

ORS 656.325 (1)(a),(f)
OAR 436-060-0095 Suspension Checklist

Chapter 436, Division 060, Claims Administration, effective January 1, 2006
FAILURE TO ATTEND OR TO COOPERATE WITH AN IME

Claimant _____ Claim Number _____

Claim status: _____Deferred _____Accepted _____Denied _____Partial Denial

IME APPOINTMENT LETTER

1. _____ IME examiner chosen from director's list *OAR 436-010-0265(1)*
2. _____ On insurer letterhead if party other than insurer schedules exam *0095(4)*
3. _____ Worker notified in writing; appointment notice sent at least 10 days prior *0095(5)*
4. _____ If represented, worker's attorney simultaneously notified in writing *0095(5)*
5. _____ Name of the examiner or the facility *0095(5)(a)*
6. _____ Statement of specific purpose of exam and identification of examiners' specialties
0095(5)(b)
7. _____ Date, time, and place of exam *0095(5)(c)*
8. _____ First and last name of Attending Physician (AP) or Authorized Nurse Practitioner (ANP) and verification AP or ANP is being informed of the exam at the very least by a copy of the appointment letter, OR a statement that there is no AP or ANP
0095(5)(d)
9. _____ If applicable, that the director has approved the examination *0095(5)(e)* *If not applicable, a statement to that effect would be appreciated*
10. _____ Reasonable costs for transportation and, if necessary, child care, meals, lodging, and other reasonable services will be reimbursed with receipts or other evidence provided
0095(5)(f)
11. _____ Offer advance of funds; a request must be made in sufficient time *0095(5)(f)*
12. _____ That an amount equivalent to net lost wages will be paid for absence from work if temporary disability is not received under ORS 656.210(4) *0095(5)(g)*
13. _____ 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 *0095(5)(h)*

14. _____ The boldface/prominent warning paragraph *0095(5)(i)*:

“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.”

15. _____ Include the following with the IME appointment notice sent to the worker *0095(6)*:

- A copy of a reimbursement request form *0095(6)(a)*
- director’s brochure “Important Information about Independent Medical Exams” *0095(6)(b)*
- Form 440-0858 “Worker Independent Medical Exam (IME) Survey *0095(6)(c)*

SUSPENSION REQUEST

1. _____ Copy of the suspension request, including all attachments, sent certified, registered, or by personal service to the worker *0095(8)*
2. _____ If represented, a copy of the suspension request, including all attachments, simultaneously sent certified, registered or by personal service to the worker's attorney *0095(8)*
3. _____ A statement that the insurer requests suspension of benefits pursuant to ORS 656.325 and OAR 436-060-0095 *0095(8)(a)*
4. _____ Identify the claim status and any accepted or newly claimed conditions *0095(8)(b)*
5. _____ Describe the worker's specific actions or inactions that prompted the request *0095(8)(c)*
6. _____ Dates of prior IMEs the worker has attended for the current open period of this claim and the names of examining physicians or facilities OR a statement that there have been no prior IMEs *0095(8)(d)*
7. _____ A copy of any approval given by the director OR a statement that approval was not necessary *0095(8)(e)*
8. _____ Any reason given by the worker or the worker's representative for failure to comply OR a statement that no reason has been provided *0095(8)(f)*

9. _____ The date and with whom the failure to comply was verified; (e.g. "On _____(date) _____(name) at _____(facility) verified the worker did not attend." OR "On _____(date) _____(insurer) received written verification from _____(worker or attorney) stating that the worker would not attend.") **0095(8)(g)**
10. _____ A copy of the IME notice of appointment letter and a copy of any written refusal to attend received from the worker or worker's attorney **0095(8)(h)**
11. _____ Any other supporting information **0095(8)(i)**
12. _____ The mandatory boldface or prominent notice to worker **0095(8)(j)**:

"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."