a claim to process a newly accepted condition will be considered a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules.

(4) Under ORS 656.206, when a worker receiving permanent total disability, incurs a new compensable injury, the worker is not entitled to vocational assistance.

(5) The requirement for the director's advance approval of services eligible for claims cost reimbursement pursuant to OAR 436-120-0720(7) will apply to any actions taken after the effective date of these rules.

(6) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive procedural rules as justice so requires.

(7) Timeliness of any document required by these rules to be filed or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or e-mailed, it must be received by the division by 11:59 p.m. Pacific time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(8) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.283(2) & 656.340
Hist.: WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0004, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0004
Notices and Reporting Requirements

(1) The insurer must inform a worker with a compensable injury of the employment reinstatement rights and responsibilities of the worker under ORS chapter 659A and this rule. This information must be given:

(a) At the time of claim acceptance, pursuant to ORS 656.262(6);

(b) At the time of contact of the worker under OAR 436-120-0320 about the need for vocational assistance, pursuant to ORS 656.340(2); and

(c) Within five days of receiving knowledge of the attending physician's release of the worker to return to work, pursuant to ORS 656.340(3), the insurer must inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659A.043 and 659A.046, and inform the employer about the worker's reemployment rights.

(2) All notices and warnings to the worker issued pursuant to OAR 436-120 must be in writing, signed and dated, and state the basis for the decision, the effective date of the action, the relevant rule(s), the worker's appeal rights required pursuant to this rule, and the telephone number of the Ombudsman for Injured Workers. However, the insurer's response does not need to be in writing when the insurer approves a worker's request for a particular vocational service. All notices and warnings are subject to the following conditions:

(a) The following headings must be used for the following notices. Should one notice be used for multiple actions, all appropriate headings must be listed:

(A) Eligibility. This notice must:

(i) Inform the worker which category of vocational assistance will be provided: NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE and NOTICE OF ENTITLEMENT TO TRAINING (or) NOTICE OF ENTITLEMENT TO DIRECT EMPLOYMENT SERVICES, EFFECTIVE (date) and;

(ii) Include the following statement in bold type:

"You have the right to request a return-to-work plan conference if the insurer does not approve a return-to-work plan within 90 days of determining you entitled to a training plan, or within 45 days of determining you entitled to a direct employment plan. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the plan developer, and any other parties involved in the return-to-work process must attend the conference. The insurer or the worker may request a conference with the division if other delays in the vocational rehabilitation process occur. Your request for this conference should be directed to the Rehabilitation Review Unit of the Workers' Compensation Division. The address and telephone number of the division are: Rehabilitation Review Unit, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 503-378-3351 or 1-800-452-0288."

(B) Ineligibility: NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(C) Selection or change of provider: SELECTION OF (OR CHANGE OF) VOCATIONAL ASSISTANCE PROVIDER, EFFECTIVE (date)

(D) End of training: NOTICE OF TRAINING END, EFFECTIVE (date)

(E) End of eligibility: NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(F) Deferral of vocational assistance eligibility determination: NOTICE OF DEFERRAL OF VOCATIONAL ASSISTANCE ELIGIBILITY DETERMINATION, EFFECTIVE (date)

(b) Warning letters do not require specific language in the headings but should include a heading clearly indicating the purpose of the warning.

(c) The insurer must simultaneously send a copy to the worker's representative. Failure to send a copy of the notice to the worker's representative stays the appeal period until the worker's representative receives actual notice.

(d) All notices and warnings except those notifying a worker of eligibility, entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact (person's name and insurer) within five days of receiving this letter to discuss your concerns. If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: Rehabilitation Review Unit, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 503-378-3351 or 1-800-452-0288."

(3) Notice of Eligibility for vocational assistance and Notice of Entitlement to Training (or) Notice of Entitlement for Direct Employment Services must include the following:

(a) Selection of the category of vocational assistance. When direct employment services are selected, the notice must state the worker is not entitled to training and must include the appeal rights language in OAR 436-120-0004(2)(d);

(b) The worker's rights and responsibilities;

(c) Procedures for resolving dissatisfaction with an action of the insurer regarding vocational assistance;

(d) The current list of vocational assistance providers, and an explanation of the worker's participation in the selection of a vocational assistance provider. This notice must include the following language in bold type:

"If you have questions about the vocational counselor selection process, contact (use appropriate reference to the insurer). If you still have questions contact the Workers' Compensation Division's toll free number at 1-800-452-0288."

(e) Information about potential reemployment assistance under OAR 436-110.

(4) Notice of Ineligibility for vocational assistance is subject to the following conditions:

(a) The notice must be sent to the worker by both regular and certified mail.

(b) The notice must include information about services which may be available at no cost from the Employment Department or the Office of Vocational Rehabilitation Services, and reemployment assistance under OAR 436-110.

(c) If the notice is based on a finding of "no substantial handicap," it must list some suitable occupations.

(d) If the insurer is not required to determine eligibility pursuant to OAR 436-120-0320(2), no Notice of Ineligibility is required unless the worker or worker's representative requested a determination of eligibility. When the ineligibility is due to no permanent disability award, the notice must inform the worker of entitlement to an eligibility determination upon a final order granting permanent disability.

(5) Notice of Denial of Vocational Service must be given by the insurer.

(6) The approved, denied or amended return-to-work plan must be sent to the worker. Notification of Denial of Return-to-Work Plan must identify any components of the plan that the insurer did not approve.

(7) Notice of End of Training must state whether the worker is entitled to further training. The effective date of the end of training letter is the worker's last date of attendance.

(8) Notice of End of Eligibility for vocational assistance must be sent by both regular and certified mail to the worker.

(9) Notice of Deferral of Vocational Assistance Eligibility Determination is subject to the following conditions:

(a) The notice must be sent to the worker by both regular and certified mail.

(b) The notice must inform the worker that the insurer will not complete the vocational eligibility process because the employer at injury has activated preferred worker benefits and the worker has chosen to accept the job offer from the employer at injury. The notice must also inform the worker that, if the job has not begun by the hire date listed in the job offer letter, the worker can request that the vocational eligibility determination be completed.

(c) This notice must include the following language in bold type:

"If you have questions about the deferral of the vocational eligibility process, contact (use appropriate reference to the insurer). If you still have questions contact the Workers' Compensation Division's toll free number at 1-800-452-0288."

(10) Warnings to the worker must state what the worker must do within a specified time to avoid ineligibility or the ending of eligibility or training.

(11) The insurer must simultaneously send a copy of the following notices to the department:

(a) Notice of Eligibility;

(b) Notice of Ineligibility;

(c) Approved Return-to-Work Plan and any amendments;

(d) Notice of End of Training;

(e) Notice of Ending of Eligibility for Vocational Assistance; and

(f) Notice of Deferral of Vocational Assistance Eligibility Determination.

(12) The insurer must file a closing status report with the division for each eligible worker within 30 days after eligibility ends. The insurer must report the following information:

(a) The date and reason for ending of eligibility, return-to-work and vocational assistance provider information.

(b) For post-1985 injuries, the insurer must also report cost information for eligibility determination and vocational services provided under these rules as required by the director.

Stat. Auth.: ORS 656.340(9), 656.726(4) & 192.410 - 192.505

Stats. Implemented: ORS 656.340(5) & 656.340(7)

Hist.: WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0600, 436-120-0610 & 436-120-0620 [WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0005
Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrative approval" means approval of the director.

(2) "Cost-of-living matrix" is a chart issued annually by the director in Bulletin 124 or in an addendum to Bulletin 124 which publishes the conversion factors, effective July 1 of each year, used to adjust for changes in the cost-of-living rate from the date of injury to the date of calculation. The conversion factor is based on the annual percentage increase or decrease in the average weekly wage, as defined in ORS 656.211.

(3) "Division" refers to the Workers' Compensation Division of the Department of Consumer and Business Services.

(4) "Employer at injury" means an employer in whose employ the worker sustained the compensable injury, or occupational disease.

(5) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon, or a self-insured employer. A vocational assistance provider acting as the insurer's delegate may provide notices and warnings required by OAR 436-120.

(6) "Permanent employment" is a job with no projected end date or a job which had no projected end date at time of hire. Permanent employment may be year-round or seasonal.

(7) "Physical Demand Characteristics of Work" Strength Rating: The physical demands strength rating reflects the estimated overall strength requirements of the job, which are considered to be important for average, successful work performance. The following definitions are used: "occasionally" is an activity or condition that exists up to 1/3 of the time; "frequently" is an activity or condition that exists from 1/3 to 2/3 of the time; "constantly" is an activity or condition that exists 2/3 or more of the time.

(a) Sedentary Work (S): Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

(b) Light Work (L): Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

(c) Medium Work (M): Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Light Work.

(d) Heavy Work (H): Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.

(e) Very Heavy (VH): Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.

(8) "Reasonable cause" may include, but is not limited to, a medically documented limitation in a worker's activities due to illness or medical condition of the worker or the worker's family, financial hardship, or circumstances beyond the reasonable control of the worker. "Reasonable cause" for failure to provide information or participate in activities related to vocational assistance will be determined based upon individual circumstances of the case.

(9) "Reasonable labor market": An occupation can be said to have reasonable employment opportunities if competitively qualified workers can expect to find equivalent jobs in the occupation within a reasonable period of time. A reasonable period of time, for workers in the majority of occupations, would be the six months that they could collect regular unemployment insurance benefits, if they were entitled to them. (*Oregon Occupational Projections Handbook, 2002–2008*)

(10) "Regular employment" means the employment the worker held at the time of the injury or at the time of the claim for aggravation, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of aggravation, the employment the worker held on the last day of work prior to the aggravation claim. If the basis for potential eligibility is a reopening to process a newly accepted condition, "regular employment" is the employment the worker held at the time of the injury; when the condition arose after claim closure, "regular employment" is determined as if it were an aggravation claim.

(11) "Substantial handicap to employment," as determined under OAR 436-120-0340, means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment. "Knowledge," "skills," and "abilities" have meanings as follows:

(a) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training and experience.

(b) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(c) "Abilities" means the cognitive, psychological, and physical capability to apply the worker's knowledge and skills.

(12) "Suitable employment" or "suitable job" means employment or a job:

(a) For which the worker has the necessary physical capacities, knowledge, skills and abilities;

(b) Located where the worker customarily worked, or within reasonable commuting distance of the worker's residence. A reasonable commuting distance is no more than 50 miles one-way modified by other factors including, but not limited to:

(A) Wage of the job. A low wage may justify a shorter commute;

(B) The pre-injury commute;

(C) The worker's physical capacities, if they restrict the worker's ability to sit or drive for 50 miles;

(D) Commuting practices of other workers who live in the same geographic area; and

(E) The distance from the worker's residence to the nearest cities or towns which offer employment opportunities.

(c) Which pays or would average on a year-round basis a suitable wage as defined in section (13) of this rule;

(d) Which is permanent. Temporary work is suitable if the worker's job at injury was temporary; and the worker has transferable skills to earn, on a year-round basis, a suitable wage as defined in section (13) of this rule; and

(e) Modified or new employment that results from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110, will be considered "suitable":

(A) Nine months from the effective date of the premium exemption if there are no worksite modifications, or

(B) Twelve months from the effective date of the worksite modification agreement, or

(C) If the worker is terminated for cause, or

(D) If the worker voluntarily resigns for a reason unrelated to the work injury.

(13)"Suitable wage" means:

(a) For the purpose of determining eligibility for vocational assistance, a wage at least 80 percent of the adjusted weekly wage as defined in OAR 436-120-0007.

(b) For the purpose of providing and/or ending vocational assistance, a wage as close as possible to 100 percent of the adjusted weekly wage. This wage may be considered suitable if less than 80 percent of the adjusted weekly wage, if the wage is as close as possible to the adjusted weekly wage.

(14) "Transferable skills" means the knowledge and skills demonstrated in past training or employment which make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

(15) "Vocational assistance" means any of the services, goods, allowances and temporary disability compensation under these rules to assist an eligible worker return to work. This does not include activities for determining a worker's eligibility for vocational assistance.

(16) "Vocational assistance provider" means an insurer or other public or private organization, authorized under these rules to provide vocational assistance to injured workers.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCB 7-1966, f. & ef. 6-30-66;WCB 6-1973, f. 12-20-73, ef. 1-11-74; WCB 45-1974(Temp), f. & ef. 11-5-74; WCD 4-1975(Admin), f. 2-6-75, ef. 2-25-75; WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0005, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05

436-120-0006
Administration of Rules

(1) At any time, the director may order the insurer to determine eligibility or provide specified vocational assistance to achieve compliance with ORS Chapter 656 and these rules. The order may be appealed as provided by statute.

(2) Orders issued by the division in carrying out the director's authority to administer and to enforce ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.283(2) & 656.313
Hist.: WCB 6-1973, f. 12-20-73, ef. 1-11-74; WCB 45-1974(Temp), f. & ef. 11-5-74; WCD 4-1975(Admin), f. 2-6-75, ef. 2-25-75; WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0003, 5-1-85; Renumbered from 436-061-0191, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0001 & 436-120-0210; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02

436-120-0007
Establishing the Adjusted Weekly Wage to Determine Suitable Wage

To determine a suitable wage as defined in OAR 436-120-0005(13), the insurer must first establish the adjusted weekly wage as described in this rule. The insurer must calculate the "adjusted weekly wage" whenever determining or redetermining a worker's eligibility.

(1) For the purposes of this rule, the following definitions apply:

(a) "Adjusted weekly wage" is the wage currently paid as calculated under this rule.

(b) "Cost-of-living adjustments" or "collective bargaining adjustments" are increases or decreases in the wages of all workers performing the same or similar jobs for a specific employer. These adjustments are not variations in wages based on skills, merit, seniority, length of employment, or number of hours worked.

(c) "Earned income" means gross wages, salary, tips, commissions, incentive pay, bonuses and the reasonable value of other consideration (housing, utilities, food, etc.) received from all employers for services performed from all jobs held at the time of injury or aggravation. Earned income also means gross earnings from self- employment after deductions of business expenses excluding depreciation. Earned income does not include fringe benefits such as medical, life or disability insurance, employer contributions to pension plans, or reimbursement of the worker's employment expenses such as mileage or equipment rental.

(d) "Job at aggravation" means the job or jobs the worker held on the date of the aggravation claim; or, for a worker not employed at time of aggravation, the last job or concurrent jobs held prior to the aggravation. Volunteer work does not constitute a job for purposes of this subsection.

(e) "Job at injury" is the job on which the worker originally sustained the compensable injury. For an occupational disease, the job at injury is the job the worker held at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease.

(f) "Permanent, year-round employment" is permanent employment in which the worker worked or was scheduled or projected to work in 48 or more calendar weeks a year. Paid leave is counted as work time. Permanent year-round employment includes trial service. It does not include employment with an annual salary set by contract or self-employment.

(g) "Temporary disability" means wage loss replacement for the job at injury.

(h) "Trial service" is employment designed to lead automatically to permanent, year-round employment subject only to the employee's satisfactory performance during the trial service period.

(2) The insurer must determine the nature of the job at injury or the job or jobs at aggravation by contacting the employer or employers to verify the worker's employment status. All figures used in determining a weekly wage by this method must be supported by verifiable documentation such as the worker's state or federal tax returns, payroll records, or reports of earnings or unemployment insurance payments from the Employment Department. The insurer must calculate the worker's adjusted weekly wage as described by this rule.

(3) When the job at injury or the job at aggravation was temporary or seasonal, calculate the worker's average weekly wage as follows, then convert to the adjusted weekly wage as described in section (6) of this rule:

(a) When the worker's regular employment is the job at injury and the worker did not hold more than one job at the time of injury, and did not receive unemployment insurance benefits during the 52 weeks prior to the injury, the worker's average weekly wage is the same as the wage upon which temporary disability is based.

(b) When the worker's regular employment is the job at aggravation and the worker did not hold more than one job at the time of aggravation, and did not receive unemployment insurance benefits during the 52 weeks prior to the aggravation, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025.

(c) If the worker held more than one job at the time of the injury or aggravation, and did not receive unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation, divide the worker's earned income by the number of weeks the worker worked during the 52 weeks prior to the date of injury or aggravation.

(d) If the worker held one or more jobs at the time of the injury or aggravation, and received unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation, combine the earned income with the unemployment insurance payments and divide the total by the number of weeks the worker worked and received unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation.

(4) When the job at injury was other than as described in section (3) of this rule, use the weekly wage upon which temporary disability was based, and then convert the weekly wage to the adjusted weekly wage as described in section (6) of this rule.

(5) When the job at aggravation was other than as described in section (3) of this rule, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025, and then convert to the adjusted weekly wage as described in section (6) of this rule.

(6) Adjusted weekly wage: After arriving at the weekly wage pursuant to this rule, establish the adjusted weekly wage by determining the percentage increase or decrease from the date of injury or aggravation, or last day worked prior to aggravation, to the date of calculation, as follows:

(a) Contact the employer at injury or aggravation regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. When the worker held two or more jobs at aggravation, contact the employer for whom the worker worked the most hours. Adjust the worker's weekly wage by any percentage increase or decrease;

(b) If the employer at injury or aggravation is no longer in business and the worker's job was covered by a union contract, contact the applicable union for any cost-of-living or collective bargaining adjustments. Adjust the worker's weekly wage by the percentage increase or decrease; or

(c) If the employer at injury or aggravation is no longer in business or does not currently employ workers in the same job category, adjust the worker's weekly wage by the appropriate factor from the cost-of-living matrix.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(5) & (6)
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88, 436-120-0030 Renumbered to 436-120-0075; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0025; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; Renumbered from 436-120-0310, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0008
Administrative Review and Contested Cases

(1) Administrative review of vocational assistance matters: Under ORS 656.283(2) and 656.340(4), a worker wanting review of any vocational assistance matter must apply to the director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0320(13) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer must apply to the director for administrative review. Because effective vocational assistance is best realized in a nonadversarial environment, the first objective of the administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director will close the record and issue a Director's Review and Order as described in subsections (f) and (g) of this section. A worker need not be represented to request or to participate in the administrative review process, which is as follows:

(a) The worker's request for review must be mailed or otherwise communicated to the department no later than the 60th day after the date the worker received written notice of the insurer's action; or, if the worker was represented at the time of the notice, within 60 days of the date the worker's representative received actual notice. Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(b) The worker, insurer, employer at injury, and vocational assistance provider must supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director. Upon the director's request, any party to the dispute must provide available information within 14 days of the request. The insurer must promptly schedule, pay for, and submit to the director any medical or vocational tests, consultations, or reports required by the director. The worker, insurer, employer at injury, or vocational assistance provider must simultaneously send copies to the other parties to the dispute when sending material to the director. If necessary, the director will assist an unrepresented worker in sending copies to the appropriate parties. Failure to comply with this subsection may result in the following:

(A) If the worker fails to comply without reasonable cause, the director may dismiss the administrative review as described in subsection (d); or, the director may decide the issue on the basis of available information.

(B) If the insurer, vocational assistance provider, or employer at injury fails to comply without reasonable cause, the director may decide the issue on the basis of available information.

(c) At the director's discretion, the director may issue an order of deferral to temporarily suspend administrative review. The order of deferral will specify the conditions under which the review will be resumed.

(d) The director may issue an order of dismissal under appropriate conditions.

(e) The director will issue a letter of agreement when the parties resolve a dispute within the scope of these rules. Any agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney. The agreement will become effective on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may reconsider approval of the agreement upon the director's own motion or upon a motion by a party. The director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) One or both parties fail to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the review.

(f) After the parties have had the opportunity to present evidence, and any meetings or conferences deemed necessary by the director have been held, the director will issue a final order. The parties will have 60 days from the mailing date of the order to request a hearing.

(g) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the proposed and final order is issued.

(h) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(i) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(j) A request for reconsideration does not stay the 60-day time period within which the parties may request a hearing.

(2) Attorney fees: In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director will award an attorney fee to be paid by the insurer or self-insured employer as provided in ORS 656.385 (§2, ch. 756, OL 2003).

The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration will be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed $2000, nor fall outside the ranges for fees as provided in the following matrix: [Matrix not included. See ED. NOTE.]

(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the case if greater than two hours. In the absence of such a statement, the director will assume the time spent on the case was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to the following:

(A) Where there is a return-to-work plan that includes the disputed service(s), the assumed value is the cost of the disputed service(s) as projected in the plan;

(B) Where the service(s) have not been incorporated in an existing return-to-work plan, the assumed value is the actual or projected cost of the service(s) up to the amount allowed in the fee schedule provided in OAR 436-120-0720;

(C) For the purposes of applying the matrix, the value of an eligibility determination is assumed to be the maximum allowed in the fee schedule provided in OAR 436-120-0720 for completing an eligibility evaluation; the value of vocational assistance or a training plan, unless determined to be otherwise, is assumed to fall within the highest category provided in the above matrix; or

(D) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above $2000, they may submit a written or faxed statement of the extraordinary circumstances to the director. Extraordinary circumstances are not established by merely exceeding eight hours or exceeding a benefit of $6000.

(d) In order to provide parties an opportunity to inform the director of agreements, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any information or statements provided to the director must simultaneously be provided to all other parties to the dispute.

(e) An assessed attorney fee will be paid within 30 days of the date the order authorizing the fee becomes final.

(3) Hearings before an administrative law judge:

(a) Under ORS 656.283(2) and 656.704(2), any party that disagrees with an order issued under subsection (1)(f) of this rule or a dismissal issued under subsection (1)(d) of this rule may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(b) Under ORS 656.704(2), any party that disagrees with an order of dismissal based on lack of jurisdiction under subsection (1)(d) of this rule or department denial of reimbursement for vocational assistance costs may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days after the party received the dismissal or written denial.

(c) Under ORS 656.704(2), an insurer sanctioned pursuant to OAR 436-120-0900, a vocational assistance provider or certified individual sanctioned pursuant to ORS 656.340(9)(b) and OAR 436-120-0915, a vocational assistance provider denied authorization pursuant to ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification pursuant to ORS 656.340(9)(a) and OAR 436-120-0810 may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 no later than 60 days after the party received notification of the action.

(d) OAR 436-001 applies to the hearing.

(4) Contested case hearings of civil penalties: Under ORS 656.740 an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty pursuant to ORS 656.745 and OAR 436-120-0900 as follows:

(a) The insurer or employer must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must file the request with the division within 60 days after the mailing date of the notice of the proposed order or assessment.

(c) The division will forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) The Hearings Division will conduct the hearing in accordance with ORS 656.740 and chapter 183.

[ED. NOTE: Matrix referenced are available from the agency.]

Stat. Auth.: ORS 656.704(2) & 656.726(4)

Stats. Implemented: ORS 183.310 - 183.555, 656.283(2), 656.340, 656.447, 656.740 & 656.745

Hist.: WCD 9-1982(Admin), f. 5-28-82, ef. 6-1-82; WCD 2-1983(Admin), f. & ef. 6-30-83; Renumbered from 436-061-0970, 5-1-85; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0191, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0210 & 436-120-0260; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0320
Determining Eligibility for Vocational Assistance and Selection of Vocational Assistance Provider

(1) Unless one of the provisions in section (2) or (12) below applies, the insurer must contact a worker with an accepted disabling claim or claim for aggravation to begin the eligibility determination within five days of any of the following:

(a) The insurer's receipt of a request for vocational assistance from the worker. If the insurer does not know the worker's permanent limitations, the insurer must contact the attending physician within 14 days of receiving the request for vocational assistance. The insurer must notify the worker, in writing, if the eligibility determination is postponed until permanent restrictions are known or can be projected.

(b) The insurer's receipt of a medical or investigative report sufficient to document a need for vocational assistance, including medical verification of projected or actual permanent limitations due to the injury.

(c) The insurer's knowledge that the claim qualifies for closure because the worker is medically stationary. If the claim qualifies for closure under ORS 656.268(1)(b) or (c), the insurer may postpone the determination until the worker is medically stationary or until permanent restrictions are known or can be projected, whichever occurs first.

(d) The worker is granted a permanent disability award.

(2) The insurer is not required to determine eligibility if:

(a) Eligibility has previously been determined under the current opening of the claim and there are no newly accepted conditions;

(b) The worker has returned to regular or other suitable employment with the employer at injury or aggravation; or

(c) The worker's claim was closed with no permanent disability award. The following by themselves do not make a worker ineligible for vocational assistance:

(A) A finding that a worker is not entitled to an additional award of permanent disability on aggravation, or

(B) A finding that a worker is not entitled to a permanent disability award because of an offset of permanent disability from a prior claim, or

(C) The worker disposes of permanent disability through a claim disposition agreement (CDA).

(d) The worker's claim was reopened as a result of a Board's Own Motion Order.

(3) The insurer must defer the determination of vocational assistance eligibility when the employer at injury activates preferred worker benefits under OAR 436-110 and the worker agrees to accept the new or modified regular job in writing.

(a) There must be a written job offer which includes the following information:

(A) The start date;

(B) That the job does not begin until the modifications are in place;

(C) Wage and hours;

(D) Job site location; and

(E) Description of job duties.

(b) The insurer must send the worker a Notice of Deferral of Vocational Assistance Eligibility Determination within 14 days of the workers signature accepting the job offer.

(c) If preferred worker benefits cannot modify the job to accommodate the worker's restrictions, as verified by the division, or the employer, the worker, or division terminate the agreement, the insurer must complete the eligibility determination process within 30 days from the date of a determination that preferred worker benefits will not be provided.

(4) If the insurer receives a request for vocational assistance from the worker or the worker's representative and the insurer is not required to determine eligibility under section (2), the insurer must notify the worker in writing, within 14 days of the request and provide:

(a) The reasons the insurer is not required to determine eligibility,

(b) The circumstance which would require the insurer to determine eligibility, and

(c) The appropriate telephone number of the division, with instructions to contact the division with questions about vocational assistance eligibility requirements and procedures.

(5) Nothing in these rules prevents the insurer from finding a worker eligible and providing vocational assistance at any time.

(6) The insurer must complete the eligibility determination within 30 days of the contact required in section (1) or if the eligibility determination was postponed within 30 days of receipt of verification of projected or actual permanent limitations. An eligibility evaluation may include a vocational evaluation that determines the category of assistance as defined in OAR 436-120-0400. The notice required under OAR 436-120-0004(2)(a)(A) must inform the worker which category of assistance will be provided.

(7) If the insurer is unable to determine eligibility or make a decision regarding a particular vocational service because of insufficient data, the insurer must explain to the worker in writing what information is necessary and when it expects to determine eligibility or make a decision.

(8) A vocational counselor certified under OAR 436-120 must determine if a worker meets eligibility criteria.

(9) The insurer must provide the vocational counselor with all existing relevant medical information regarding the worker's physical capacities and limitations.

(10) After the worker's permanent limitations are known or can be projected, the worker must, upon written request from the insurer, provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(11) A worker entitled to an eligibility evaluation is eligible for vocational services if all the following additional conditions are met:

(a) The worker is authorized to work in the United States.

(b) The worker is available in Oregon for vocational assistance. The insurer must consider the worker available in Oregon if the worker lives within commuting distance of Oregon or documents, in writing, willingness to relocate to or within commuting distance of Oregon within 30 days of being found eligible. The worker is responsible for costs associated with being available in Oregon. The requirement that the worker be available in Oregon for vocational assistance does not apply if the Oregon subject worker did not work and live in Oregon at the time of the injury.

(c) As a result of the limitations caused by the injury or aggravation, the worker:

(A) Is not able to return to regular employment;

(B) Is not able to return to any other suitable and available work with the employer at injury or aggravation; and

(C) Has a substantial handicap to employment and requires assistance to overcome that handicap.

(d) None of the reasons for ineligibility under OAR 436-120-0350 applies under the current opening of the claim.

(12) A worker whose permanent total disability benefits have been terminated by an order that becomes final is eligible for vocational assistance.

(13) Upon determining the worker eligible, the insurer and worker will jointly select a vocational assistance provider. No later than 20 days from the date the insurer determined the worker eligible, the insurer must either notify the worker of the selection of vocational assistance provider, or if the parties are unable to agree, refer the dispute to the director. The worker and insurer must follow the same procedure to select a new vocational assistance provider.

(14) Unless all parties otherwise agree in writing, vocational assistance will be due at any given time with respect only to one claim of the worker. If the worker is eligible for vocational assistance under two or more claims, and there is a dispute about which claim gives rise to the need for vocational assistance pursuant to these rules, the director will select the claim for the injury which results in the most severe vocational impact. If services are provided under more than one claim at a time pursuant to a written agreement of all parties, time and fee limits may extend beyond the limits otherwise imposed in these rules.

Stat. Auth.: ORS 656.726(4) & 656.340(9)
Stats. Implemented: ORS 656.206, 656.340, OL, Ch. 461
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0111, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0060; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0035; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0330 & 436-120-0370; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0340
Determining Substantial Handicap

(1) A certified vocational counselor must perform a substantial handicap evaluation as part of the eligibility determination unless the insurer finds that the worker has a substantial handicap to employment.

(2) To complete the substantial handicap evaluation the vocational counselor must submit a report documenting the following information:

(a) Relevant work history for at least the preceding five years;

(b) Level of education, proficiency in spoken and written English or other languages, where relevant, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage as determined under OAR 436-120-0007 and suitable wage as defined by OAR 436-120-0005(13);

(d) Permanent limitations due to the injury;

(e) An analysis of the worker's transferable skills, if any;

(f) A list of physically suitable jobs for which the worker has the knowledge, skills and abilities, which pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g) below;

(g) An analysis of the worker's labor market utilizing standard labor market reference materials including but not limited to Employment Department (OED) information such as Oregon Wage Information (OWI), Oregon Comprehensive Analysis File and other publications of the Occupational Program Planning System (OPPS) and material developed by the division. When using the OWI data, the presumed standard will be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate. When such data is not sufficient to make a decision about substantial handicap, the vocational counselor must perform individual labor market surveys as described in OAR 436-120-0410(7); and

(h) Consideration of the vocational impact of any limitations which existed prior to the injury.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.340(5) & (6)
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0350
Ineligibility and End of Eligibility for Vocational Assistance

A worker is ineligible or the worker's eligibility ends when any of the following conditions apply:

(1) The worker does not or no longer meets the eligibility requirements as defined in OAR 436-120-0320. The insurer must have obtained new information which did not exist or which the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility.

(2) The worker is determined not to have permanent disability after a finding of eligibility.

(3) The worker's lack of suitable employment is not due to the limitations caused by the injury or which existed before the injury. When ending a worker's eligibility, the insurer must have obtained new information which did not exist or which the insurer could not

have discovered with reasonable effort at the time the insurer determined eligibility.

(4) The worker has been employed at least for 60 days in suitable employment after the injury or aggravation and any necessary worksite modification is in place, unless OAR 436-120-0350(17) applies.

(5) The worker, prior to beginning an authorized return-to-work plan, refused an offer of suitable employment, or left suitable employment after the injury or aggravation for a reason unrelated to the limitations due to the compensable injury. If the employer-at-injury offers employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(6) The worker, prior to beginning an authorized return-to-work plan, refused or failed to make a reasonable effort in available light-duty work intended to result in suitable employment. Prior to finding the worker ineligible or ending eligibility, the insurer must document the existence of one or more suitable jobs which would have been available for the worker upon successful completion of the light-duty work. If the employer-at-injury offers such employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(7) The worker, after completing an authorized training plan, refused an offer of suitable employment.

(8) The worker has declined or has become unavailable for vocational assistance for reasonable cause. If the insurer does not believe the worker had reasonable cause, the insurer must warn the worker prior to finding the worker ineligible or ending the worker's eligibility under this section. Declining vocational assistance to accept modified or new employment that results from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110, will be considered reasonable cause.

(9) The worker has failed, after written warning, to participate in the vocational assistance process, or to provide relevant information. No written warning is required if the worker refuses a suitable training site after the vocational counselor and worker have agreed in writing upon a return-to-work goal.

(10) The worker has failed, after written warning, to comply with the return-to-work plan. No written warning is required if the worker fails to attend 2 consecutive training days and fails, without reasonable cause, to notify the vocational counselor or the insurer.

(11) The worker's lack of suitable employment cannot be resolved by providing vocational assistance. This includes circumstances in which the worker cannot benefit from, or participate in, vocational assistance because of medical conditions unrelated to the injury.

(12) The worker has misrepresented a matter material to evaluating eligibility or providing vocational assistance.

(13) The worker has refused, after written warning, to return property provided by the insurer or reimburse the insurer after the insurer has notified the worker of the repossession; or the worker has misused funds provided for the purchase of property or services. No vocational assistance will be provided under the current or subsequent openings of the claim until the worker has returned the property or reimbursed the funds.

(14) The worker physically abused any party to the vocational process, or after written warning, has continued to sexually harass or threaten to physically abuse any party to the vocational process. This section does not apply if such behavior is the result of a documented medical or mental condition. In such a situation, eligibility should be ended under section (11) of this rule.

(15) The worker has entered into a claim disposition agreement (CDA) which disposes of vocational assistance eligibility. The parties may agree in writing to suspend vocational services pending approval by the Workers' Compensation Board (Board) or an administrative law judge. The insurer must end eligibility when the Board or administrative law judge approves the CDA. No notice regarding the end of eligibility is required.

(16) The worker has received maximum direct employment services and is not entitled to other categories of vocational assistance.

(17) The worker has been suitably employed in modified or new employment that results from employer at injury activation of preferred worker benefits as provided in OAR 436-120-0005(12)(e).

(18) The worker is unavailable for vocational assistance due to short-term incarceration.

Stat. Auth.: ORS 656.340(9) & 656.726(4)

Stats. Implemented: ORS 656.340

Hist.: WCD 11-1982(Temp), f. 12-29-82 eff. 1/1/83; WCD 2-1983, 6-30-83, eff. 6-30-83; WCD 5-1983, 12-14-83, eff. 1-1-84; Renumbered from 436-061-0126, 5-1-85; WCD 7-1985, 12-12-85, eff. 1/1/86; Renumbered from 436-120-0090, WCD 11-1987, 12-17-87, eff. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0045; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04, cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0360
Redetermining Eligibility for Vocational Assistance

If a worker was previously found ineligible or the worker's eligibility ended for any of the reasons specified in sections (1) through (8), or any of the conditions described in sections (9) through (11) exists, the insurer must redetermine eligibility upon notification of a change of circumstances. The insurer must complete the eligibility evaluation within 35 days of the following:

(1) The worker, for reasonable cause, declined or was not available for vocational assistance, or the barrier causing the worker's lack of suitable employment could not be resolved by providing vocational assistance, and those circumstances have changed. The insurer may require the worker to provide documentation the barrier no longer exists, including medical or psychological reports relating to noncompensable conditions. If the worker declined vocational assistance to accept modified or new employment that resulted from an employer at injury activated use of the preferred worker benefits, under OAR 436-110, and the job was not suitable, the worker must request redetermination within 30 days of termination of the employment for which preferred worker benefits were provided.

(2) The worker was not available in Oregon, and the worker becomes available. The worker must request redetermination within six months of the worker's receipt of the insurer's notice.

(3) The worker's claim was denied, and the claim is later accepted and all appeals exhausted.

(4) The worker was not awarded permanent disability and the worker is later awarded permanent disability.

(5) The worker was not authorized to work in the United States, and the worker is now authorized to work in the United States. The time limit set in this section applies to any worker found ineligible or whose eligibility ended because the worker was not authorized to work in the United States regardless of the date the notice of ineligibility or end of eligibility was issued. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker has applied for authorization to work in the United States and is awaiting a decision by the U.S. Citizenship and Immigration Services (USCIS). The worker must promptly provide the insurer with a copy of any decision by the USCIS. The insurer must redetermine eligibility upon receipt of documentation of the worker's authorization to work in the United States.

(6) The worker was unavailable for vocational assistance due to short-term incarceration for a matter unrelated to the worker's claim and is now available. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker is now available to participate in vocational assistance.

(7) The worker returned to work prior to the worker becoming medically stationary, and the physician later rescinded the release.

(8) The worker returned to work prior to becoming medically stationary, and the worker requests a redetermination within 60 days of the mailing date of the Notice of Closure.

(9) Prior to claim closure a worker's limitations due to the injury became more restrictive.

(10) Prior to claim closure the insurer accepts a new condition which was not considered in the original determination of the worker's eligibility.

(11) The worker's temporary disability compensation is redetermined and increased. The worker must make a written request to the insurer to redetermine vocational eligibility within 60 days of receiving notification of the increase in temporary disability compensation.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0095; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0055; WCD 23-1996; f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0400
Selection of Category of Vocational Assistance

(1) The insurer must select the category of vocational assistance prior to referral to a vocational assistance provider . The insurer must notify the worker and document the reason for its decision.

(2) The insurer must select one of the following categories of vocational assistance:

(a) Direct employment services, if the worker has the necessary transferable skills to obtain suitable new employment.

(b) Training, if the worker needs training in order to return to employment which pays a wage significantly closer to 100 percent of the adjusted weekly wage. "Significantly closer" may vary depending on several factors, including, but not limited to, the worker's wage at injury, adaptability, skills, geographic location, limitations and the potential for the worker's income to increase with time as the result of training.

(3) The insurer must reconsider the category of vocational assistance within 30 days of the insurer's knowledge of a change in circumstances including, but not limited to, the following:

(a) A change in the worker's permanent limitations;

(b) A change in the labor market; or

(c) The category of vocational assistance proves to be inappropriate.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0083 & 0085; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0410
Vocational Evaluation

A certified vocational counselor must complete the vocational evaluation. Vocational evaluation may include one or more of the following:

(1) Vocational testing must be administered by an individual certified to administer the test.

(2) A work evaluation must be performed by a Certified Vocational Evaluation Specialist (CVE), certified by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists.

(3) On-the-job evaluations must evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job environment.

(a) First, the vocational counselor must perform a job analysis to determine if the job is within the worker's capacities. The insurer must submit the job analysis to the attending physician if there is any question about the appropriateness of the job.

(b) The evaluation should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(c) The evaluation does not establish any employer-employee relationship.

(d) A written report must evaluate the worker's performance in the areas originally identified for assessment.

(4) Situational assessment is a procedure that evaluates a worker's aptitude or work behavior in a particular learning or work setting. It may focus on a worker's overall vocational functioning or answer specific questions about certain types of work behaviors.

(a) The situational assessment requires these steps: planning and scheduling observations; observing, describing and recording work behaviors; organizing, analyzing and interpreting data; and synthesizing data including behavioral data from other pertinent sources.

(b) The assessment should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(5) Work adjustment is work-related activities that assist workers in understanding the meaning, value, and demands of work. It may include the assistance of a job coach.

(6) Job analysis is a detailed description of the physical and other demands of a job based on direct observation of the job.

(7) Labor market surveys are obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.

(a) A labor market survey is needed when standard labor market reference materials do not have adequate information upon which to base a decision, or there are questions about a worker's specific limitations, training and skills, which must be addressed with employers to determine if a reasonable labor market exists.

(b) The person giving the information must have hiring responsibility or direct knowledge of the job's requirements; and the job must exist at the firm contacted.

(c) The labor market survey report must include, but is not limited to, the date of contact; firm name, address and telephone number; name and title of person contacted; the qualifications of persons recently hired; physical requirements; wages paid; condition of hire (full-time, part-time, seasonal, temporary); date and number of last hire(s); and available and anticipated openings.

(d) Specific openings found in the course of a labor market survey are not, in themselves, proof a reasonable labor market exists.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef 1-1-95, Renumbered from 436-120-0081; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0420; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0430
Direct Employment

(1) The insurer must provide an eligible worker with four months of direct employment services dating from the date the insurer approves a direct employment plan or the completion date of an authorized training plan. Direct employment services include, but are not limited to, the following:

(a) Employment counseling.

(b) Job search skills instruction, which teaches workers how to write resumes, research the job market, locate suitable new employment, complete employment applications, interview for employment, and develop other skills related to looking for suitable new employment.

(c) Job development, which assists the worker to contact appropriate prospective employers, and with related return-to-work activities.

(d) Job analysis.

(2) The insurer must provide return-to-work follow-up for at least 60 days after the worker becomes employed to ensure the work is suitable and to provide any necessary assistance which enables the worker to continue the employment.

(3) Direct employment services are available for more than four months if the worker was unable to participate for reasonable cause.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0060, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88, Renumbered from 436-120-0030; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0075 & 436-120-0083; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0440
Training

(1) Training services include plan development, training, monthly monitoring of training progress, and job placement services as necessary.

(2) Training is limited to an aggregate of 16 months, subject to extension to 21 months by the director for a worker with an exceptional disability resulting from the compensable condition(s) and any limitations which existed prior to the injury or an exceptional loss of earning capacity.

(a) "Exceptional disability" is defined as disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury which results in impairment equal to or greater than Class III as defined in OAR 436-035.

(b) An "exceptional loss of earning capacity" exists when no suitable training plan of 16 months or less is likely to eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain a wage "significantly closer," as described in OAR 436-120-0400(2)(b), to the worker's adjusted weekly wage and at least 10 percent greater than could be expected with a shorter training program.

(3) A worker enrolled and actively engaged in training must receive temporary disability compensation subject to OAR 436-060, and payment of awards of permanent disability are suspended. At the insurer's discretion, training costs may be paid for periods longer than 21 months, but in no event will temporary disability compensation be paid for a period longer than 21 months.

(4) The selection of plan objectives and kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment. Notwithstanding OAR 436-120-0320(11)(b), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate or cost effective than other alternatives. The plan must be developed and monitored by a vocational assistance provider certified pursuant to these rules.

(5) Training status continues during the following breaks:

(a) A regularly scheduled break of not more than six weeks between fixed school terms;

(b) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; and

(c) A period of illness or recuperation which does not prevent completion of the training by the planned date.

(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan. The following conditions apply:

(a) Training time is limited to a duration of 12 months.

(b) The on-the-job training contract between the training employer, the insurer, and the worker must include, but is not limited to, the worker's name; the employer's legal business name, Workers' Compensation Division Employer Registration number, and the name of the individual providing the training; the training plan start and end dates; the job title, the job duties, and the skills to be taught; the base wage and the terms of wage reimbursement; and an agreement that the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee. If the training prepares a worker for a job unique to the training site, the contract must acknowledge that the training may not prepare the worker for jobs elsewhere.

(c) The insurer must not reimburse the training employer 100 percent of the wages for the entire contract period.

(d) The insurer must pay temporary disability compensation as provided in ORS 656.212.

(e) The worker's schedule must be the same as for a regular full-time employee. The schedule may be modified to accommodate the worker's documented medical condition or class schedule.

(7) Skills training is offered through a community college, based on predetermined curriculum, at the training employer's location. Skills training is subject to the following conditions:

(a) Training is limited to 12 months.

(b) Training does not establish any employer-employee relationship with the training employer. The activity is primarily for the worker's benefit. The worker does not receive wages. The training employer makes no guarantee of employing the worker when the training is completed.

(c) The training employer has a sufficient number of employees to accomplish its regular work and the training of the worker, and the worker does not displace an employee.

(d) The worker's schedule must be the same as for a regular full-time employee. The schedule may be modified to accommodate the worker's documented medical condition or class schedule.

(8) Rehabilitation facilities training provides evaluation, training and employment for severely disabled individuals.

(9) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment. It is limited to six months.

(10) Formal training may be offered through a vocational school licensed by an appropriate licensing body, or community college or other post-secondary educational facility which is part of a state system of higher education. Courseload must be consistent with the worker's abilities, limitations and length of time since the worker last attended school. Courses must relate to the vocational goal.

(11) The worker is entitled to job placement assistance after completion of training.

(12) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of employment before ending eligibility.

(13) Training ends and the plan must be re-evaluated when any of the following occurs:

(a) A change in the worker's limitations which renders the training inappropriate.

(b) The worker's training performance is unsatisfactory and training is not likely to result in employment in that field. In an academic program, the worker fails to maintain at least a 2.00 grade point average for at least two grading periods or to complete the minimum credit hours required under the training plan. The vocational counselor must report any unsatisfactory performance and the insurer must give the worker a written warning of the possible end of training at the first indication of unsatisfactory performance.

(14) The insurer will not provide any further training to a worker who has completed one training plan unless the worker has sustained a compensable aggravation or newly accepted condition which renders the worker incapable of obtaining suitable employment, or the previous plan was inadequate to prepare the worker for suitable employment because of an error or omission by the insurer.

(15) Training will end if any of the following applies:

(a) The worker has successfully completed training;

(b) The worker's eligibility has ended under OAR 436-120-0350; or

(c) The worker is not enrolled and actively engaged in the training. However, none of the following will be considered as ending the worker's training status:

(A) A regularly scheduled break of not more than six weeks between fixed school terms;

(B) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; or

(C) A period of illness or recuperation which does not prevent completion of the training by the planned date.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; Renumbered from 436-061-0060, WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; Renumbered from 436-120-0030, WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from 436-120-0075 & 436-120-0085, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0450 & 436-120-0460,WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0455
Optional Services

(1) Optional services are services provided to an ineligible worker or services provided to an eligible worker in excess of those described in these rules. Such services are at the discretion of an insurer.

(2) The insurer must not use optional services to circumvent the intent of these rules.

Stat. Auth.: ORS 656.283, 656.340, 656.704 & 656.726
Stats. Implemented: ORS 656
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0910, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0500
Return-to-Work Plans: Development and Implementation

(1) A return-to-work plan should be a collaborative effort between the vocational counselor and the injured worker, and should include all the rights and responsibilities of the worker, the insurer, and the vocational counselor. Prior to submitting the plan to the insurer, the vocational counselor must review the plan and plan support with

the worker. Certain information may be excluded, as allowed by OAR 436-010. The injured worker must be given the opportunity to review the plan with the worker's representative prior to signing it. The vocational assistance provider must confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature. The counselor must submit copies signed by the vocational counselor and the worker to all parties If the insurer lacks sufficient information to make a decision, the insurer must advise the parties what information is needed and when it expects to make a decision.

(2) If the insurer does not approve a return-to-work plan within 90 days of determining the worker is entitled to a training plan, or within 45 days of determining the worker is entitled to a direct employment plan, the insurer must contact the division within five days to schedule a conference. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the plan developer, and any other parties involved in the return-to-work process must attend the conference. The conference may be postponed for a period of time agreeable to the parties. The insurer or the worker may request a conference with the division if other delays in the vocational rehabilitation process occur.

(3) If, during development of a return-to-work plan, an employer offers the worker a job, the insurer must perform a job analysis, obtain approval from the attending physician, verify the suitability of the wage, and confirm the offer is for a bona fide, suitable job as defined in OAR 436-120-0005(12). If the job is suitable, the insurer must help the worker return to work with the employer. The insurer must provide return-to-work follow-up during the first 60 days after the worker returns to work. If return to work with the employer is unfeasible or, during the 60-day follow-up the job proves unsuitable, the insurer must immediately resume development of the return-to-work plan.

(4) If the vocational goal or category of assistance is later changed, the insurer must amend the plan. All amendments to the plan must be initialed by the insurer, vocational assistance provider, and the worker.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340(9)
Hist.: WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0172, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from OAR 436-120-0105 & 436-120-0170; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; Renumbered from 436-120-0600, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0510
Return-to-Work Plan Support

(1) The injured worker and vocational counselor must work together to develop a return-to-work plan that includes consideration of the following:

(a) The injured worker's transferable skills;

(b) The injured worker's physical and mental capacities and limitations;

(c) The injured worker's vocational interests;

(d) The injured worker's educational background and academic skill level;

(e) The injured worker's pre-injury wage; and

(f) The injured worker's place of residence and that labor market.

(2) Return-to-work plan support must contain, but is not limited to, the following:

(a) Specific vocational goal(s) and projected return-to-work wage(s).

(b) A description of the worker's current medical condition, relating the worker's permanent limitations to the vocational goals.

(c) A description of the worker's education and work history, including job durations, wages, Standard Occupational Classification (SOC) codes, Dictionary of Occupational Titles (DOT) codes or other standardized job titles and codes, and specific job duties.

(d) If a direct employment plan, a description of the worker's transferable skills which relate to the vocational goals and a discussion of why training will not bring the worker a wage significantly closer to 100 percent of the adjusted weekly wage at the time of injury.

(e) If a training plan, a discussion of why direct employment services will not return the worker to suitable employment.

(f) A summary of the results of any evaluations or testing. If the results do not support the goals, the vocational assistance provider must explain why the goals are appropriate.

(g) A summary of current labor market information which shows the labor market supports the vocational goals and documents that the worker has been informed of the condition of the labor market.

(h) A labor market survey as prescribed in 436-120-0410(7), if needed.

(i) If the labor market information does not support the goals, the vocational assistance provider must explain why the goals are appropriate. The worker and worker's representative, if any, must acknowledge in writing an awareness of the poor labor market conditions and a willingness to proceed with the plan in spite of these conditions. In the case of a training plan, this acknowledgment must include an understanding the insurer will provide no additional training should the worker be unable to find suitable employment because of the labor market.

(j) A job analysis prepared by the vocational assistance provider, signed by the worker and by the attending physician or a qualified facility designated by the attending physician, and based on a visit to a worksite comparable to what the worker could expect after completing training. If the attending physician is unable or unwilling to address the job analysis and does not designate a facility as described above, the insurer may submit the job analysis to a qualified facility of its choice. The insurer must submit the resulting information to the attending physician for concurrence. If the attending physician has not responded within 30 days of the date of request for concurrence, the plan may proceed.

(k) A signed on-the-job training contract, if applicable.

(l) A description of the curriculum, which must be term by term if the curriculum is for formal training.

(m) If material pertinent to a return-to-work plan is contained in a previous eligibility the insurer may attach a copy of the evaluation to the plan.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94,cert. ef. 1-1-95; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0105; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0520
Return-to-Work Plan: Responsibilities of the Eligible Worker and the Vocational Assistance Provider

(1) The worker must participate and maintain contact with the vocational counselor throughout plan development and as required in the plan, and must inform the vocational counselor of anything which might affect the worker's participation in or successful completion of the plan. If the worker stops attending training for any reason, the worker must notify the vocational counselor by the close of the next working day.

(2) Vocational counselors are responsible for the following:

(a) During plan development, the vocational counselor must provide resource materials about jobs, training programs (if appropriate), labor markets and other pertinent information to help the worker select a vocational goal; direct information gathering; and otherwise help the worker analyze and evaluate options.

(b) The vocational counselor must help the worker plan the curriculum and help the worker enroll. The vocational assistance provider must contact the worker, trainers and training facility counselors to the extent necessary to assure the worker's participation and progress.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0115; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0530
Return-to-Work Plan Review

The director may review return-to-work plans and supporting information. If the director finds a return-to-work plan or its supporting information does not conform to these rules:

(1) The director must notify the insurer and vocational assistance provider in writing of the preliminary finding of nonconformance. The notification must inform the insurer of changes or information required to bring the plan into conformance.

(2) The insurer must, within 30 days of notification, make appropriate changes, supply additional information requested by the division, or explain why no change(s) should be made.

(3) If the insurer does not respond timely or is unable to bring the plan into conformance, the director will return the plan to the parties with notification that the plan does not conform to OAR 436-120 and may order the insurer to develop a plan that conforms to the rules.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0172, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0170 & 436-120-0215; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0700
Direct Worker Purchases

(1) The insurer must provide direct worker purchases as necessary for an eligible worker's participation in vocational assistance and to meet the requirements of a suitable job. A worker is no longer eligible for these purchases once eligibility ends unless the purchases are necessary to complete a plan. Direct worker purchases include partial purchase, lease, rental and payment.

(2) Direct worker purchases will not include purchases of real property; payment of fines or other penalties; or payment of additional driver's license costs, increased insurance costs or any other costs attributable to problems with the worker's driving record.

(3) In making its decision regarding a direct worker purchase, the insurer may choose the least expensive, adequate alternative. If the worker wants a direct worker purchase which is more expensive than that authorized by the insurer, the worker may select that alternative, and the worker shall pay the difference in cost.

(4) Within 14 days of its receipt of a request for a direct worker purchase, the insurer must approve the purchase or notify the worker of its denial.

(5) The insurer must pay for approved direct worker purchases in time to prevent delay in the provision of services.

(6) The worker may pay for mileage, child or senior care, or for purchases such as clothing, books and supplies or the worker may request an advance of any of these costs based on documentation of need.

(a) The insurer must reimburse costs within 28 days of receiving the written request from the worker and any required supporting documentation.

(b) The insurer must return denied requests for reimbursement to the worker within 28 days of the insurer's receipt with an explanation of the reason for nonpayment.

(7) The insurer must assign to the worker right and title to the nonexpendable direct worker purchases paid by the insurer as follows:

(a) The insurer must make such assignment no later than the 60th day of continuous employment unless the worker remains eligible and the suitability of the employment is in question.

(b) The insurer may repossess nonexpendable property if the worker no longer requires the property for training or employment.

(c) The insurer may require repayment of advancements or reimbursements if the worker misrepresented information material to the purchase decision or if the worker used the funds for something other than the approved purchase.

Stat. Auth.: ORS 656.340(9) & 656.726(3)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0087; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0710
Direct Worker Purchases: Kinds

The insurer must provide the direct worker purchases described in sections (1) through (12) of this rule without regard to the worker's pre- or post-injury income. The insurer may not require the worker to submit a financial statement in order to qualify for direct worker purchases listed in sections (1) through (12). In determining the necessity of direct worker purchases described in sections (13) through (18), the insurer must consider, among all factors, the worker's pre-injury net income as compared with the worker's post-injury net income. Permanent partial disability award payments will not be considered as income. For the insurer to find the purchase necessary, the worker's pre-injury net income, as adjusted by the cost-of-living matrix, must be greater than the worker's post-injury net income, unless the worker can establish financial hardship. The insurer may require the worker to provide information about expenditures or family income when the worker claims a financial hardship.

(1) Tuition, fees, books and supplies for training or studies. Payment is limited to those items identified as mandatory by the instructional facility, trainer or employer. The insurer must pay the cost in full, and will not require the worker to apply for grants to pay for tuition, books or other expenses associated with training.

(2) Wage reimbursement for on-the-job training. The amount must be stipulated in a contract between the training employer and the insurer.

(3) Travel expenses for transportation, meals and lodging required for participation in vocational assistance. For the purposes of this section, "participation in vocational assistance" includes, but is not limited to job search, required meetings with the vocational assistance provider, and meetings with employers or at training sites as required by the plan or plan development. The conditions and rates for payment of travel expenses are as follows:

(a) Transportation. Costs will be paid at public transportation rates when public transportation is available; otherwise, mileage will be paid at the rate of reimbursement for State of Oregon classified employees. Costs incidental to mileage, such as parking fees, also will be paid. For workers receiving temporary total disability or equivalent income, private car mileage will be paid only for mileage in excess of the miles the worker traveled to and from work at the time of injury. Mileage payment in conjunction with moving expenses will be allowed only for one vehicle and for a single one-way trip. To receive reimbursement for private car mileage, the worker must provide the insurer with a copy of the driver's valid driver's license and proof of insurance coverage.

(b) Meals and lodging, overnight travel. For overnight travel, meal and lodging expense will be reimbursed at the rate of reimbursement for State of Oregon classified employees.

(c) Special travel costs. Payment will be made in excess of the amounts specified in this section when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds prevailing costs in the travel area are substantially higher than average.

(4) Tools and equipment for training or employment. Payment is limited to items identified as mandatory for the training or initial employment, such as starter sets. Purchases will not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker possesses.

(5) Moving expenses. Payment is limited to workers with employment or training outside reasonable commuting distance. In determining the necessity of paying moving expenses, the insurer may consider the availability of employment or training which does not require moving, or which requires less than the proposed moving distance. Payment is limited to moving household goods weighing not more than 10,000 pounds. If necessary, payment includes reasonable costs of meals and lodging for the worker's family and mileage pursuant to subsection (3)(a) of this rule.

(6) Second residence allowance. The purpose of the second residence is to enable the worker to participate in training outside reasonable commuting distance. The allowance must equal the rental expense reasonably necessary, plus not more than $200 a month toward all other expenses of the second residence, excluding refundable deposits. In order to qualify for second residence allowance, the worker must maintain a permanent residence.

(7) Primary residence allowance. This allowance is applicable when the worker must change residence for training or employment. Payment includes the first month's rent and the last month's rent only if required prior to moving in.

(8) Medical examinations and psychological examinations for conditions not related to the compensable injury when necessary for determining the worker's ability to participate in vocational assistance.

(9) Physical or work capacities evaluations.

(10) Living expense allowance during vocational evaluation. Payment is limited to workers involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not receiving temporary disability payments. The worker will not be barred from receiving a living expense allowance if the worker is unable to

participate five hours daily because of limitations caused by the injury. Payment must be based on the worker's temporary total disability rate if the worker's claim were reopened.

(11) Work adjustment, on-the-job evaluation, or situational assessment cost(s).

(12) Membership fees and occupational certifications, licenses, and related testing costs. Payment under this category is limited to $500.

(13) Clothing required for participation in vocational assistance or for employment. Allowable purchases do not include items the trainer or employer would provide or the worker possesses.

(14) Child or disabled adult care services. These services are payable when required to enable the worker to participate in vocational assistance at rates prescribed by the State of Oregon's Department of Human Services. For workers receiving temporary total disability compensation or equivalent income, these costs will be paid only when in excess of what the worker paid for such services at the time of injury, adjusted using the cost-of-living matrix.

(15) Dental work, eyeglasses, hearing aids and prosthetic devices. These are not related to the compensable injury and enable the worker to obtain suitable employment or participate in training.

(16) Dues and fees of a labor union. Payment will be limited to initiation fees, or back dues and one month's current dues.

(17) Vehicle rental or lease. There is no reasonable alternative enabling the worker to participate in vocational assistance or accept an available job. The worker must provide the insurer with proof of a valid driver's license and insurance coverage. Payment under this category is limited to $1,000.

(18) Any other direct worker purchase the insurer considers necessary for the worker's participation as described in the introductory paragraph of this rule. Payment under this category is limited to $1,000.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0087; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0720
Fee Schedule and Conditions for Payment of Vocational Assistance Costs

(1) The director has established the following fee schedule for professional costs and direct worker purchases. The schedule sets maximum spending limits per claim opening for each category; however, the insurer may spend more than the maximum limit if the insurer determines the individual case so warrants. Spending limits are to be adjusted annually, effective July 1. The annual adjustment is based on the conversion factor described in OAR 436-120-0005(2) and published with the cost-of-living matrix.

(2) For workers found to have an exceptional disability or exceptional loss of earning capacity as defined in OAR 436-120-0440 the fee schedule spending limits for the Training category and DE/Training Combined category listed below must be increased by 30%.

(3) Amounts include professional costs, travel/wait, and other travel expenses: [Table not included. See ED. NOTE.]

(4) Wage reimbursement for on-the-job training contracts are not covered by the fee schedule.

(5) Services and direct worker purchases provided after eligibility ends to complete a plan or employment is subject to the maximum amounts in effect at the time of closure.

(6) The insurer must pay, within 60 days of receipt, the vocational assistance provider's billing for services provided under the insurer-vocational assistance provider agreement. The insurer must not deny payment on the grounds the worker was not eligible for the assistance if the vocational assistance provider performed the services in good faith without knowledge of the ineligibility.

(7) An insurer entitled to claims cost reimbursement pursuant to OAR 436-110 for services provided pursuant to OAR 436-120 is subject to the following limitations:

(a) Optional services are not reimbursable.

(b) The insurer must obtain the director's approval in advance for any (waiver of the provisions of OAR 436-120).

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340 & 656.258
Hist.: WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0120, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88 ; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0070 & 436-120-0215; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0755
Reimbursement of Vocational Assistance Costs from the Workers' Benefit Fund

(1) The director will reimburse the insurer or self-insured employer for costs associated with providing vocational benefits when:

(a) The director issues an order overturning the insurer's or self-insured employer's denial of vocational benefits; and

(b) The insurer's or self-insured employer's denial is later upheld by a final order.

(2) To receive reimbursement from the Workers' Benefit Fund, the insurer or self-insured employer must provide the division with the following documentation, within one year from the date of the final order:

(a) Injured worker's name and Workers' Compensation Division's claim file number;

(b) Date and order number of the director's order appealed;

(c) Itemized listing with dates of service for all costs incurred after the date of the director's order that was reversed. All costs, in order to be reimbursed, must meet all conditions set forth in OAR 436-120, and reimbursement requests must:

(A) Use terms, "direct employment" or "training" to show the category of vocational assistance provided;

(B) List vocational provider costs by category of "professional services";

(C) List direct worker purchases by the categories in OAR 436-120-0710, to include purchase dates and costs;

(D) Show temporary total disability paid between the start and end dates of the return to work plan; and

(E) List any other costs incurred in providing vocational benefits as a result of the order that was appealed.

(d) Signed certified statement that the requested reimbursement amount was actually paid; and

(e) The insurer's or self-insured employer's name and address where reimbursement is to be sent.

(3) The director may require additional information to clarify and process a reimbursement request.

(4) No reimbursement is allowed for the insurer's administrative costs.

Stat. Auth.: 656.726(4)
Stats. Implemented: ORS 656.313, 656.605, OL 2005, Ch. 588, sec. 4 & 5
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06

436-120-0800
Authorization of Vocational Assistance Providers

(1) A vocational assistance provider must be authorized by the director under this rule.

(2) A vocational assistance provider must submit an application which includes the following:

(a) A description of the specific vocational services to be provided and verification of staff certifications pursuant to these rules;

(b) The plan for supervising and training staff; and

(c) Evidence of compliance with applicable state and federal requirements.

(3) The director may approve or deny authorization based on the completed application and the department's certification records.

(a) The authorization will specify the scope of authorized vocational services as determined by the vocational assistance provider's staff certifications.

(b) Vocational assistance providers whose authorization is denied under this rule may appeal as described in OAR 436-120-0008.

(4) An authorized vocational assistance provider must:

(a) Notify the division within 30 days of any changes in office address, telephone number, contact person or staff, and update the roster of certified staff which includes staff certification numbers.

(b) Adequately train and supervise certified staff; and

(c) Provide each certified staff person with department rules, bulletins, and other information, as provided by the director.

(d) The vocational assistance provider must maintain the worker's vocational assistance files for four years after the end of vocational assistance with that vocational assistance provider, or in a pre-1986 case, for five years after the end of vocational assistance with that provider.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 8-1981(Admin) (Temp), f. 12-31-81, ef. 1-1-82; WCD 9-1982(Admin), f. 5-28-82, ef. 6-1-82; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0180, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-061-0200 & 436-120-0203; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0810
Certification of Individuals

Individuals determining workers' eligibility and providing vocational assistance must be certified by the director and on the staff of an authorized vocational assistance provider, insurer, or self-insured employer.

(1) An applicant for certification must submit an application, as prescribed by the director, demonstrating the qualifications for the specific classification of certification as described in OAR 436-120-0830.

(2) Department certification is not required to perform work evaluations, but the work evaluator must be certified by the professional organizations described in OAR 436-120-0410(2).

(3) The director may approve or disapprove an application for certification based on the individual's application.

(a) Certification will be granted for five years. A vocational counselor who is nationally certified as described in OAR 436-120-0830(1)(a) will be granted an initial certification period to coincide with their national certification.

(b) Individuals whose certification is denied under this rule may appeal as described in OAR 436-120-0008.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0205; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 6-2005, f. 6-9-05, cert. ef. 7-1-05; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0820
Renewal of Certification

(1) A certified individual must renew their certification every five years by submitting the following documentation to the director no later than 30 days prior to the end of their certification period:

(a) Current certification by the Commission on Rehabilitation Counselor Certification (CRCC) or the Commission for Case Managers Certification (CCMC) or the Certification of Disability Management Specialists Commission (CDMSC); or

(b) Verification of a minimum of 60 hours of continuing education units pursuant to this rule within the five years prior to renewal. At least seven and one-half hours must be for training in ethical practices in rehabilitation counseling.

(2) The department will accept continuing education units for training approved by the CRCC, CCMC or the CDMSC; courses in or related to psychology, sociology, counseling, and vocational rehabilitation, if given by an accredited institution of higher learning; training presented by the department pertaining to OAR 436-120, 436-105, and 436-110; and any continuing education program certified by the department for vocational rehabilitation providers. Sixty minutes of continuing education will count as one unit, except as noted in section (3) of this rule.

(3) In the case of college course work, the department will grant credit only for grades of C or above and will multiply the number of credit hours by six to establish the number of continuing education units.

(4) Failure to meet the requirements of this section will cause an individual's certification to expire. Such an individual may reapply for certification upon completion of the required 60 hours of continuing education.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0830
Classification of Vocational Assistance Staff

Individuals providing vocational assistance will be classified as follows:

(1) Vocational Rehabilitation Counselor certification allows the individual to determine eligibility and provide vocational assistance services. Vocational Rehabilitation Counselor certification requires:

(a) Certification by the following national certifying organizations: Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC);

(b) A master's degree in vocational rehabilitation counseling and at least six months of direct experience;

(c) A master's degree in psychology, counseling, or a field related to vocational rehabilitation, and 12 months of direct experience; or

(d) A bachelor's or higher degree and 24 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree.

(2) Vocational Rehabilitation Intern certification allows an individual who does not meet the requirements for certification as a Vocational Rehabilitation Counselor the opportunity to gain direct experience. Vocational Rehabilitation Intern certification requires a master's degree in psychology, counseling, or a field related to vocational rehabilitation; or a bachelor's degree and 12 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree. The Vocational Rehabilitation Intern certification is subject to the following conditions:

(a) The intern must be supervised by a certified Vocational Rehabilitation Counselor who must co-sign and assume responsibility for all the intern's eligibility determinations, return-to-work plans, vocational and billing reports.

(b) When the intern has met the experience requirements, the intern may apply for certification as a Vocational Rehabilitation Counselor.

(3) Return-to-Work Specialist certification allows the person to provide job search skills instruction; job development; return-to-work follow-up and labor market survey; and to determine eligibility for vocational assistance, except where such determination requires a judgment as to whether the worker has a substantial handicap to employment. This certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, education, a human services related field, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-month basis. To conduct only labor market research and/or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

(4) To meet the direct experience requirements for Vocational Rehabilitation Counselor, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (A) through (J) of this subsection for the required number of months, with at least six months of the experience in one or more of functions listed in paragraphs (A) through (D) of this subsection. The qualifying job functions are:

(A) Return-to-work plan development and implementation;

(B) Employment counseling;

(C) Job development;

(D) Early return-to-work assistance which must include working directly with workers and their employers;

(E) Vocational testing;

(F) Job search skills instruction;

(G) Job analysis;

(H) Transferable skills assessment or employability evaluations;

(I) Return-to-work plan review and approval; or

(J) Employee recruitment and selection for a wide variety of occupations.

(5) To meet the direct experience requirements for Vocational Rehabilitation Intern or Return-to-Work Specialist, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule for the required number of months.

(6) To receive credit for direct experience, the individual must:

(a) Perform one or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule at least 50 percent of the work time for each month of direct experience credit. Qualifying job functions performed in a job which is less than full time will be prorated. For purposes of this rule, full time will be 40 hours a week. An individual will not receive credit for any function performed less than 160 hours.

(b) Provide any documentation required by the director, including work samples. The director may also require verification by the individual's past or present employers.

(7) All degrees must be from accredited institutions and documented by a copy of the transcript(s) with the application for certification.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0205; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0840
Professional Standards for Authorized Vocational Assistance Providers and Certified Individuals

(1) Authorized vocational assistance providers and certified individuals must :

(a) Determine eligibility and provide assistance in an objective manner not subject to any conditions other than those prescribed in these rules;

(b) Fully inform the worker of the categories and kinds of vocational assistance pursuant to OAR 436-120 and reemployment assistance pursuant to OAR 436-110;

(c) Document all case activities in legible file notes or reports;

(d) Provide only vocationally relevant information about workers in written and oral reports;

(e) Recommend workers only for suitable employment;

(f) Fully inform the worker of the purpose and results of all testing and evaluations and

(g) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Authorized vocational assistance providers and certified individuals must not:

(a) Provide evaluations or assistance if there is a conflict of interest or prejudice concerning the worker;

(b) Enter into any relationship with the worker to promote personal gain, or the gain of a person or organization in which the vocational assistance provider or certified individual has an interest;

(c) Engage in, or tolerate, sexual harassment of a worker. "Sexual harassment" means deliberate or repeated comments, gestures or physical contact of a sexual nature;

(d) Violate any applicable state or federal civil rights law;

(e) Commit fraud, misrepresent, or make a serious error or omission, in connection with an application for authorization or certification;

(f) Commit fraud, misrepresent, or make a serious error or omission in connection with a report or return-to-work plan, or the vocational assistance activities or responsibilities of a vocational assistance provider under OAR chapter 436;

(g) Engage in collusion to withhold information, or submit false or misleading information relevant to the determination of eligibility or provision of vocational assistance;

(h) Engage in collusion to violate these rules or other rules of the department, or any policies, guidelines or procedures issued by the director;

(i) Fail to comply with an order by the director to provide specific vocational assistance, except as provided in ORS 656.313; or

(j) Instruct any individual to make decisions or engage in behavior which is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.313, 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0207; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0900
Audits, Penalties and Sanctions

(1) Insurers and employers at injury must fully participate in any department audit, periodic program review, investigation or review, and provide records and other information as requested.

(2) If the director finds the insurer or employer at injury failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director.

(b) Recovery of reimbursements.

(c) Denial of reimbursement requests.

(d) An insurer or employer may be assessed a civil penalty under ORS 656.745 for any violation of statutes, rules, or orders of the director.

(3) In determining the amount of a civil penalty to be assessed the director may consider:

(a) The degree of harm inflicted on the worker;

(b) Whether there have been previous violations or warnings; and

(c) Other matters as justice may require.

(4) Pursuant to ORS 656.447, the director may suspend or revoke an insurer's authority to issue guaranty contracts upon determination that the insurer has failed to comply with these rules.

Stat. Auth.: ORS 656.340 & 656.726(4)
Stats. Implemented: ORS 656.340, 656.447 & 656.745(1) & (2)
Hist.: WCD 4-1981, f. 12-4-81, ef. 1-1-82; WCD 2-1983, f. 6-30-83, ef. 6-30-83; WCD 5-1983, f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0981, 5-1-85; WCD 7-1985, f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, eff. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0255 & 436-120-0270; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

436-120-0915
Sanctions of Authorized Vocational Assistance Providers and Certified Individuals

(1) Vocational assistance providers and certified individuals must fully participate in any department audit, periodic program review, investigation or review, and provide records and other information as requested.

(2) If the director finds any authorized vocational assistance provider or certified individual failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director.

(b) Probation, in which the department systematically monitors the vocational assistance provider's or individual's compliance with OAR 436-120 for a specified length of time. Probation may include the requirement an individual receive supervision, or successfully complete specified training, personal counseling or drug or alcohol treatment.

(c) Suspension, which is the termination of authorization or certification to determine eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The vocational assistance provider or individual may reapply for authorization or certification at the end of the suspension period. If granted, the vocational assistance provider or individual will be placed on probation as described in subsection (2)(b) of this rule.

(d) Revocation, which is a permanent termination of authorization or certification to determine eligibility and provide vocational assistance to Oregon injured workers.

(3) The director will investigate violations of OAR 436-120 and may impose a sanction under these rules. Before issuing a suspension or revocation, the director will send a notice of the proposed action and provide the opportunity for a show-cause hearing. The process is as follows:

(a) The director will send by certified mail a written notice of intended suspension or revocation and the grounds for such action. The notice must advise of the right to participate in a show-cause hearing.

(b) The vocational assistance provider or individual has 10 days from the date of receipt of the notification of proposed action in which to request a show-cause hearing.

(c) If the vocational assistance provider or individual does not request a show-cause hearing, the proposed suspension or revocation will become final.

(d) If the vocational assistance provider or individual requests a show-cause hearing, the director will send a notification of the date, time and place of the hearing.

(e) After the show-cause hearing, the director will issue a final order which may be appealed as described in OAR 436-120-0008(3).

(4) For the purposes of section (3) "show-cause hearing" means an informal meeting with the director in which the vocational assistance provider or certified individual will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a vocational assistance provider or certified individual's authority to provide vocational assistance services to injured workers.

(5) The director may bar a vocational assistance provider or individual who has received a suspension or revocation under this rule from sponsoring or teaching continuing education programs.

Stat. Auth.: ORS 656.340(9) & 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, eff. 1-1-88; Renumbered from 436-120-0207, WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0850, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 8-2007, f. 11-1-07, cert. ef. 12-1-07

DIVISION 140

CONSTRUCTION CARVE-OUT PROGRAMS

436-140-0001
Authority for Rules

These rules are promulgated under the director's authority pursuant to ORS 656.726(4) and 656.174.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0002
Purpose

The purpose of these rules is to implement ORS 656.170 and 656.172, and to establish and provide procedures and requirements for the administration and enforcement of programs entered into under ORS 656.170 and 656.172.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0003
Applicability of Rules

(1) These rules shall be applicable on their effective date and thereafter to carry out the provisions of ORS 656.170 and 656.172.

(2) Notwithstanding sections 2 and 3, chapter 841, Oregon Laws 1999 (ORS 656.170 and 656.172), prior to January 1, 2002 the director may issue letters of eligibility to only two qualified unions for participation in an alternative dispute resolution system authorized under section 2 of the 1999 Act (656.170). The director may not issue letters of eligibility after January 1, 2002.

(3) These rules apply to parties to a collective bargaining agreement only insofar as and only to the extent that the agreement contains the provisions provided by ORS 656.170, has been approved by the director, and for which eligibility has been established under these rules.

(4) Except as otherwise provided by law, the provisions of ORS Chapter 656, OAR chapters 436, and 438 apply to programs entered into under these rules, unless the collective bargaining agreement expressly specifies otherwise.

(5) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0005
Definitions

For the purpose of these rules, unless the context requires otherwise:

(1) "Alternative dispute resolution system" means a process that exists outside the normal Workers' Compensation system to settle disputes arising from a workers' compensation claim.

(2) "Arbitration" means the hearing and determination of a case in controversy by an arbiter.

(3) "Collective bargaining representative" means a person who represents a union.

(4) "Construction carve-out program" means a program established pursuant to ORS 656.170 and 656.172 for either an alternative dispute resolution system or use of a list of medical service providers, or both, which the director has approved and for which eligibility has been established under these rules.

(5) "Director" means the Director of the Department of Consumer and Business Services, or the director's delegate for the matter.

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

(7) "Employer" is limited to a private employer, or group of employers, engaged in construction; construction maintenance; or activities limited to rock, sand, gravel, cement and asphalt operations; heavy duty mechanics; surveying; or construction inspection.

(8) "Employee" is limited to an employee of an employer defined by section (7) of this rule.

(9) "Insurer" includes "insurer," "guaranty contract insurer," and "self-insured employer" as defined by ORS 656.005.

(10) "Letter of eligibility" means a letter issued by the director under ORS 656.172(4) indicating that eligibility to participate in a construction carve-out program has been established under ORS 656.170 and 656.172.

(11) "Mediation" means the act or process of intervening between conflicting parties to promote reconciliation, settlement, or compromise.

(12) "Plan administrator" means the person responsible for administering the Construction Carve-Out Program.

(13) "Union" means a collective bargaining union that is recognized or certified as the exclusive bargaining representative of employees for an employer or group of employers.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0006
Administration of Rules

Any orders issued by the division in carrying out the director's authority under ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0008
Administrative Review

(1) If the director determines that a proposed construction carve-out program is not eligible, the director will issue a notice to the employer or collective bargaining representative.

(a) Under ORS 656.704(2), if the employer or collective bargaining representative disagrees with the notice, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the notice.

(b) OAR 436-001 applies to the hearing.

(2) If the director determines that the acts or omissions of a construction carve-out program justify suspension, the director may issue a notice of intent to suspend eligibility pursuant to OAR 436-140-0090 and schedule a hearing on the matter of suspension. The notice must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130. At a hearing on a notice of intent to suspend, the employer or collective bargaining representative must show cause why eligibility should not be suspended.

(a) If the director determines that the acts or omissions of the employer or collective bargaining representative justify suspension, the director may issue an order suspending eligibility. If the director determines that the acts or omissions of the employer or collective

bargaining representative do not justify suspension, the director shall issue an order withdrawing the notice.

(b) The order must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(c) If the employer or collective bargaining representative disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(d) OAR 436-001 applies to the hearing.

(3) If the director determines that the acts or omissions of a construction carve-out program justify revocation, the director may issue a notice of intent to revoke eligibility pursuant to OAR 436-140-0090. The notice must be served upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(a) The revocation shall become effective within 10 days after service of notice, unless within such period of time the employer or collective bargaining representative correct(s) the grounds for revocation to the satisfaction of the director or files a written request for hearing with the director.

(A) If the employer or collective bargaining representative request(s) a hearing, the director will set a date and time, and give at least 10 days' notice of the hearing. At hearing, the employer or collective bargaining representative must show cause why eligibility should not be revoked.

(B) Within 30 days after the hearing, the director shall issue an order affirming or withdrawing the revocation. The director shall serve a copy of the order upon the employer or collective bargaining representative as provided in OAR 436-140-0130.

(C) If the employer or collective bargaining representative disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(b) An emergency revocation issued pursuant to OAR 436-140-0090(5), is effective immediately. To contest the revocation, the employer or collective bargaining representative must file a request for hearing within 60 days of the mailing date of the order; the revocation shall remain in effect until the director orders otherwise. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172, 656.174, 656.704 & OL 2005, Ch. 26
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-140-0010
Qualifying

(1) An employer, group of employers or collective bargaining representative may not establish or continue to participate in a construction carve-out program under ORS 656.170 until the proposed program has been approved by the director and the director has issued a letter of eligibility. An application containing the information described in subsections (2) and (3) of this rule must be submitted to the director.

(2) The employer or group of employers must provide at least the following:

(a) Payroll records sorted by National Council on Compensation Insurance (NCCI) classification for one of the three years prior to the year in which the collective bargaining agreement takes effect.

(b) A proposed plan for the construction carve-out program, along with four copies, in which it is demonstrated how the proposed construction carve-out program will meet the requirements of ORS 656.170, 656.172, and these rules;

(c) A copy of the collective bargaining agreement;

(d) An estimate of the number of employees covered by the collective bargaining agreement;

(e) A copy of a valid license when that license is required of the employer or group of employers to conduct business in Oregon;

(f) A signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(g) The name, address, and telephone number of the contact person of the employer or group of employers;

(h) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement; and

(i) If applicable, a list of the names, addresses, and specialties of the medical service providers who will provide medical services under the construction carve-out program, together with appropriate evidence of any licensing, registration or certification requirements for that individual to practice. This list shall indicate which medical service providers will act as attending physicians.

(3) The collective bargaining representative must provide at least the following:

(a) A copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(b) The name, address, and telephone number of the contact person for the collective bargaining representative.

(4) Within 45 days of receipt of the information required by subsections (2) and (3), the director will notify the applicants that the program is or is not approved. A letter of eligibility will be issued if the program is approved. If the program is not approved, a notice will be issued. The notice will include the reasons the program is not approved and a notice of appeal rights under OAR 436-140-0008(1). The notice will be served upon the employer and/or collective bargaining representative as provided in OAR 436-140-0130.

(5) Upon issuance of a letter of eligibility, those provisions of the collective bargaining agreement or other documents entered into under ORS 656.170(1) are considered valid and binding, subject to the terms of the agreement.

(6) One in-state location shall be established where the construction carve-out program is administered and records are maintained.

(7) No construction carve-out program shall be approved that diminishes the entitlement of an employee to compensation as provided by ORS Chapter 656.

(8) No more than two unions may qualify for participation in a construction carve-out program. In establishing qualification, the director will process all applications in the order in which they are received.

(9) The employer, or group of employers, and collective bargaining representative shall meet the reporting requirements under OAR 436-140-0070 in order to continue to participate in a construction carve-out program.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0020
Alternative Dispute Resolution

(1) A construction carve-out program may establish and operate an alternative dispute resolution system governing disputes between employees, employers, and their insurers. Any such system may include, but not be limited to:

(a) Limitations on the liability of the employer while determinations regarding the compensability of an injury are being made;

(b) A method for resolving disputes involving compensability of injuries and the amount of compensation due for a compensable injury, medical services, and legal services;

(c) A method for payment of compensation for injuries incurred under the collective bargaining agreement, when the worker is no longer subject to the agreement; or

(d) Arbitration and mediation procedures.

(2) If a construction carve-out program establishes an alternative dispute resolution system, a dispute to which that system applies shall first be processed through that system before it is brought before another forum.

(3) The plan administrator shall provide a written summary of the alternative dispute resolution system process to all parties to a dispute, or upon request. The written summary shall include at least the following:

(a) The title, address, and telephone number of a contact person for the alternative dispute resolution system process;

(b) The types of disputes to which the alternative dispute resolution system will apply and the types of disputes, if any, to which the dispute resolution processes provided by ORS Chapter 656, OAR chapters 436, and/or 438 will apply;

(c) A description of the procedures and time frames at each level of the alternative dispute resolution system process; and

(d) A statement of the right of an aggrieved party to request review by the Workers' Compensation Board, and reference to the

applicable Board rules, after completion of the alternative dispute resolution system process.

(4) Written notification must be provided to all parties, including the worker's attorney if the worker is represented, when the alternative dispute resolution system receives a dispute for resolution and when the dispute resolution system issues any decision in that dispute. The notice shall inform the parties of the status of the dispute, and of the next level of the dispute resolution process.

(5) The time frame for resolution of a dispute by the alternative dispute resolution system, from date of receipt of a dispute until agreement or completion of the highest level of the system, including issuance of a final decision, shall not exceed 180 days without approval of all parties.

(6) The director may, at any time and/or upon request, issue an order to further the dispute resolution system process.

(7) The alternative dispute resolution system shall develop a record sufficient for any party to appeal a decision by the alternative dispute resolution system.

(8) An aggrieved party to any decision, order or award of compensation issued under the alternative dispute resolution system may request review by the Workers' Compensation Board in accordance with Chapter 656 and OAR chapter 438 after completion of the alternative dispute resolution system.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0030
Medical Services

(1) A construction carve-out program may establish a list of medical service providers that the parties agree is the exclusive source of all medical treatment provided under ORS Chapter 656.

(2) A construction carve-out program shall establish a method for access to medical services for workers no longer subject to the agreement when those injuries were sustained under the collective bargaining agreement.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0040
Compensation

Benefit amounts that exceed the statutory rates under ORS Chapter 656 shall not be subject to reimbursement from the Workers' Benefit Fund.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0045
Multiple Claims; Expiration or Termination of Collective Bargaining Agreement; Responsibility

(1) Disputes involving multiple claims when one or more of the claims are not subject to the collective bargaining agreement shall be resolved pursuant to ORS 656.307, 656.308, and OAR chapter 436.

(2) Upon expiration of the collective bargaining agreement without renewal, or after termination of any arrangement under ORS 656.170 and 656.172, the insurer is responsible for benefits and claims in accordance with the provisions of ORS Chapter 656 unless otherwise provided for under the agreement.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0050
Duties and Responsibilities of Employer

(1) An employer or group of employers that participates in a construction carve-out program shall comply with coverage requirements under ORS 656.017.

(2) The participating employer or group of employers shall report all claims made under the program to the insurer as with other claims.

(3) The participating employer or group of employers shall comply with the terms of the collective bargaining agreement and construction carve-out program.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0060
Insurer Duties and Responsibilities

(1) An insurer who contracts to provide coverage to an employer or group of employers under a construction carve-out program shall timely report claims made under the construction carve-out program to the director.

(2) The insurer shall provide benefits in accordance with the terms of the collective bargaining agreement and construction carve-out program.

(3) The insurer shall segregate all loss and payroll data for reporting and research purposes. Data shall be forwarded to the director upon request.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0070
Reporting Requirements

(1) In order to ensure the construction carve-out program continues to comply with the eligibility requirements of these rules, the employer, or group of employers, and collective bargaining representative shall:

(a) Upon renegotiation of the collective bargaining agreement, provide the director with a copy no less than 30 days before the agreement takes effect, including an estimate of the number of employees covered by the agreement; and

(b) On an annual basis, provide the director the following:

(A) A copy of a valid license when that license is required of the employer or group of employers to conduct business in Oregon;

(B) A signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(C) The name, address, and telephone number of the contact person of the employer or group of employers;

(D) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement;

(E) A copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(F) The name, address, and telephone number of the contact person for the collective bargaining representative.

(2) Upon request of the director, a construction carve-out program shall provide a listing by category of medical service providers, including provider names, specialty, Tax ID number, Oregon license number, business address and phone number. The listing shall include all health care providers participating in the construction carve-out program.

(3) Nothing in this rule limits the director's authority to require information as necessary to monitor compliance with these rules.

(4) The plan administrator and/or insurer may apply to the director for approval to modify forms or notices required by rule or bulletin. No modified form or notice shall be used without the director's prior approval.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0090
Suspension or Revocation

(1) Prior eligibility of a construction carve-out program may be suspended or revoked if any of the following occur:

(a) The director finds a serious danger to the public health or safety;

(b) The construction carve-out program fails to provide services under the terms of the collective bargaining agreement;

(c) The employer, or group of employers, collective bargaining representative, and/or insurer fails to comply with ORS Chapter 656, OAR 436-140, or orders of the director; or

(d) The employer, or group of employers, collective bargaining representative, and/or insurer submits any false or misleading information pertaining to the eligibility.

(2) The director shall provide written notice of intent to suspend or revoke eligibility.

(a) The notice shall:

(A) Describe generally the acts and the circumstances that would be grounds for suspension or revocation; and

(B) Advise of the right to a hearing in the case of revocation; and the date, time and place of the hearing in the case of suspension.

(b) The notice shall be served as provided in OAR 436-140-0130.

(3) The hearing shall be conducted as provided in OAR 436-140-0008.

(4) Suspension or revocation shall have the effect of removing director approval and eligibility of the construction carve-out program. A revoked program will have to re-apply for director approval and a letter of eligibility to be effective.

(5) Notwithstanding any other provision of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the eligibility of a construction carve-out program without opportunity for a hearing. The order must be served upon the employer and/or collective bargaining representative as provided in OAR 436-140-0130. Such order shall be final, unless the parties request a hearing. The process for review shall be as provided in OAR 436-140-0008.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0100
Monitoring/Auditing

(1) The director may conduct periodic audits of construction carve-out programs as necessary to ensure compliance with ORS 656.170, 656.172, and these rules.

(2) All records of a construction carve-out program shall be produced upon request of the director.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0120
Sanctions and Civil Penalties; Rule Violations

(1) Pursuant to ORS 656.745 any employer, group of employers, and/or insurer shall be subject to penalties if the director finds it in violation of OAR 436-140 or an order of the director. The penalty shall not be more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation.

(2) Any complaint alleging a violation of these rules shall be made in writing to the director. The complaint must:

(a) State the grounds for the alleged rule violation;

(b) Include the specific instances of the alleged rule violation;

(c) State the complainant's request for correction and relief; and

(d) Include sufficient documentation to support the complaint.

(3) If the director determines upon investigation that a rule violation has occurred, the director may issue penalties pursuant to ORS 656.745 and this rule.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

436-140-0130
Service of Orders

(1) An order or notice of the director shall include a notice of the party's appeal rights and shall be served upon the party when the director does any of the following:

(a) Notifies an applicant that a program is not approved pursuant to OAR 436-140-0010(4);

(b) Suspends or revokes eligibility of a construction carve-out program pursuant to OAR 436-140-0090; or

(c) Assesses a civil penalty under the provisions of OAR 436-140-0120.

(2) The director shall serve the order by delivering a copy to the party in the manner provided by Oregon Rules of Civil Procedure 7D(3), or by sending a copy to the party by certified mail with return receipt requested.

Stat. Auth.: ORS 656.726(4) & 656.174
Stats. Implemented: ORS 656.170, 656.172 & 656.174
Hist.: WCD 10-2000, f. 12-11-00, cert. ef. 12-15-00

DIVISION 150

WORKERS' BENEFIT FUND CLAIMS PROGRAM

436-150-0001
Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4) and section 6, chapter 974, Oregon Laws 2001.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0002
Purpose

The purpose of these rules is to establish guidelines for regulating, managing, and disbursing moneys in the Workers' Benefit Fund for the purpose of advancing funds to injured workers who have not received payment of compensation due from an insurer in default.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0003
Applicability of Rules

(1) These rules carry out the provisions of section 6, chapter 974, Oregon Laws 2001.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0005
Definitions

As used in OAR 436-150-0001 through 436-150-0040, unless the context requires otherwise:

(1) "Compensation," for the purposes of this program, means temporary and permanent disability due injured workers pursuant to ORS Chapter 656, and out-of-pocket expenses for injured workers in accordance with OAR 436-009-0025, such as prescription and mileage reimbursements. Compensation does not include amounts payable to providers, or benefits payable pursuant to claim settlements or claim disposition agreements.

(2) "Default" means an insurer has failed to make payments of compensation due injured workers pursuant to ORS Chapter 656 for which there is no dispute over the right of the worker to receive such compensation or the amount therein.

(3) "Director" means the director of the Department of Consumer and Business Services or the director's delegate for the matter.

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

(5) "Insurer" means a guaranty contract insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state.

(6) "Oregon Insurance Guaranty Association" or "OIGA" means the association created by ORS 734.550.

(7) "Paying Agency" means the insurer, or the insurer's authorized representative, responsible for paying compensation due under ORS Chapter 656.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0006
Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS Chapter 656 and these rules are considered orders of the director.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0008
Administrative Review

(1) Any party as defined by ORS 656.005, and including the Oregon Insurance Guaranty Association, aggrieved by a proposed order

or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

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

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

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

Stat. Auth.: ORS 656.445 & 656.726(4)
Stats. Implemented: ORS 656.445, 656,704, 656.740 & OL 2005, Ch. 26
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06

436-150-0010
Criteria for Eligibility

(1) In order for the director to authorize expenditures from the Workers' Benefit Fund Claims Program there must be:

(a) Verification from an authority from the insurer's state of domicile that the insurer responsible for payment of compensation is in default, such as a notice of voluntary or involuntary rehabilitation, conservatorship, or other information indicating the insurer cannot or will not make payments of compensation; and

(b) An order of the director authorizing disbursements to injured workers from the Workers' Benefit Fund Claims Program. The order shall specify the qualifying claims, duration of payment obligation, and maximum expenditure limitation. The maximum expenditure limitation may not exceed the amount of securities on deposit for the insurer pursuant to ORS 731.628.

(2) When expenditures are authorized pursuant to section (1) of this rule, the paying agency shall provide the director with sufficient information, as specified in OAR 436-150-0030(2), to enable the director to advance funds to eligible injured workers.

(3) To be eligible for payment under the program:

(a) Compensation must be due and payable pursuant to ORS Chapter 656; and

(b) There must be an effective guaranty contract or record of insurance policy on file with the director by the insurer covering the employer on the date of injury.

(4) Payments to eligible injured workers in accordance with these rules shall be applied toward the insurer's payment obligations under ORS Chapter 656 and will be deducted from compensation due, pursuant to ORS 734.570.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0020
Limitation of Program

(1) Payment of compensation shall be limited to the amount of securities on deposit for the insurer pursuant to ORS 731.628 and only to the extent the monies are available in the Workers' Benefit Fund.

(2) Payments for individual claims shall be limited to compensation that becomes due and payable during the period of default.

(3) Notwithstanding any other provision of these rules, the director may, in the director's discretion, authorize additional benefits for specific claims in cases of extreme hardship.

(4) In the event of insufficient funds in the Workers' Benefit Fund, the director shall have final authority to determine an equitable distribution, which will proportionately distribute the available funds among the claims having qualified for reimbursement under the Program.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0030
Payment of Benefits

(1) Payment of compensation may be made by the director after receipt of documentation that compensation is due and payable.

(2) Documentation to support payment from the Workers' Benefit Fund Claims Program shall be submitted by the paying agent to include, but not be limited to:

(a) Insurer name, address, and policy number;

(b) Injured worker name, address, insurer claim number, Workers' Compensation Division claim number, and date of injury;

(c) Employer name and address;

(d) Amount, duration, and purpose of compensation due;

(e) Amounts payable for support pursuant to ORS 656.236, along with supporting documentation; and

(f) Any other information deemed necessary by the director.

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

436-150-0040
Accounting and Repayment of Payment of Benefits

(1) The director shall establish an account of record to monitor all expenditures and transactions relating to the Workers' Benefit Fund Claims Program and these rules. The accounting shall provide a detailed record of payments to each injured worker and the respective insurer responsible for the claim to include, but not be limited to, information as specified in OAR 436-150-0030(2).

(2) When the obligation to make payment of compensation is assumed by the Oregon Insurance Guaranty Association (OIGA) due to the insolvency of an insurer, the OIGA shall reimburse the Workers' Benefit Fund for all moneys advanced to injured workers for covered claims, as specified by OAR 734.510(4) and these rules. The OIGA shall reimburse the director within 60 days of receipt of sufficient information necessary to support the covered claims. All moneys received from the OIGA by the director shall be placed into the Workers' Benefit Fund.

(3) If an insurer defaults in its payments to injured workers, but later resumes its obligation to make payments, the insurer shall reimburse the director for any moneys paid to the injured worker. Such payment shall be in such amounts and at such intervals as prescribed by an order of the director. Failure of the insurer to comply with the order of the director may result in civil penalty pursuant to ORS 656.745.

(4) Any dispute over an amount owing the director in accordance with these rules shall be resolved pursuant to OAR 436-150-0008(2).

Stat. Auth.: Sec. 6, Ch. 974, OL 2001 & ORS 656.726(4)
Stats. Implemented: Sec. 6, Ch. 974, OL 2001
Hist.: WCD 12-2001, f. 12-7-01, cert. ef. 1-1-02

DIVISION 160

GENERAL PROVISIONS

436-160-0001
Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4).

Stat. Auth.: ORS 656.264 & 656.726(4)
Stats. Implemented: ORS 656.017, 656.407, 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0002
Purpose

The director's purpose is to allow certain workers' compensation filing or reporting via electronic data interchange.

Stat. Auth.: ORS 656.264 & 656.726(4)
Stats. Implemented: ORS 656.017, 656.407, 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0003
Applicability of Rules

(1) These rules apply to workers' compensation related transactions filed with the director via electronic data interchange on or after January 1, 2004.

(2) The director may, unless otherwise obligated by statute, waive any procedural rules in this rule division as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)

Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

Electronic Data Interchange

436-160-0004
Adoption of Standards

(1) For proof of coverage, the director adopts, by reference, IAIABC EDI Implementation Guide for Proof of Coverage, Release 2, dated May 1, 2002 including the definition of standards and procedures, unless otherwise provided in these rules.

(2) For medical bill data, the director adopts, by reference, IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, dated July 4, 2002, unless otherwise provided in these rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.264
Stats. Implemented: ORS 656.017, 656.407, 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0005
General Definitions

For the purpose of these rules, unless it conflicts with statute or rule:

(1) "ANSI" means the American National Standards Institute.

(2) "Conditional data element" means an element that becomes mandatory under certain conditions. Once mandatory, a conditional data element will cause a rejection of the transaction if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

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

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

(5) "Electronic Data Interchange" or "EDI" means a computer to computer exchange of information in a standardized electronic format.

(6) "Electronic Record" means information created, generated, sent, communicated, received, or stored by electronic means.

(7) "FEIN" means the federal employer identification number or other federal reporting number used by the insurer, insured, or employer for federal tax reporting purposes.

(8) "Header record" means the record that precedes each transmission for the purpose of identifying a sender, the date and time of the transmission, and the transaction set within the transmission.

(9) "IAIABC" means the International Association of Industrial Accident Boards and Commissions, a professional trade association comprised of state workers' compensation regulators and insurance representatives (www.iaiabc.org).

(10) "Information" means data, text, images, sounds, codes, computer programs, software, databases, or the like.

(11) "Industry code" means the code which indicates the nature of the employer's business, which is contained in the Standard Industrial Classification (SIC) manual published by the Federal Office of Management and Budget, or in the North American Industrial Classification System (NAICS) published by the U.S. Census Bureau.

(12) "Insurer" means workers' compensation insurance carrier providing coverage to an employer, or a self-insured employer.

(13) "Mandatory data element" means an element that will cause a rejection of a transaction if the data element is omitted or submitted in a format not capable of being processed by the division's information processing system.

(14) "Optional data element" means an element that an insurer should report to the director if the information is available to the insurer. Optional data elements will not cause a rejection if missing or invalid.

(15) "Proof of coverage" means an electronic record or set of records identifying an insurer as providing workers' compensation coverage for a specific employer.

(16) "Record" means electronic record.

(17) "Sender" means the person or entity reporting electronic data interchange transactions to the division. Sender may include vendors or insurers.

(18) "Trading partner agreement" means the agreement entered into pursuant to OAR 436-160-0020 between the director and an insurer to conduct transactions via EDI.

(19) "Trailer record" means the record that designates the end of a transmission and provides a count of transactions contained within the transmission, not including the header and trailer records.

(20) "Transaction" means a set of EDI records, defined according to standards in OAR 436-160-0004.

(21) "Transmission" means a defined set of transactions, including both header and trailer records to be sent to the division or sender via EDI.

(22) "Vendor" means an agent identified in a trading partner agreement to submit transmissions to the division on behalf of an insurer. Vendors may include service companies, third party administrators, and managing general agents.

Stat. Auth.: ORS 656.264, 656.726(4)
Stats. Implemented: ORS 84.004 & 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0006
Administration of Rules

Orders issued by the division in carrying out the director's authority to enforce ORS Chapter 656 are considered orders of the director.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0010
Security

(1) The sender will verify that an electronic signature, record, or performance is that of a specific person.

(2) The sender will utilize anti-virus software to eliminate any viruses on all electronic transmissions. The sender will maintain the anti-virus software with the most recent anti-virus update files from the software provider. The sender will notify the director immediately if a virus is detected.

Stat. Auth.: ORS 656.264 & 656.726(4)
Stats. Implemented: ORS 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0020
Trading Partner Agreement

(1) An insurer must enter into a trading partner agreement with the director before the division will begin testing with or accept production electronic transmissions from the insurer or from a vendor on behalf of that insurer.

(2) The trading partner agreement will include:

(a) A statement that the insurer will remain responsible and liable for all electronic records transmitted to the director;

(b) Transmission protocol between sender and director;

(c) A specific description of the form, format, and delivery of electronic transmissions pursuant to OAR 436-160-0004 and 436-160-0050;

(d) Specific identifying information for insurer, third party administrator, if any, and vendor, if any;

(e) Cost allocation of transactions, if any;

(f) The time frame for the director to submit acknowledgements of transmissions; and

(g) Any other necessary statements, conditions or requirements to facilitate EDI.

Stat. Auth.: ORS 656.264 & 656.726(4)
Stats. Implemented: ORS 84.013 & 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0030
Retention of Electronic Records

Insurers and self-insured employers must retain workers' compensation records pursuant to OAR 436-050-0120, 436-050-0220, and 436-009-0030. Records may be retained in electronic format if the records can be reproduced.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.455 & 731.475
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0040
Recognized Filing Date

(1) Unless otherwise stated in the trading partner agreement, an electronic record is sent when it:

(a) Is addressed or directed properly to an information processing system designated or used by the division to receive electronic records or information;

(b) Is in a form and format capable of being processed by that system; and

(c) Enters an information processing system outside the control of the sender or enters a region of the information processing system designated or used by the division and that is under control of the division.

(2) Unless otherwise stated in the trading partner agreement an electronic record is received when it:

(a) Enters an information processing system designated or used by the division to receive electronic records or information of the type sent and from which the division is able to retrieve the electronic record; and

(b) Is in a form and format capable of being processed by the division's information processing system.

(3) For the purpose of these rules, an electronic transaction is capable of being processed by the division's information processing system when all the required data elements are in the form and format specified in these rules, in the proper sequence, and in accordance with the terms of the trading partner agreement.

Stat. Auth.: ORS 656.264 & 656.726(4)
Stats. Implemented: ORS 84.013 & 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0050
Form, Format, and Delivery for Electronic Data Reporting

The form, format, and delivery of data elements and definitions will conform to the standards specified in OAR 436-160-0004, or as otherwise identified in the trading partner agreement.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 84.013 & 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0060
Testing Procedures and Requirements

(1) Proof of coverage testing:

(a) Each transmission for test purposes will conform to the standards specified in OAR 436-160-0004, or as otherwise identified in the trading partner agreement. Test files will be evaluated in terms of whether the data was sent in the correct, standardized format.

(b) To gain approval to send production transmissions, the sender must be able to:

(A) Transmit records via electronic data interchange; and

(B) Accomplish secure file transfer protocol uploads and downloads.

(c) To initiate a test for EDI, the sender must contact the director.

(d) The sender must demonstrate the ability to send transmissions to the director that are readable, in the correct format, and can be processed through the division's information processing system. A successful EDI test is determined by the resolution of any consistently recurring fatal technical errors identified by the division such that:

(A) Transmissions are sent to the director without errors in the header or trailer record;

(B) Transmissions are sent to the director without transaction level technical errors; and

(C) The sender can receive and process the automated EDI acknowledgement transaction.

(e) To move from test to production, the sender must achieve 90% accuracy for transactions sent for a minimum of three consecutive transmissions during the test (i.e. 90% of the transactions must have been accepted by the division and the sender has received a transaction accepted acknowledgement). The director will consider the sender's anticipated volume of production transactions to determine the number of transactions per test transmission required.

(f) Once approved, sender must maintain the accuracy as defined in subsections (d) and (e) of this section. Failure to meet technical requirements may result in the revocation of EDI transmission approval.

(g) The director will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in subsections (d) and (e) of this section during production.

(h) During the EDI test phase, insurer will continue to submit filings via paper. Once the sender becomes approved and moves into production, insurer will not submit same transaction filings via paper. If a problem occurs with EDI transmission during production, insurer may return to paper filing to meet statutory filing requirements until the problem is corrected.

(2) Medical bill data testing and transition to production:

(a) To initiate a test for EDI, the sender must contact the director.

(b) Each transmission for test purposes must conform to the standards specified in OAR 436-160-0004, or as otherwise identified in the trading partner agreement. Test files will be evaluated in terms of whether the data was sent in the correct, standardized format.

(c) To gain approval to send production transmissions, the sender must be able to:

(A) Transmit records via electronic data interchange; and

(B) Accomplish secure file transfer protocol uploads and downloads.

(d) The sender must demonstrate the ability to send transmissions to the director that are readable, in the correct format, and can be processed through the division's information processing system. A successful EDI FTP test is determined by the resolution of any consistently recurring fatal technical errors identified by the division such that:

(A) Transmissions are sent to the director without structural errors;

(B) Transmissions are sent to the director without transaction level technical errors; and

(C) The sender can receive and process the automated EDI acknowledgement transactions.

(e) To move from test to production, 80 percent of the sender's transactions must have been accepted by the division by the end of the testing period, allowing for corrected and resubmitted transactions. The director will consider the sender's anticipated volume of production transactions to determine the number of transactions per test transmission required.

(f) Once approved, sender must maintain the accuracy as defined in subsections (d) and (e) of this section. Failure to meet technical requirements may result in additional testing requirements.

(g) The director will inform the sender and insurer (if different) if accuracy standards for technical requirements fall below standards prescribed in subsections (d) and (e) of this section during production.

(h) During the EDI test phase, insurer will not be required to file the same medical bill data via Bulletin 220. If the test phase is not completed satisfactorily, as detailed in (e) above, the insurer may be required to submit data for the period covered by the unacceptable test via Bulletin 220 standard, and then complete a new EDI test.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 84.013 & 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0070
Electronic Signature

The sender's federal employer identification number (FEIN) plus its postal code as reported in the header record and stated in the trading partner agreement is the unique identifier that is the electronic signature for electronic data interchange.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 84.001 - 84.061 & 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0080
Acknowledgements

(1) Proof of Coverage:

(a) The director will respond to the sender with an electronic transaction accepted or transaction rejected acknowledgement of the insurer's transactions.

(b) The insurer must correct and resubmit any transactions rejected for which law or rule require filing, reporting, or notice to the director.

(2) Medical Bill Data:

(a) The sender will receive both functional and detailed electronic acknowledgements for each batch sent. The detailed acknowledgement will contain transaction accepted or transaction rejected acknowledgement of all of the insurer's transactions in the batch.

(b) The insurer must correct and resubmit any transactions rejected for which law or rule require filing, reporting, or notice to the director.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0090
Address Reporting

The sender will follow the standard United States Postal Service guidelines in reporting all addresses, as follows:

(1) The physical (street) address, or an attention line, must be in address line one. The attention line, if used, must be in line one.

(2) If the physical address is used in address line one, the mailing address may be used in address line two. If address line one was used as the attention line, then the physical (street) address must be in address line two.

(3) Physical (street) address and attention line must be on separate address lines.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

Proof of Coverage

436-160-0300
Proof of Coverage Definitions

(1) Unless otherwise provided in these rules, the definitions and standards identified in OAR 436-160-0004 and 436-160-0005 apply.

(2) For the purpose of OAR 436-160-0300 through 436-160-0360 "establishing documents" is a term used in the IAIABC EDI Implementation Guide for Proof of Coverage to denote certain transaction types. The establishing document transaction types listed in OAR 436-160-0350(2)(c) can be used to file a guaranty contract under that rule. In Oregon, a reinstatement, an add location, and an add employer transaction type can also be an establishing document. A change policy number transaction type is not an establishing document.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0310
Proof of Coverage Electronic Filing Requirements

(1) The chart in Appendix "A" shows all proof of coverage data elements accepted via EDI in Oregon, and whether the data element is mandatory (M), conditional (C), or optional (O) for each transaction type.

(2) Unless otherwise provided in these rules, the data elements shall have the meaning provided in the data dictionary pursuant to OAR 436-160-0004.

(3) Transactions will be rejected if mandatory or required conditional data elements are omitted or submitted in a format that is not capable of being processed by the division's information processing system designated for proof of coverage transactions.

(4) Optional data element(s) in a transaction will be ignored if the optional data element is either omitted, or submitted in a format that is not capable of being processed by the division's information processing system designated for proof of coverage transactions.

(5) Unless otherwise provided in these rules, an insurer approved for production transmissions will transmit proof of coverage via EDI, and will not submit like paper documents to the director except as provided in OAR 436-160-0340.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-160-0320
Proof of Coverage Acknowledgement

(1) The division will respond to transmissions submitted with either a transaction accepted or a transaction rejected acknowledgement.

(2) A transaction rejected acknowledgement will be sent for all transactions incapable of being processed by the division's information processing system, including, but not limited to:

(a) An omitted mandatory data element;

(b) An improperly populated data element field, e.g. numeric data element field is populated with alpha or alphanumeric data, or is not a valid value;

(c) Transactions or electronic records within the transaction which require matching and cannot be matched to the division's database;

(d) Illogical data in mandatory or required conditional field, e.g. termination date is before coverage effective date;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid triplicate code; or

(g) Illogical event sequence relationship between transactions, e.g. endorsement transaction submitted before a policy transaction is submitted.

(3) A transaction accepted acknowledgement will be sent for all transactions that are in a format capable of being processed by the division's information processing system and are not rejected pursuant to section (2) of this rule.

(4) An insurer's obligation to file proof of coverage for the purposes of this rule is not satisfied unless the director acknowledges acceptance of the transaction.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-160-0330
Proof of Coverage Effective Dates

(1) For all binder or new policy establishing document transactions submitted pursuant to OAR 436-160-0350, the coverage effective date will also be the guaranty contract effective date.

(2) For all other establishing document transactions that meet the guaranty contract filing requirements of OAR 436-160-0350, the transaction set type effective date will also be the guaranty contract effective date.

(3) For reinstatement transactions the transaction set type date will be a new guaranty contract effective date only if the transaction set type effective date is later than the expiration date of guaranty contract liability under ORS 656.427 as calculated by the division. If the transaction set type effective date is on or before the expiration date of guaranty contract liability, that guaranty contract will remain in effect as previously filed.

(4) For all other transactions, the effective date will be the transaction set type effective date.

(5) The policy expiration date submitted on a transaction does not terminate liability under a guaranty contract. Liability under a guaranty contract filed by an insurer continues until it is terminated pursuant to OAR 436-160-0360 and ORS 656.427.

(6) For reissue, renewal, reinstatement, or endorsement transactions, the transaction effective date will be the transaction effective date submitted by the insurer.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03

436-160-0340
Proof of Coverage Changes or Corrections

(1) Changes or corrections to proof of coverage information must be submitted pursuant to the standards referenced in OAR 436-160-0004.

(2) To report changes or corrections of an insured employer's name or address pursuant to ORS 656.419(4), or changes or corrections to other data elements, the insurer must transmit the appropriate transaction to specify what data is being changed or corrected.

(3) The insurer's policy number is used to assist in matching each transaction to the appropriate employer. When an insurer changes a policy number, the insurer must report that change with or prior to the next transaction submitted for that policy. Failure to report a change in the policy number will render future filings incapable of being processed by the division's information processing system and the insurer will receive a transaction rejected acknowledgement.

(4) If changing a partner name of an insured or employer does not change the entity, a new guaranty contract does not need to be filed.

(5) A transaction to change the effective date of coverage is capable of being processed by the division's information processing system

only if the new date does not create a lapse in coverage. To report a change to the effective date of coverage which results in a lapse, the insurer must submit transactions to terminate the current guaranty contract and file a new guaranty contract.

(6) To add or delete coverage for corporate officers, members of a limited liability company, partners, sole proprietors or other non-subject workers, the insurer must file written notice to the director listing the individual names as required by ORS 656.419.

(7) Transactions to change the wrap-up indicator, business market, assignment date, and professional employer organization (worker leasing company) indicator are not capable of being processed by the division's information processing system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.264 & 656.419
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-160-0350
Guaranty Contract Filing Requirements

(1) For the purpose of these rules, an electronic guaranty contract consists of an executed trading partner agreement containing the guaranty described in subsection (2)(a) of this rule, and an accepted proof of coverage insured and employer electronic record.

(2) To file a guaranty contract via EDI, an insurer must do all of the following:

(a) Enter into a trading partner agreement with the director pursuant to OAR 436-160-0020 that contains a statement of assumption of liability and guaranty of payment pursuant to ORS 656.419(1);

(b) Transmit an electronic record of the proof of coverage data elements identified as mandatory or required conditional pursuant to OAR 436-160-0310, including a unique FEIN for each legally distinct employer included in the establishing document transaction; and

(c) Transmit an establishing document transaction: binder, new policy, renew policy, rewrite/reissue policy, reinstatement, add location, add employer, or add jurisdiction. A renew policy, add location, or add employer transaction will only establish a guaranty contract if the data elements have not previously been transmitted, the employer FEIN is not a duplicate per section (3) below, and coverage for that unique employer FEIN has not been previously established by the reporting carrier. A reinstatement transaction will only establish a new guaranty contract if there is a lapse in coverage and the requirements of ORS 656.419 and OAR 436-160-0350 are otherwise met.

(3) A duplicate FEIN or a FEIN previously reported under the same policy will be recorded as an additional employer location and/or an assumed business name, but will not establish an additional guaranty contract.

(4) Reinstatement, rewrite, and reissue transaction types must follow a cancellation transaction.

(5) If an employer elects to include any non-subject worker(s) under coverage pursuant to ORS 656.419(2)(d), or subsequently to exclude such workers from coverage, the insurer must submit a transaction with a reason code for including or excluding a corporate officer, partner, member, sole proprietor, or any other person.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

436-160-0360
Guaranty Contract Terminations

(1) For the purposes of EDI, to terminate a guaranty contract when an insurer receives written notice of cancellation of coverage from an employer pursuant to ORS 656.423, the insurer must:

(a) Provide notice to the director no more than seven calendar days after the effective date of termination by transmitting the transaction type for cancellation by insured or nonrenewal by insured. The "transaction effective date" will be used to report the effective date of termination pursuant to ORS 656.427;

(b) Retain the employer's written notice for inspection by the division; and

(c) Provide written notice to the employer pursuant to ORS 656.427(1) and (3).

(2) For the purposes of EDI, to terminate a guaranty contract for any other reason, the insurer must:

(a) Provide notice to the director no more than seven calendar days after the effective date of termination by transmitting the transaction type for cancellation or nonrenewal pursuant to section (5) below; and

(b) Provide written notice to the employer pursuant to ORS 656.427(1) and (3).

(3) The date of termination must be included in the written notice to the employer to terminate a guaranty contract. For the purposes of notice to the director, the transaction effective date is the termination effective date.

(4) A delete location transaction can be used to notify the director that one or more locations for an employer are no longer workplaces of the employer. This transaction does not meet the requirements of ORS 656.427 for notice of termination.

(5) If the intent of an insurer is to terminate guaranty contract liability for all insureds under a policy, the insurer must use a cancellation or nonrenewal transaction type and must report all covered employers.

(6) Delete jurisdiction transactions are not capable of being processed by the division's information processing system and will result in a transaction rejected acknowledgement being sent to the sender.

(7) Failure to provide timely notice to the director of termination of an insurer's guaranty contract may result in civil penalties pursuant to ORS 656.745.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.419, 656.423 & 656.427
Hist.: WCD 3-2003, f. 3-18-03, cert. ef. 4-1-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04

Insurers' Obligation to Report Medical Bill Data

436-160-0400
Medical Bill Definitions

Unless otherwise provided in these rules, the definitions and standards identified in OAR 436-160-0004 and 436-160-0005 apply.

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist.: WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0410
Medical Bill Electronic Filing Requirements

(1) The chart in Appendix "B" shows all medical bill data elements accepted via EDI in Oregon, and whether the data element is mandatory (M), conditional (C), or optional (O) for each transaction type.

(2) Unless otherwise provided in these rules, the data elements must have the meaning provided in the data dictionary pursuant to OAR 436-160-0004.

(3) Transactions will be rejected if mandatory or required conditional data elements are omitted or submitted in a format that is not capable of being processed by the division's information processing system designated for medical bill transactions.

(4) Optional data element(s) in a transaction will be ignored if the optional data element is either omitted, or submitted in a format that is not capable of being processed by the division's information processing system designated for medical bill transactions.

(5) Unless otherwise provided in these rules, an insurer approved for production transmissions will transmit medical bill data via EDI, and will not submit the same medical bill data via Bulletin 220 proprietary format to the director.

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist.: WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0420
Medical Bill Acknowledgement

(1) The sender will receive both a functional acknowledgement and a detailed acknowledgement for each medical bill batch submitted. The detailed acknowledgement will indicate either a transaction accepted (TA) or a transaction rejected (TR) acknowledgement for each individual transaction.

(2) A transaction rejected acknowledgement will be sent for all transactions incapable of being processed by the division's information processing system, including, but not limited to:

(a) An omitted mandatory data element;

(b) An improperly populated data element field, e.g. numeric data element field is populated with alpha or alphanumeric data, or is not a valid value according to the standards adopted in 436-160-0004;

(c) Transactions or electronic records within the transaction which require matching and cannot be matched to the division's

database, e.g. cancellation of an original bill that does not match on Unique Bill ID;

(d) Illogical data in mandatory or required conditional field, e.g. service date is before date of injury;

(e) Duplicate transmission or duplicate transaction within the transmission;

(f) Invalid bill submission reason code; or

(g) Illogical event sequence relationship between transactions, e.g. cancellation transaction submitted before an original bill is submitted.

(3) A transaction accepted acknowledgement will be sent for all transactions that are in a format capable of being processed by the division's information processing system and are not rejected pursuant to section (2) of this rule.

(4) An insurer's obligation to file medical bill data for the purposes of this rule is not satisfied unless the director acknowledges acceptance of the transaction.

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist.: WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

436-160-0430
Medical Bill Data Changes or Corrections

(1) Changes or corrections to medical bill information must be submitted according to the standards referenced in OAR 436-160-0004.

(2) To report changes or corrections of an original bill, the insurer must first submit a cancellation of the original bill and then a replacement transaction with the corrected information.

(3) The Unique Bill ID will be used to match cancellations and replacements to the original bill. Failure to match on this data element will result in a rejected transaction.

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.264
Hist.: WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08

DIVISION 170

INDEPENDENT CONTRACTORS

436-170-0002
Purpose of Rule

The Landscape Contractors Board, Department of Revenue, Department of Consumer and Business Services, Employment Department, and Construction Contractors Board must adopt rules together to carry out ORS 670.600. 670.600 defines "independent contractor" for purposes of the programs administered by these agencies. This rule is intended to ensure that all five agencies apply and interpret ORS 670.600 in a consistent manner; to clarify the meaning of terms used in ORS 670.600; and, to the extent possible, to enable interested persons to understand how all five agencies will apply ORS 670.600.

Stat. Auth: ORS 656.726(4), 670.605
Stats. Implemented: ORS 316.162, 670.600
Hist.: WCD 1-2007, f. 1-30-07, cert. ef. 2-1-07

436-170-0100
Statutory Context

(1) ORS 670.600 generally establishes three requirements for "independent contractors." One requirement is that an "independent contractor" must be engaged in an "independently established business." Another requirement is related to licenses and certificates that are required for an "independent contractor" to provide services. A third requirement is that an "independent contractor" must be "free from direction and control over the means and manner" of providing services to others.

(2) The specific focus of this rule is the "direction and control" requirement. See ORS 670.600 for the requirements of the "independently established business" test and for licensing and certification requirements.

Stat. Auth: ORS 656.726(4), 670.605
Stats. Implemented: ORS 316.162, 670.600
Hist.: WCD 1-2007, f. 1-30-07, cert. ef. 2-1-07

436-170-0200
Direction and Control Test

(1) ORS 670.600 states that an "independent contractor" must be "free from direction and control over the means and manner" of providing services to others. The agencies that have adopted this rule will use the following definitions in their interpretation and application of the "direction and control" test:

(a) "Means" are resources used or needed in performing services. To be free from direction and control over the means of providing services an independent contractor must determine which resources to use in order to perform the work, and how to use those resources. Depending upon the nature of the business, examples of the "means" used in performing services include such things as tools or equipment, labor, devices, plans, materials, licenses, property, work location, and assets, among other things.

(b) "Manner" is the method by which services are performed. To be free from direction and control over the manner of providing services an independent contractor must determine how to perform the work. Depending upon the nature of the business, examples of the "manner" by which services are performed include such things as work schedules, and work processes and procedures, among other things.

(c) "Free from direction and control" means that the independent contractor is free from the right of another person to control the means or manner by which the independent contractor provides services. If the person for whom services are provided has the right to control the means or manner of providing the services, it does not matter whether that person actually exercises the right of control.

(2) Right to specify results to be achieved. Specifying the final desired results of the contractor's services does not constitute direction and control over the means or manner of providing those services.

Stat. Auth: ORS 656.726(4), 670.605
Stats. Implemented: ORS 316.162, 670.600
Hist.: WCD 1-2007, f. 1-30-07, cert. ef. 2-1-07

436-170-0300
Application of "Direction and Control" Test in Construction and Landscape Industries

(1) The provisions of this section apply to:

(a) Architects licensed under ORS 671.010 to 671.220;

(b) Landscape architects licensed under ORS 671.310 to 671.479;

(c) Landscaping businesses licensed under ORS 671.510 to 671.710;

(d) Engineers licensed under ORS 672.002 to 672.325; and

(e) Construction contractors licensed under ORS chapter 701.

(2) A licensee described in section (1) that is paying for the services of a subcontractor in connection with a construction or landscape project, will not be considered to be exercising direction or control over the means or manner by which the subcontractor is performing work when the following circumstances apply:

(a) The licensee specifies the desired results of the subcontractor's services by providing plans, drawings, or specifications that are necessary for the project to be completed.

(b) The licensee specifies the desired results of the subcontractor's services by specifying the materials, appliances or plants by type, size, color, quality, manufacturer, grower, or price, which materials, appliances or plants are necessary for the project to be completed.

(c) When specified by the licensee's customer or in a general contract, plans, or drawings and in order to specify the desired results of the subcontractor's services, the licensee provides materials, appliances, or plants, including, but not limited to, roofing materials, framing materials, finishing materials, stoves, ovens, refrigerators, dishwashers, air conditioning units, heating units, sod and seed for lawns, shrubs, vines, trees, or nursery stock, which are to be installed by subcontractors in the performance of their work, and which are necessary for the project to be completed.

(d) The licensee provides, but does not require the use of, equipment (such as scaffolding or fork lifts) at the job site, which equipment is available for use on that job site only, by all or a significant number of subcontractors requiring such equipment.

(e) The licensee has the right to determine, or does determine, in what sequence subcontractors will work on a project, the total amount of time available for performing the work, or the start or end dates for subcontractors working on a project.

(f) The licensee reserves the right to change, or does change, in what sequence subcontractors will work on a project, the total amount of time available for performing the work, or the start or end dates for subcontractors working on a project.

Stat. Auth: ORS 656.726(4), 670.605
Stats. Implemented: ORS 316.162, 670.600
Hist.: WCD 1-2007, f. 1-30-07, cert. ef. 2-1-07