

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROPOSED OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 001**

PROCEDURAL RULES GOVERNING RULEMAKING AND HEARINGS

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Notice of Proposed Rulemaking Hearing**

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Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services, Workers' Compensation Division		OAR CHAPTER 436	
Agency and Division		Administrative Rules Chapter Number	
Fred Bruyns		(503) 947- 7717 Fax (503) 947-7581	
Rules Coordinator		Telephone	
PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879			
Address			
		Room 260 (2 nd floor), Labor & Industries Building	
January 22, 2004	2:00 p.m.	350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

NOTE: The hearing will convene at 2:00 p.m. and end when all present who have indicated their intention to testify have been called to present testimony. Written testimony will be accepted until 5:00 p.m., January 27, 2004 (must be received by the Workers' Compensation Division).

**The site of the hearing is accessible for individuals with mobility impairments.
Auxiliary aids for persons with disabilities are available upon advance request.**

RULEMAKING ACTION

ADOPT: 436-001-0300, 436-030-0023

AMEND: OAR chapter 436, divisions 001, 009, 010, 030, 060, and 120

REPEAL: OAR ~~436-001-0025~~, 436-001-0025, 436-001-0045, 436-001-0055, 436-001-0065, 436-001-0090, 436-001-105, 436-001-120, 436-001-0135, 436-001-0140, 436-001-0171, 436-001-0175, 436-001-0191, 436-001-0195, 436-001-0205, S436-001-0231, 436-001-0255, 436-001-0285, 436-001-0295, 436-010-0350, 436-030-0581, 436-060-0210, 436-120-0920

AMEND AND RENUMBER: OAR 436-030-0045 to 436-060-0018

ORS 656.726(4), 656.704

Stat. Auth.

ORS 183.335; OAR 137-001; OAR 436-001

Other Authority

ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)

Stats. Implemented

RULE SUMMARY

The agency proposes to amend these rules and replace temporary rules issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature:

- Senate Bill 233 changed the time frame for appeal of a proposed order or proposed assessment of civil penalty from 60 days following the party's receipt of notice to 60 days from the date the order is mailed by the department. Related proposed rule changes affect OAR 436-010, 436-030, and 436-120.
- Senate Bill 285 allows an insurer or self-insured employer to contest its Notice of Closure if it disagrees with the findings used to rate impairment, and OAR 436-030 has been revised accordingly.
- Senate Bill 620 requires payment of fees to workers' attorneys when a claimant prevails at the administrative level in certain medical and vocational disputes or when the attorney is instrumental in obtaining a settlement. This fee provision affects OAR 436-001, 436-009, 436-010, and 436-120.
- Senate Bill 914 eliminates the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim, and the director proposes to amend OAR 436-060 to require reporting within 14 days after acceptance or denial of the claim. Senate Bill 914 also clarified the statute regarding the department's obligation both to administer and pay supplemental disability benefits if the

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insurer or self-insured employer chooses to have the department do so, and related amendments are proposed to OAR 436-060.

- House Bill 2305 addresses how medical records may be released, consistent with the federal Health Insurance Portability and Accountability Act, and related changes are proposed to OAR 436-010 and 436-060.
- House Bill 3669 gives additional authority to nurse practitioners to treat injured workers and authorize temporary disability payments. Amendments are proposed to OAR 436-009, 436-010, 436-030, 436-060, and 436-120 to reflect this change. This bill was a result of legislative action after development of the legislative concepts by nurse practitioners and the Management Labor Advisory Committee.

In addition, these proposed rules:

436-001

- Update the rulemaking notice rule.
- Update the contested case rules to establish consistency with the Attorney General's Model Rules of Procedure applicable to hearings before the Office of Administrative Hearings, OAR 137-003. Because the model rules control, duplicative or inconsistent rules are proposed to be repealed. Remaining supplementary rules are updated. Significant changes include filing of hearing requests; delegation of authority to the ALJ; clarifications regarding scope of review; admissibility of reproductions of originals; attorney fee matrix to implement SB 620 (2003); and a new process for alternative dispute resolution.

436-009

- Adopt updated medical fee schedules.
- Incorporate data reporting requirements currently published in Bulletin 220.
- Add Group number nine to the fee schedule of Medicare ambulatory service center groups.
- Require insurers and self-insured employers to keep track of dates of receipt of medical bills.
- Provide that if a provider's usual and customary fee is excessive compared to similar providers, the director may determine a reasonable fee based on the usual and customary fee of similar providers.
- Increase the dollar amount of each conversion factor by 2.33%, based on the annual increase in the physicians' component of the consumer price index.
- Require electronic billings to include a "zz" modifier.
- Modify the definitions of first and second level physical capacity evaluations and of work capacity evaluation.
- Provide that pharmacy fees shall be paid at 85% of the Average Wholesale Price (AWP) – a reduction from 95% in the current rules -- with a \$10 dispensing fee – an increase from \$6.70 in the current rules.
- Provide that a brand name drug that has a generic equivalent will be reimbursed at the lesser of 85% of the AWP for the brand name or 85% of the average AWP for a generically equivalent drug, plus dispensing fee, unless the prescribing medical provider writes "Do not substitute" or similar phrase on the prescription.
- Provide that reimbursement for Oxycontin, Vioxx, Celebrex and Neurontin is limited to an initial 5-day supply unless the prescriber writes a clinical justification for the drug.

436-010

- Provide that a dispute may be resolved by agreement between the parties, and that the director may then issue a letter of agreement in lieu of an administrative order.
- Allow reimbursement to medical service providers such as physical therapists even if a physician fails to sign the required treatment plan within 30 days of starting treatment.
- Require that, except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are compensable for a maximum supply of 10 days.
- Require insurers to forward requested medical information to new attending physicians or authorized nurse practitioners within 14 days of a request.
- Require that the insurer forward a copy of the insurer medical examination report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt of the report.
- Require that the insurer 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.
- Delete the provision that allows an insurer or the director to request an examination to determine the extent of impairment.

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Notice of Proposed Rulemaking Hearing

436-030

- Prescribe the conditions under which a Notice of Closure may be corrected or rescinded by the insurer or self-insured employer.
- Move rule 0045, “Disabling/Nondisabling Reporting Requirements and Change in Status Determinations” to OAR 436-060.
- Clarify criteria for determination and periodic review of permanent total disability; define “withdrawn from the workforce”; require that preexisting disability be included in redetermination of permanent total disability status.
- Reorganize procedural requirements for reconsideration of the notice of closure.
- Require that medical arbiter panel requests be received within ten working days of the start of the reconsideration.
- Prescribe the conditions for submission of surveillance videotapes.
- Provide for a medical arbiter deselection process; if the claim qualifies for the process, each party may eliminate one physician from the list of arbiters provided by the director.
- Repeal the rule prescribing how the director issues penalty orders.

436-060

- Revise the requirements and limitations for release of medical information by the insurer.
- Adopt rule 0018, “Nondisabling/Disabling Reclassification (amended and renumbered from 436-030-0045); Requires the insurer to reclassify a non-disabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in rule 0018; simplifies related notification requirements.
- Require that if permanent partial disability is paid monthly, it be paid at 4.35 times the weekly temporary disability rate.
- Require the insurer to send a lump-sum application (for payment of a permanent partial disability award) to the worker or his or her attorney within five business days of a request.
- Clarify actions required if the worker cooperates after the insurer has requested suspension of benefits or if the worker documents that the failure to cooperate was reasonable.
- Require that notices of claim acceptance be copied to the worker’s representative and attending physician.
- Require a claim denial notice to include one of three specific statements if the denial was based in whole or in part on an insurer medical examination.
- Require that if the insurer receives medical bills after claim denial, it send a copy of the denial to the medical provider and explain the status of the denial.
- Require the insurer to pay for a worker requested medical examination that the worker fails to attend, but not for a subsequent examination unless the worker failed to attend the first exam for reasons beyond the worker’s control.
- Require that if claim responsibility is at issue, insurers share claim information without charge.
- Provide time frames for monetary adjustments among insurers.
- Provide for civil penalties if an insurer intentionally or repeatedly fails to give notice as required by ORS 656.331 and OAR 436-060-0015.

436-120

- Require the insurer to notify the worker in writing, within 14 days of a request for vocational assistance when the insurer is not required to determine eligibility.
- Refer vocational professionals to the *Oregon Wage Information* (OWI) publication in lieu of the *Oregon Automated Reporting System (OARS) Job Order Wage Report*, both published by the Oregon Employment Department. The OARS publication will no longer provide job/wage data effective 4/1/04. When using the OWI wage information data, the presumed standard shall be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate.
- Eliminate the requirement that vocational counselors sign statements that their eligibility determinations were based on substantial handicap assessments.
- Specify the conditions under which training may be terminated for failure to attend.
- State additional circumstances that require vocational eligibility to be redetermined.
- Provide that for workers found to have an exceptional disability or exceptional loss of earning capacity, certain fee schedule spending limits are increased by 30%.

**Oregon Administrative Rules, Chapter 436
Notice of Proposed Rulemaking Hearing**

- Increase the direct worker purchase training category fee schedule maximum by 10% due to state-wide tuition increases.
- Provide that 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.

Request for public comment:

The agency requests public comment on whether other options should be considered for achieving the rules' substantive goals while reducing the negative economic impact of the rules on business.

Address questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us Proposed rules are available on the Workers' Compensation Division's Web site: <http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules> or from WCD Publications at 503-947-7627 or fax 503-947-7630.

January 27, 2004
5 p.m.

Last Day for Public Comment

/s/ John L. Shilts December 15, 2003
Authorized Signer and Date

John L. Shilts, Administrator, Workers' Compensation Division
Printed name

*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

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

In the Matter of)	Statutory Authority,
The Amendment of:)	
OAR 436-001, Procedural Rules Governing Rulemaking and Hearings)	Statutes Implemented,
OAR 436-009, Oregon Medical Fee and Payment Rules)	Statement of Need,
OAR 436-010, Medical Services)	
OAR 436-030, Claims Evaluation, Determination, and Reconsideration)	Principal Documents Relied Upon,
OAR 436-060, Claims Administration)	Statement of Fiscal Impact
OAR 436-120, Vocational Assistance to Injured Workers)	

Statutory Authority: ORS 656.704, 656.726(4)

Other Authority: ORS 183.335; OAR 137-001; OAR 436-001

Statutes Implemented: ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)

Need for the Rule(s):

Rule revisions are needed to make permanent the changes implemented by temporary rules effective 1/1/04. The temporary rules were issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669. In addition, rule revisions are needed to effectively carry out existing workers' compensation laws: These changes were discussed with advisory committees comprised of people and organizations affected by the rules, and a number of the changes were made at the request of these committees, as well as other customers and stakeholders. Specific substantive changes are listed on the Notice of Proposed Rulemaking Hearing. A number of "housekeeping" changes are proposed. In general, substantive revisions are needed to:

- Carry out the director's duties to publish and update medical fee schedules under ORS 656.248.
- Establish time frames for certain actions required by statutes and rules.
- Require more thorough notification of medical providers and the injured worker regarding decisions and actions affecting the claim.
- Provide for a medical arbiter deselection process in reconsideration proceedings.
- Provide an alternative source of labor market information to be used in determining eligibility for vocational assistance.

Documents Relied Upon: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669; fiscal impact statement forms for SB 285, 620, and 914; advisory committee meeting minutes and audio tapes; issues documents, and medical cost analyses. These documents will be available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7810.

Fiscal and Economic Impact:

SB 233 and HB 2305, in so far as they affect these rules, should have no fiscal impact on any party.

SB 285 is expected to increase the number of reconsideration requests by about 4%, based on historical data. Most of these requests will include a medical arbiter examination. However, a downward trend in reconsideration requests means the net effect will be approximately a 1.7% increase, which will be absorbed by existing division resources. The fiscal impact on insurers and self-insured employers cannot be determined at this time, but may be slightly positive, since appeal will generally only be made if a party thinks it is in the party's financial interest to do so.

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Statement of Need and Fiscal Impact

SB 620-related rule changes will have a fiscal impact on insurers and self-insured employers, estimated to be \$500,000 to \$700,000 annually. Currently, the Workers' Compensation Division receives approximately 1,000 disputes (administrative reviews) per year. Workers prevail in nearly 50% of these, for which we estimate a \$1,000 attorney fee per case. There is a potential for fees to slightly increase the number of disputes. These dollars will flow to Oregon attorneys, the majority of whom are self-employed or employed by small businesses. The overall cost increase to the workers' compensation system would be about 0.1 to 0.2%.

SB 914-related rule changes should result in savings for insurers, self-insured employers, and the Workers' Compensation Division. Elimination of the reporting of "deferred" claims will reduce the number of documents that must be completed and filed. However, the extent of savings cannot be quantified at this time.

HB 3669 increased the authority of nurse practitioners to provide medical services and authorize temporary disability. This change should positively impact nurse practitioners. Medical payments to nurse practitioners will therefore not go to medical providers who can be attending physicians under Oregon law. We do not know how many workers will choose to treat with nurse practitioners, but we estimate any impact on other provider types will be small, and there should be no fiscal impact to the workers' compensation system as a whole.

The proposed 2.33% increase to the medical conversion factors would increase overall medical payments by between 1.0 and 1.2%. Based on actuarial analysis, expected reductions in other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates.

The proposed change in the pharmacy reimbursement formula and increased dispensing fee is projected to reduce insurers' and self-insured employers' pharmacy costs by at least 6%. Pharmacies, wholesalers, and manufacturers would therefore have decreased revenues equal to insurers' savings.

The proposed incentive to dispense generic drugs should reduce insurers' and self-insurers' costs slightly. Use of generics is already quite common, so savings for insurers and reduced revenues to brand-name manufacturers is expected to be minor.

The proposal to limit Oxycontin, Vioxx, Celebrex and Neurontin to an initial 5-day supply unless the physician provides a clinical justification is expected to reduce costs for insurers and self-insured employers. While these drugs represent approximately 13% of total prescriptions, they account for about 34% of total prescription payments. We do not know how many physicians will write clinical justifications or prescribe a suitable alternative medication. This change would result in reduced revenues for the manufacturers of these brand-name drugs.

The proposed requirements to notify medical providers of certain actions taken regarding claims would slightly increase insurers' and self-insured employers' administrative costs. However, during advisory meetings, insurer representatives told us that certain notifications are already common practice.

The increase in the direct worker purchase training category fee schedule maximum by 10% is estimated to cost insurers and self-insured employers an additional \$250,000 to \$375,000 annually. The change is proposed because tuition costs have risen sharply, e.g. community college costs rose 12% in the past year. The 30% increase allowed for workers with exceptional disabilities is expected to have a minor effect on costs because very few workers meet the criteria for exceptional disability.

Additional changes to these rules are expected to have no significant fiscal impact on any party.

Administrative Rule Advisory Committee consulted: Yes

October 16, 2003, November 3, 2003, November 17, 2003, November 18, 2003, November 21, 2003

/s/ John L. Shilts

December 15, 2003

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of Oregon)	
Administrative Rules, chapter 436, divisions:)	
001, Procedural Rules Governing Rulemaking and Hearings)	
009, Oregon Medical Fee and Payment Rules)	SUMMARY OF
010, Medical Services)	TESTIMONY AND
030, Claim Closure and Reconsideration)	AGENCY RESPONSES
060, Claims Administration)	
120, Vocational Assistance to Injured Workers)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to provide the Director with a record of the agency conclusions about the major issues raised.

The amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated January 1, 2004. On January 22, 2004 a public rulemaking hearing was held as announced at 2:00 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, Rules Coordinator, acted as presiding officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through 5:00 p.m. January 27, 2004.

The following individuals gave oral testimony on these rules at the public hearing:

Subject

Division	Testimony received from:
009	Dave Dery, P.T., Work Injury Management Association of Oregon
009	Mark Healy, O.T., Work Injury Management Association of Oregon
009	Cathy Zarosinski, Oregon Physical Therapy Association
009	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	Colleen Guido, Department of Consumer and Business Services, Workers’ Compensation Division
060	Jennifer Flood, Department of Consumer and Business Services, Workers’ Compensation Division

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

The following written testimony was received:

Subject	Exhibit #	Testimony received from:
Division		
NA	1	Testimony withdrawn at request of submitter
010	2	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009 & 010	3	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009	4	David Silver, M.D.
030	5	Rodger M. Hepburn, Attorney, Reinisch Mackenzie Healey Wilson & Clark, PC
009	6	Karen Elton-Walz, PT, MA, OCS, COMT, Therapeutic Associates; Central Oregon Physical Therapy
060	7	Jennifer Flood, Department of Consumer and Business Services, Workers' Compensation Division
060	8	Bradford A. Vinson, Attorney, Starr & Vinson, P.C.
009	9	Colleen Guido, Department of Consumer and Business Services, Workers' Compensation Division
009	10	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	11	Dave Dery, P.T., and Mark Healy, O.T., Work Injury Management Association of Oregon
009	12	Michael Casey, M.D.
120	13	Nyla L. Jebousek, Attorney
120	14	Robert J. Malone, CPDM, Vocational Unit Supervisor, Liberty Northwest Insurance
009, 010, 030, 060	15	Linda Jefferson, Oregon Self-Insurers Association
010	16	Nancy Bieber, Department of Consumer and Business Services, Information Management Division

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Summary of Public Testimony & Agency Responses**

009	17	Kevin C. Tribout, PMSI
009	18	Perry Lewis, Third Party Solutions
009	19	Tom Holt, Executive Director, Oregon State Pharmacists Association
001	20	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
030	21	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
060	22	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
120	23	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
009 & 010	24	Linda Olsen, Medical Audit Review Manager, SAIF Corporation
010	25	Morris D. Haney, DPDM, Operations Manager, WMCI Prime Evaluations
009	26	Gene Ogrod, M.D., CEO, Oregon Medical Association

The following is a summary of the testimony received and the agency’s responses to that testimony. If oral and written testimony were submitted by the same party, summarized oral testimony is listed separately only if and to the extent it differs from written testimony.

OAR 436-001-0155(1)

Testimony: Exhibit # 20

The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers’ Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): “. . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law.”

Response: We agree. Under ORS 656.726(4)(a), “Mailing date” determines timeliness.

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

OAR 436-001-0240(8)

Testimony: Exhibit # 20

Section (8) of this rule is superfluous. Although this matches the Workers' Compensation Board's requirements affecting document reproductions, it serves no purpose for the Workers' Compensation Division. At the board, all documents are submitted as a group. At the division, the insurer submits most documents as part of the initial review. This rule would require certification of the few additional documents submitted at hearing, and there is no reason for the distinction.

Response: We agree that this proposed requirement is unnecessary. The Workers' Compensation Division has not experienced problems with document reproductions. Section (8) will not be included the permanent rule.

OAR 436-001-0265(2)

Testimony: Exhibit # 20

Two additional factors should be considered in determining attorney fees:

- ‘“Attorney time devoted” shall be limited to those hours that a reasonable attorney, well-trained in workers' compensation law, would expend on the matter at issue.’
- ‘Proof of “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.’

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of “extraordinary circumstances” the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of \$10,000.

OAR 436-009-0004

Testimony: (Exhibit #3)

Widely used medical fee schedules take effect January 1st of each year. Medical providers and health insurers generally begin using them for services provided after that date. The Workers' Compensation Division has to adopt fee schedules via rule-making, and updated schedules become effective April 1st, causing a “gap” during which insurers and providers still use the “old” schedules only for injured workers. We propose that rule 0004 be permissive, allowing

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

providers to bill and insurers to pay, using current codes and schedules. This change will not have an effect until January 1, 2004, and any administrative or data collection issues can be addressed prior to that time.

Response: We agree this is a good idea, but believe there are logistical problems that we need to address before this can be done. By making it permissive, there can be disagreement about which codes to use, giving rise potentially to more disputes. In the event of a dispute, which set of standards apply? This is an issue we would like to explore with external advisors at more length prior to the next rule revisions, and leave as is for now.

OAR 436-009-0008

Testimony: (Exhibit #3)

We support the incorporation of the provisions of Senate Bill 620 (Ch. 756, OL2003) and approach for calculating appropriate attorney fees. However, the proposed revisions fail to include attorney fees for represented medical providers who prevail in a medical treatment or fee dispute with an insurer. Section 2 of SB 620 amends ORS 656.385(1) to allow the award of attorney fees to a claimant who prevails, not just a worker. If the Legislature had intended to limit attorney fees to a worker's attorney, it would use the word "worker," as it did elsewhere in the bill. The injured worker benefits if a represented medical provider prevails in a medical dispute; e.g. if a medical provider doesn't challenge an insurer's denial of palliative care (even though it is appropriate and the provider would prevail in a dispute), OAR 436-009-0015(1)(c) allows the provider to bill the worker.

Response: ORS 656.385, as revised by SB 620 refers solely to attorney fees paid to the claimant or the claimant's attorney. We believe the reference uses "claimant" to mean the injured worker. We do not believe the intent was to provide insurer-paid attorney fees to medical providers.

OAR 436-009-0008(1)(b), (2)(a), (2)(b), & (5)

Testimony: Exhibit # 24

All language regarding attorney fees associated with medical billing disputes must be stricken from the Division 009 rules. Senate Bill 620 does not provide authority to award attorney fees when medical fees are the subject in dispute. Division 009 is promulgated under the authority of ORS 656.248, and SB 620 does not refer to ORS 656.248, but only to ORS 656.245, 260, 327, and .340.

Response: We agree and will delete all references to attorney fees from this rule.

OAR 436-009-0008(2)(a)

Testimony: Exhibit #24

Proposed subsection (2)(a) states: "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." We do not send fee disputes to MCOs even if they have a dispute

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resolution process in place. It is our understanding that MCOs do not want to become involved in fee disputes. Providers and workers are already informed of their appeal rights with the director through the explanation of benefits they receive with payment. The proposed language should be deleted as it adds a layer of bureaucracy to a process that already works well.

Response: This concept is not new, but moved from (1)(c) of this rule and simplified. The purpose of the rule is to clarify the process that is current practice. While in general the rules require a party to first go through the MCO process, that is not a reasonable requirement if there is no MCO process. Other timelines and procedures then apply. If an insurer is notifying parties with the bill of their entitlement to appeal to the director, that already complies with the new rule, and does not add a layer of bureaucracy.

OAR 436-009-0008(4)(c)(A), (B), & (C)

Testimony: Exhibit #24

We appreciate the department's acknowledgement of the need to allow medical providers and insurers to resolve disputes without going through the formal dispute process. However, the rule states the director may revise the final agreement or reinstate the review under certain conditions. All issues should be addressed before the agreement becomes final. If the department's concern is that workers may not truly understand the process, limit the use of agreements to include insurers, providers, and workers who are represented. A final agreement is just that, final.

Response: We believe that the short list of conditions listed would require a reinstatement of the review except the provision that allows reinstatement if all parties agree. We believe that if all parties agree, the director should allow it. The others allow reinstatement if one or both parties fails to honor the agreement, the agreement becomes infeasible or it was based on a misrepresentation.

OAR 436-009-0010(3)(a)

Testimony: Exhibit #10

The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend this subsection accordingly. Also, delete the language that requests the provider's social security number and instead refer to the option of providing a federal tax reporting identification number.

Response: We will make this change.

OAR 436-009-0010(7)

Testimony: Exhibit #24

We recommend deletion of the second sentence of this section, that states in part that mere submission of the bill by the provider shall serve as warrant that the fee submitted is the provider's usual fee for the services provided. Inconsistent billing patterns may indicate unintentional mistakes or possibly fraud. The language of this rule would make a lack of knowledge defense by the provider difficult to make, when that may in fact be the case. If the

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department is concerned that insurers will not pay bills because they believe they don't represent the provider's usual fees, there is already a dispute process in place to address that concern. If the department is concerned insurers may misuse this rule, again, there is a process in place that can also result in penalties to insurers.

Response: We believe it is appropriate to expect medical providers to "warrant" that their bill is their usual and customary fee, and have had no complaints from medical providers that this is a potential problem for them.

OAR 436-009-0020(3)(b)(C) & (3)(j)

Testimony: Exhibit #24

This rule requires payment in full to out of state hospitals, and the wording of the rule even inhibits an insurer's ability to reimburse at the rate of that state. Out of state providers will not negotiate a lower fee when they know they must be reimbursed in full by the insurer. The rule should either be eliminated entirely or revised to say services will be paid as negotiated. If the concern is that the worker should not be billed for balances not paid by Oregon insurers, the rule should require a clause in the agreement stating that the worker will not be billed for the remaining balance for compensable services related to the workers' compensation claim.

Response: We are concerned about workers being burdened with balance billing if insurers are able to negotiate a lower price with the hospital, but also are concerned about making it difficult for insurers to control costs. This is a complex issue, and we will keep it on the issues document for the next rule revision process.

OAR 436-009-0030 Appendix A language:

Testimony: Exhibit #10

The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend the Appendix accordingly. Delete references to the provider's social security number and instead refer to the federal tax reporting identification number. See the testimony regarding OAR 436-009-0010(3)(a) for this exhibit number.

Response: We will make this change.

OAR 436-009-0030(9)(b)(B)

Testimony: Exhibit #24

The last sentence should end "ICD-9-CM diagnostic code" rather than procedure code.

Response: We will make this change.

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OAR 436-009-0030(9)(d)

Testimony: Exhibit #10

Revise the following sentence as shown: ~~Only~~ insurers transmitting data for more than one insurer may batch multiple insurer data files in one ~~file~~ transmission . . . “

Response: We will make this change.

OAR 436-009-0040(3)

Testimony: (Exhibit #3)

We support the revision to allow an insurer to dispute (under OAR 436-009-0008) a provider’s “usual and customary” fee as being unreasonably high; however, if the provider prevails, he or she should be able to recover reasonable attorney fees.

Response: Based on past experience, we believe there will be few cases where the provider’s usual and customary fee is found to be unreasonably high. Most fees are governed by the fee schedule, and this only applies for the relatively rare cases of “pay as billed,” and the insurer believes the provider’s charges are unreasonable compared to the industry as a whole. We do not believe the current statute has a provision for an award of attorney fees to medical providers.

OAR 436-009-0040(4)

Testimony: Exhibit #24

We are still concerned about the impact of much higher workers’ compensation conversion factors, when compared to healthcare factors, on employer medical and insurance costs. The consumer price index (CPI) relates to what consumers pay, not to what it costs to provide services. It appears you want to automatically apply the medical component of the CPI to the fee schedule each year. The statute requires more rigorous review prior to adjusting fees than to merely apply the CPI automatically without hearing or due process. Consider alternatives to the CPI; at least it should not be the sole determinant to changing the fee schedule each year.

The annualized average rate of increase in the CPI over the last 56 years is 5.3%. Since 1990 it is 3.9%. In only four of the last 56 years has the increase been less than the current 2.3%. Between 65% and 72% of medical dollars paid are subject to the conversion factors. We estimate the 2.3% increase will increase our medical costs by \$1.6 million dollars. If over the next four years the rate increase is at the average since 1990 (3.9%), at the end of 5 years, just due to the increase in the conversion factors, we will have an increase of \$13.45 per year.

The department’s fiscal impact statement said other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates. Our calculations don’t come close to offsetting payment of an additional \$1.6 million. The 6%+ savings projected based on proposed pharmacy changes appear to be based on the assumption that we reimburse pharmacies at the current rate of AWP minus 5% plus a \$6.70 dispensing fee. The assumption is incorrect. SAIF and the other major workers’ compensation carrier in Oregon use a Pharmacy Benefits Manager (PBM), and the rates we have negotiated with our pharmacies through the PBM are much more in line with the proposed reimbursement rates than the current rates.

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Response: By this current rule revision, we are simply increasing the conversion factor for this year only, for the first time in several years. Each year we will consider an adjustment based on an array of relevant factors. We do believe the increase will be offset by other cost drivers.

OAR 436-009-0040(4)

Testimony: (Exhibit #3)

We support the 2.33% increase in the conversion factors.

Response: We will include this provision in the permanent rules.

OAR 436-009-0070(2) & (3)

Testimony: Exhibit #9

“. . . by the attending physician” and “attending physician’s” were inadvertently deleted in the proposed rules. The deleted wording should be reinserted, as well as “or authorized nurse practitioner,” and thus make the wording match the temporary rule.

Response: We agree and will make the appropriate revisions.

OAR 436-009-0070(4) and (12)

Testimony: Exhibit # 6

See amended testimony submitted as Exhibit #11.

Response: NA

OAR 436-009-0070(4)(a) & (b)

Testimony: Exhibit #24

This rule should make it clear that additional time components should be billed only when multiple or additional body parts are reviewed. Some providers are confused on this issue.

Response: We agree, but believe the proposed language makes this clear.

OAR 436-009-0070(4)(a)

Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] **“This [first level PCE] is a limited evaluation to measure the musculoskeletal components of a specific body part as required for claim closure which are: AROM, motor power using 5/5, and 2 point discrimination.”**

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Response: The proposed rules incorporate these recommended changes, and the changes will be included in the permanent rules.

OAR 436-009-0070(4)(b)

Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “Additional 15 minute increments (~~per additional body part~~) ~~may be necessary to establish endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion)~~ **may be necessary to measure additional body parts, and/or establish endurance, and/or to project tolerances.**”

Response: This change was incorporated in the proposed rule and will be incorporated in the permanent rule.

OAR 436-009-0070(4)(c) & (d)

Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “**This [work capacity evaluation] is a PCE . . . with special emphasis on 1) the ability to perform essential physical function of the job, based on a specific job analysis as related to the accepted condition, 2) the ability to sustain activity over time and 3) the reliability of the evaluation findings. Other general evaluation information . . . may be included in accordance with requirements for claim closure. This level requires not less than 4 hours of actual claimant contact** [current rule wording requires not less than 6 hours]. **A record review is required before the evaluation begins.**”

Delete subsection (4)(d).

Response: Most of the concepts in this suggestion were incorporated in the proposed rules and will be incorporated in the permanent rules.

OAR 436-009-0070(12)

Testimony: Exhibit #9

The division inadvertently deleted “attending physician” from the table in this section (next to N0001/brief narrative). The deleted wording should be reinserted, as well as “or authorized nurse practitioner.” To be consistent, add to “complex narrative” (Code N0002), “by the attending physician or authorized nurse practitioner.”

Response: We will make the change.

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OAR 436-009-0070(12)

Testimony: Exhibit #11

We propose a price increase for physical capacity evaluations (PCEs). Clinics routinely have labor expenses above and beyond the identified evaluation contact time: 10 to 30 minutes authorization process, 15 minutes clerical support, 15-30 minutes of record review by therapist(s), 15-30 minutes of report time by therapist(s), and 15-30 minutes for clerical support to transcribe and mail the report. Under the current fee schedule, therapists perform PCEs for less money than a standard procedure when breaking it down into 15-minute billable units. We request the following fee increases:

Code 99196	First Level PCE	Increase Relative Value to 2.77
Code 99197	Second Level PCE	Increase Relative Value to 5.54
Code 99193	Additional 15 minutes	Increase Relative Value to 0.94

Response: The relative value units for these services were developed by a broad group of stakeholders, and reimbursement for these procedures will be increased by the across-the-board increase in the conversion factors. Any specific change to the relative value units or a particular conversion factor would need to be developed through a thorough interchange between various stakeholders.

OAR 436-009-0090

Testimony: Exhibit #4

Regarding the proposal to limit reimbursement for four drugs – Oxycontin, Vioxx, Celebrex, and Neurontin – to an initial 5-day supply unless the physician writes a clinical justification, this will create more paperwork for providers – in contrast to the goals of the Paperwork Reduction Taskforce, which was formed by the Workers’ Compensation Division a few years ago, in recognition of providers’ paperwork burdens.

“Clinical justification” is not defined. Who reviews it, the claims examiner? IMEs or file reviews about whether a patient should take a prescribed drug or a less expensive drug will result in more paperwork and expense to “justify the justification.”

Only changes in U.S. law can slow the increases in drug prices – pressuring providers to use less desirable drugs is not the answer. The four drugs listed represent improvements over alternatives in many situations. Before Neurontin was available, physicians prescribed carbamazepine, which can cause bone marrow failure, and now use of carbamazepine requires a complete baseline blood screening test and follow-up white blood counts. Celebrex and Vioxx are superior to alternatives in pre-operative patients, as they do not interfere with the effect of platelets on blood clotting. If we keep the list, Bextra, another cox-inhibitor, should be added to the list or it will likely be prescribed in place of Vioxx and Celebrex at no savings to the system (from addendum to Exhibit 4). The cost of Oxycontin is exorbitant. Its value is that it need only be taken twice per day. Some alternatives are less easily controlled, such as methadone, though long acting forms of morphine may be less expensive. It would be useful to provide cost information to providers.

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I recommend that the Department consider creating a program that would address the problem of drug costs that relies on clinical studies of comparative effectiveness of drugs and the education of practitioners. I suggest a Pharmacy Review Program, in which the cost and usage information from insurers is shared with a group of physicians, pharmacists, and workers. Publish cost summaries of frequently prescribed medications, along with the costs and suggested dose schedules for alternatives. I respectfully request that this rule not be enacted, and that a program which shares information about drug costs and alternatives be created.

See response to testimony below.

Testimony: Exhibit #12

The division does have an obligation to be concerned about the cost of medications. However, the proposed rule making reimbursement for (more than a five-day supply of) Oxycontin, Vioxx, Celebrex, and Neurontin contingent on the physician's clinical justification, implies that, unless there is a watchdog, physicians routinely prescribe medications that are not "clinically indicated." The only thing these drugs have in common is their cost. It would be more honest to use the term "unless economically indicated."

See response to testimony below.

Testimony: Exhibit #15

The proposed rule does not reflect the consensus of the Pharmacy Fee Advisory Task Force. The minutes from the final meeting show the group favored a dispensing fee somewhere between \$6.70 and \$8.70. Also, the meeting summary noted general support for limiting certain brand name, cost-driver medications to a three business day supply on the initial prescription, unless clinical justification is provided. We recommend in section (1): an \$8.70 dispensing fee; in section (2), a limit of a three-day supply of the named drugs (or a clinical justification) with the qualification "on the initial prescription," and, also in section (2), insertion of the word "generic" as follows: ". . . clinical justification for prescribing that drug [Oxycontin, Vioxx, Celebrex, or Neurontin] rather than a less costly **generic** drug with a similar therapeutic effect.

See response to testimony below.

Testimony: Exhibit #17

We oppose the reduction in the pharmacy reimbursement rate. We feel that the division did not examine the financial impact on the pharmacy provider who may be forced to fill prescriptions at a reimbursement rate below the provider's cost, or the cost savings role proper pharmacy care can provide, in the form of early return to work and fewer surgeries. Finally, we feel the division failed to fully examine the most detrimental impact, reduced worker access to quality pharmacy care, because workers' compensation pharmacy is purely voluntary for the pharmacy provider.

Workers' compensation pharmacy claims require more of a pharmacist's professional time and carry far greater risks than State Medicaid or Group Health prescriptions. In fact, most states today provide a higher reimbursement rate for workers' compensation prescriptions than are paid through Medicaid or Group Health.

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Our data shows that once a drug or drug ingredient exceeds \$33, the pharmacy begins to lose money on each prescription. Regardless of the proposed increase in the dispensing fee, the reduced reimbursement for the drug ingredient cost will cause pharmacists to lose money on many workers' compensation prescriptions. Pharmacy providers will be unwilling to lose money on high priced prescriptions and begin to withdraw from serving injured workers. California provides an example for Oregon. Effective 1/1/04, reimbursement for workers' compensation prescriptions was reduced to the MediCal rate (AWP – 10%). Several large pharmacy chains have stated that they no longer fill workers' compensation prescriptions. A recent study by the California Pharmacy Association Educational Foundation found that 65 percent of its members said that they would no longer fill workers' compensation prescriptions at the MediCal rate. Oregon has proposed an even more drastic cut that would cause greater access issues for Oregon. An NCCI October 2003 study found reducing fee schedule reimbursements to dangerously low levels would cause pharmacy access issues for injured workers.

Oregon already has one of the lowest reimbursement rates to pharmacists. Reducing reimbursement to the pharmacy does not control the underlying problem: the rising costs of prescription drugs. We suggest that the division look to other health care models and engage in practices that will help control the root problem of rising drug prices by: 1. Creating tighter controls on physician prescribing patterns, 2. Utilizing step therapy programs at the physician and pharmacist level, and 3. Creating non-restrictive formularies or preauthorization controls.

Our data show that nearly 57% of Oregon workers' compensation pharmacy transactions are already generic. This number is very close to what Group Health or State Medicaid programs can achieve with generic mandates, so the intent of the proposed rule to drive more generic utilization will not reduce system costs. Further, our data shows that 83% of brand drug fills have no generic substitute. Pharmacy providers will lose money on nearly all of these transactions because the proposed reimbursement level is below pharmacies' cost of doing business.

We request that the division rescind the proposed rule and that the division postpone any final decision on the proposed rule until more testimony and input from pharmacy providers and other stakeholders can be provided.

See response to testimony below.

Testimony: Exhibit #18

Within our program, generics average around 60% or above of prescriptions dispensed. We expect little increase in generic volume, as the percentages are already relatively high. If proposed rates are implemented, brand fills with no generic available will be dispensed at under cost. We recommend either leaving current reimbursement levels for brand drugs as is, or if need be AWP minus 10% + \$10.00. Consider payment for generics at a higher level to support their use. We suggest an AWP plus option: AWP + 5% plus \$8.50.

Regarding limitations affecting Oxycontin, Vioxx, Celebrex, and Neurontin, the rules need to address if the justification covers just the initial fill or multiple refills. If repeat justifications are needed, who is responsible to obtain or provide them, the patient, pharmacist, doctor? Any delay in obtaining pain medication needs to be avoided if at all possible.

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Within current rules payment will be based upon the lower of either the provider's usual and customary charge or the fee established by this rule. This provision gives the director authority to determine if a submitted U&C is excessive when compared to other providers. This provision is ambiguous and provides interpretation on a case-by-case basis as to what is reasonable for payment if not paid at established rates. In many states disputes have arisen over what constitutes usual & customary. We recommend deletion of the reference to usual & customary and make the rule reflect a true fee based system. Proposed amended language: "Payment will be ~~the lower of either the provider's usual and customary charge or the~~ **fee established by this rule.**"

See response to testimony below.

Testimony: Exhibit #19

We participated in the Workers' Compensation Pharmacy Fee Advisory Task force, and the proposed rule appears to be consistent with the recommendations of the Task Force. By increasing the dispensing fee to a level that more appropriately reflects pharmacy dispensing costs, lowering the AWP rate, and requiring clinical justification for the use of certain drugs, the proposed rule provides appropriate incentives for pharmacists and pharmacies to encourage use of *cost-effective* drug therapies. We recommend you clarify the clinical justification process such that once submitted, the justification carries over to any refills authorized the prescribing practitioner.

See response to testimony below.

OAR 436-009-0090(1)

Testimony: Exhibit #24

The Pharmacy Fee Advisory Taskforce made its final recommendation to the Department of Consumer and Business Services to modify the rules as follows: 1) If a brand medication has a generic equivalent, the pharmacist will dispense the generic; 2) If a brand drug has a therapeutic equivalent, the pharmacist would contact the physician to see if the therapeutic substitution could be made, and that a higher dispensing fee -- \$10.00 -- would be appropriate in these instances, but not across the board; all other fills and refills of the therapeutic equivalent should remain at \$6.70; and 3) See OAR 436-010-0230(6) for Exhibit #24.

See response to testimony below.

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OAR 436-009-0090

Testimony: Exhibit #26

Regarding the proposal to limit reimbursement of OxyContin, Vioxx, Celebrex, and Neurontin to an initial five-day supply unless the medical provider writes a “clinical justification” for the drug: The Oregon Medical Association (OMA) recently polled a sample of its members who treat workers’ compensation patients. The results suggest that adoption of the proposed rule would discourage physicians from seeing workers’ compensation patients and that it would affect patients’ access to timely care.

“Clinical justification” is not defined in the proposed rules, and the absence of clear definition will erect paperwork barriers, adding unnecessary costs and jeopardizing timely access to care. What criteria will be used to determine what is clinically justified and what is not? Will a physician need to repeat the justification every time he or she writes a script for the same patient?

These drugs are not first line drugs, so other drugs will have been tried first. What is the need for requiring additional documentation? The prescription itself should stand as “clinical justification” by the prescribing physician. The OMA would be interested in exploring other possibilities, such as the Pharmacy Review Program, which was recommended by Dr. David Silver. We request that the proposed rules not be implemented and that other alternatives be discussed.

Response: Revamping the pharmacy fee schedule has indeed required a careful balance between many competing forces. Last year, WCD convened a Pharmacy Fee Advisory Task Force which met four times over several months to review concerns and make recommendations about pharmacy fees. The recommendations were then reviewed by the medical rules External Advisory Committee and the Medical Advisory Committee. Finally, we received a great deal of public comment, much of it directly in contrast to other comment. Some comments have contended the dispensing fee is higher than recommended by the Pharmacy Task Force. Others have expressed concern that the reduction in the percentage of AWP will drive many pharmacies from participation in workers’ compensation. We note that the Oregon system already tended to have a lower percentage of AWP than other states’ workers’ compensation schedules, but also higher dispensing fees. We believe this combination favors and encourages dispensing lower cost alternatives wherever allowable. We have made some adjustments to the rule based on the public comment. We have increased the percentage of AWP from 85% to 88%, while decreasing the dispensing fee from \$10 per prescription filled to \$8.70 per prescription filled. This will create a somewhat smaller impact on payment to pharmacies. For the less expensive drugs, the new payment will be a little lower than proposed. For example, a drug with an AWP of \$20.00 will be paid at \$26.30 instead of \$27.00. Under the current schedule, it would be paid at \$25.70. Higher cost drugs will be cut less than under the proposed rules. For example, a drug with an AWP of \$100 will be paid at \$96.70 instead of \$95.00. Under current rules, it would be paid at \$101.70. These changes will still provide incentive to dispense lower cost drugs over higher cost drugs.

Another change made as the result of the testimony received was to eliminate Neurontin from the list of drugs requiring clinical justification. Unlike the other drugs on the list, this drug was not

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part of the studies completed by the Oregon Health Plan, and is not covered by the Oregon Health Plan drug formularies. We added Bextra to the list because it is another cox inhibitor like Celebrex and Vioxx which are on the list. We are also sensitive to the concerns raised by the OMA and medical providers. We not only clarified the language to make it clear that the clinical justification need only be a simple statement explaining why the prescribed drug is the best drug for this patient, but also that the justification is not subject to review and approval by the insurer. The intent, as expressed by the Pharmacy Fee Task Force, is to create a “pause” to let the doctor consider if a therapeutically similar, less expensive drug might be as effective in treating the patient. Oxycontin alone accounts for over 10% of every dollar spent for drugs in Oregon’s workers’ compensation system, and over 1/5th of every dollar is spent on Oxycontin and the cox inhibitors. It was suggested that rather than create this paperwork “hassle,” WCD appoint an advisory council to advise medical providers on the options to prescribing the identified “cost-driver” drugs. We will look into that as an alternative with the OMA and the workers’ compensation Medical Advisory Committee during the upcoming year.

OAR 436-010-0008

Testimony: Exhibit #3

See recommendations regarding OAR 436-009-0008 for Exhibit #3.

OAR 436-010-0008(13)

Testimony: Exhibit #24

“Professional Hours Devoted” should contain the statement about the hours that a reasonable attorney, well trained in workers’ compensation law, would expend on the matter at issue. The rule should also provide that “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix. The attorney fee provisions in Senate Bill 620 do not include ORS 656.247 or 656.248 and therefore do not apply to medical fee disputes.

Response: It was the intent in creating and adopting a matrix system to keep the attorney fee procedure as simple and non-contentious as possible. We believe that qualifiers such as these suggestions will complicate rather than simplify the process and give rise to more disputes.

OAR 436-010-0210(7)

Testimony: Exhibit #24

Nurse practitioners should be required to complete a self-test on the key elements of workers’ compensation law and their responsibilities to treat Oregon injured workers, a concept supported at a recent Nurse Practitioner sub-committee meeting.

Response: A voluntary self-test is included in the packet of materials provided to the nurse practitioners. We do not believe the statute supports a rule requiring it.

OAR 436-010-0220(3)(f)

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Testimony: Exhibit #24

Should the referral to an attending physician for completion of the closing examination count as a worker choice? The language in subsection (f) does not cover this scenario.

Response: We agree this referral does not count as a choice and have revised the language.

OAR 436-010-0230(4)(a)

Testimony: (Exhibits #2 and #3)

We support the intent of the proposed change. The current rule provides a basis for insurer denial of payment to a physical therapist if the attending physician fails to sign the treatment plan within 30 days of the beginning of treatment. The attending physician's timeliness is outside the control of the physical therapist, yet it is the therapist who has suffered the financial consequences of the current rule – not the worker or the physician.

However, the rule remains ambiguous. The third sentence in subsection 0230(4)(a) still requires the physician to sign within 30 days. Some insurers will likely deny payment and the therapist will be required to go through a fee dispute resolution process. We propose the alternative of making reimbursement contingent on having the ancillary care provider send the treatment plan to the physician and to the insurer within seven days of beginning treatment. This gives the physician and the insurer an early opportunity to review the plan and raise any concerns or questions. We also propose requiring the physician to sign a copy of the treatment plan within 30 days after treatment begins and send the plan to the insurer.

Response: We have revised the language to add clarity about what is due, when it is due, and what the appropriate consequences are.

OAR 436-010-0230(4)(a)

Testimony: Exhibit #24

The requirement for a signed treatment plan by the attending physician should not be deleted. The current requirement that an attending physician sign the plan within 30 days of the start of ancillary services allows for checks and balances between the ancillary provider and the attending physician. Without a signed plan and a connection to payment for the ancillary services, treatment could continue indefinitely – even if the worker stops treating with his or her attending physician.

Response: The requirement for the attending physician is not deleted, but the rule is changed to make it clear that the attending physician, not the ancillary care provider, is held accountable.

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OAR 436-010-0230(6)

Testimony: Exhibit #15

The Pharmacy Fee Advisory Task Force also addressed dispensing of drugs by a physician's office. We believe the group's intent was to limit the amount dispensed to a five-day supply. We recommend this section be revised to include a five-day limit.

Response: There was a lot of discussion about this issue, and 10 days was selected because of the need to dispense an adequate amount of antibiotics to complete a course of therapy.

OAR 436-010-0230(6)

Testimony: Exhibit #24

This section should not be modified but remain as is allowing for medications to be dispensed from physician offices only in the case of an emergency. The Pharmacy Fee Advisory Taskforce unanimously, and all but two members of the Division 009 & 010 Advisory Committee, recommended that this rule not be changed (current wording: "Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable."). The proposed rule allows for a maximum supply of 10 days. If the rule was intended to allow patients access to first script medications, the rule doesn't limit fills to first scripts. The rule may promote additional office visits for additional medication, increasing costs for both office visits and dispensing fees. If the physician provides an initial supply and writes a prescription for the longer term, the insurer will pay two dispensing fees instead of one..

Response: The rule allowing a 10-day supply is a compromise between competing interests on this issue. We agree with the physicians who support this concept that there are times when it is medically in the best interests of the patient to assure the patient receives the prescribed drugs. We also understand the concerns about quality control expressed by others. A 10-day supply will allow the doctor to dispense a reasonable starter course of medication or a complete course of antibiotics (in most cases.)

OAR 436-010-0240(12)

Testimony: Exhibit #16

I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

Response: We agree and have modified the language to clarify this requirement.

OAR 436-010-0240(12)

Testimony: Exhibit #24

This rule requires a nurse practitioner to refer a worker to an attending physician for a closing examination, and does not limit the requirement to disabling claims. If closing examinations are required on non-disabling claims, this will add a cost to the system that is unwarranted and unnecessary. In addition, if the nurse practitioner believes the worker has no permanent impairment, the nurse practitioner should be able to state this and not refer to an attending

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physician. For each referral, the insurer will have to pay a new patient level office visit fee in addition to a closing examination fee.

Response: As noted above, we have clarified that this rule applies only to disabling claims. The provision that exempts certain claims from the requirement to complete a closing exam when an attending physician finds “no impairment” cannot be applied to claims managed by an authorized nurse practitioner because “no” or “zero” impairment are findings of impairment and cannot legally be made by the nurse practitioner.

OAR 436-010-0240(18)(b)&(c)

Testimony: Exhibit #15

For clarity and consistency, we recommend the following wording change to these subsections: “For the purpose of this rule, ‘protected health information in the medical record’ means any oral or written information . . . (c) . . . Upon request, the entire health information record, including any protected health information, in the possession of the medical provider . . .

Response: We have modified the rule to add clarity.

OAR 436-010-0250(13)

Testimony: Exhibit #24

Regarding elective surgery notifications, we would like the opportunity to state that more information is needed before deciding if a second surgical opinion is warranted. The current form doesn’t allow for any objection, other than to notify the physician a second surgical opinion is being obtained. Also, insurers should have 14 rather than 7 days to respond to an elective surgery request, as seven days does not allow sufficient time to assess the need for a second surgical opinion.

Response: We believe this recommendation is a significant departure from the current process and should be reviewed by a broader group of external advisors. We can include a review of the elective surgery procedure during the next revision of these rules if external parties wish to do so.

OAR 436-010-0265(11)

Testimony: Exhibit #24

We object to the proposed requirement that the insurer send a copy of the insurer medical examination (IME) report to the attending physician within 72 hours of receipt. IME providers can forward the report to the attending physician sooner; by transferring the responsibility to the insurer, the rule adds unnecessary delay to delivery of the report. We also propose the language about the IME should refer to “examining physician or IME company” to more accurately describe whose responsibility it is to send the report to the attending physician.

Response: We revised this requirement in the proposed rules because it is an administrative requirement more properly imposed on the insurer managing the claim than on a doctor

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providing an examination. The change is in response to considerable evidence that examining physicians are not fulfilling this requirement, which then interferes with a workers' ability to obtain a Worker Requested Medical Examination. We have modified the language to add "(s)" to physicians to clarify that the responsibility to send a report to the insurer is a collective responsibility of physicians completing the examination and report.

OAR 436-010-0265(11)

Testimony: Exhibit #25

Regarding the proposed requirement that the insurer forward a copy of the insurer medical examination (IME) report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt: I am not opposed to the rule, but note that this rule section already requires the IME physician to send a copy of the report to the attending physician within seven days. Is it really necessary for the treating physician to receive a copy from two sources? This duplicates effort and expense. The insurer usually includes a concurrence request along with the report, whereas the IME physician provides no explanation as to why it has been sent. I propose that the responsibility for sending a copy of the IME report to the treating physician be with the insurer and that OAR 436-010-0265(11) be removed from the medical rules.

Response: We have deleted the requirement for the IME doctor to submit a copy to the attending physician.

OAR 435-010-0270(3)

Testimony: Exhibit #3

This issue was presented to the Medical Advisory Committee as Primary Issue #8 under Division 010. The stated option was to "require the insurer to provide simultaneous notice to the medical providers [Emphasis added] on denials, partial denials or changes in status, whether or not a denial is on appeal." The proposed section only requires notice to the attending physician or authorized nurse practitioner, and not any other medical service providers, such as a physical therapist, who may be the only provider actively treating the worker. Therapists suffer financial losses when they are not informed that a claim has been denied. If notified, the therapist can contact the worker's private health insurer, if any, or discuss payment terms with the worker if treatment is to continue. The insurer should contact any medical service provider known to the insurer when it denies or partially denies a previously accepted claim.

Response: In the Oregon workers' compensation system, the attending physician has a gate-keeper function that makes it imperative for the attending physician to know what the status of the claim is. The AP makes referrals to other providers and has oversight responsibility for care provided. The insurer may not even be aware of everyone who might be providing care until it receives bills for payment. This provision is a compromise to assure the gate-keeper has adequate information to make decisions about a workers' care, while maintaining a reasonable administrative burden on the insurer.

OAR 436-010-0270(4)

Testimony: Exhibit #24

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Regarding the addition of a time frame for insurer responses to requests for prior medical records, the rule section should specify that the request be in writing, so insurers can comply with the specific needs of requesters.

Response: To require the request be in writing is not necessary and may be overly prescriptive.

OAR 436-010-0270(7)(a)

Testimony: Exhibit #24

We object to the specificity of this proposed language. Nurse practitioners are probably not as prevalent as other medical practitioners that would also qualify as suitable attending physicians in certain geographic areas. We anticipate this would add additional mileage expense to the claim. We propose you change the language in the first sentence to “Reimbursement . . . for transportation costs . . . may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician or nurse practitioner who is in a geographically closer medical community in relationship to the worker’s home.”

Response: The intent of SB 3669 was to allow workers access to nurse practitioners in all cases, but was not intended to require a worker to select a nurse practitioner instead of a physician only because the nurse practitioner was closer geographically to the worker. We needed to make this distinction clear in the rule that a worker is entitled to full reimbursement for transportation costs so long as they are receiving care from the closest type of practitioner of their choice.

OAR 436-010-0280(1)

Testimony: Exhibit #16

I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

Response: We have made this clarification.

OAR 436-030-0165(3)(c)

Testimony: Exhibit #5

The three-day response time for the deselection process is not long enough. A longer period, perhaps ten days, would seem more appropriate. In order to respond, the file must be pulled and reviewed to see what conditions are at issue, and arbiter options must be discussed with the client. In the rare occasion where the parties may want to stipulate on an arbiter, there is insufficient time to contact the opposing counsel and come to an agreement.

Response: The medical arbiter deselection process represents a way whereby the parties retain some control over the selection of the arbiter physician. But in implementing this process, a price has been paid, that being in terms of timeliness. The new timelines associated with deselection can be challenging. However, over the past year most attorneys have adjusted to the demands of this new process by restructuring their intake process for referrals from their clients.

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Historically, the department did look at various aspects of the deselection process, including timeliness, during the pilot study of 2001. An eleven member advisory committee from the workers' compensation industry provided input at that time, followed by in-depth questioning of the actual participants in the pilot (claims handlers, attorneys, etc.). By consensus, it was decided that a three-day turn around for response to the deselection notification letter was adequate.

Part of the consensus process was the fact that the statute allows the department a period of 60 days within which to process, schedule and obtain a medical arbiter evaluation. While this may seem generous, the reality is that the Appellate Review Unit needs all the time it can garner to ensure the medical arbiter's report is received and they secure any clarification of arbiter findings that may be required in time to be used in the order on reconsideration. The medical arbiter scheduling process diminishes the time rapidly because of numerous steps involved, plus the department's obligation to schedule the exam at least two weeks out from the date of the medical arbiter appointment letter, which is triggered only after the deselection response period has expired. This coupled with the time lag often associated with obtaining the arbiter's written report, makes it impractical to lengthen the period of response as suggested by this testimony.

The rule will remain as proposed.

OAR 436-030-0055(1)(h)

Testimony: Exhibit #15

The proposed definition for "withdrawn from the workforce" needs additional clarification of what constitutes a withdrawal from the workforce by adding "Such withdrawal is considered to be complete and permanent."

Response: Adding the suggested language would not be accurate unless it was applicable to the period in question, which is already addressed in OAR 436-030-0055(3)(d) and (4)(a). The proposed rule will be modified but based on Exhibit #21 testimony.

OAR 436-030-0003(3)(a)

Testimony: Exhibit #21

A verb is required in the second sentence of this rule.

Response: Agreed. The rule will be modified to include a verb.

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OAR 436-030-0007(1)(b)

Testimony: Exhibit #21

The proposed change could be construed to give the director authority to abate or amend an Order on Reconsideration at any time even after the case has gone to the Board for a hearing. There is no reason for the director to maintain jurisdiction once a hearing has been requested. We suggest that the current language remain.

Response: The intent of the rule change is to clarify that the director does have and has had the authority to withdraw an order on reconsideration up to the time the order becomes final. The director has been given by the Legislature the plenary authority to decide matters committed to DCBS, unless clearly limited by statute. There is no legislatively imposed limitation on the director's authority to withdraw an order on reconsideration prior to that order becoming final. The rule will remain as proposed.

OAR 436-030-0007(3)(a)

Testimony: Exhibit #21

This rule illustrates the inconsistency in appeal procedures that will exist if all of the rule divisions are adopted as proposed. In other divisions, it is proposed that appeals are timely if received by the due date, rather than mailed by that date. This is a different standard than contained in this rule and a different standard than that used by the Worker's Compensation Board. Stakeholders are best served by a consistent regulatory standard. All rules should use the mailing date, for reasons expressed in Division 001 testimony.

Division 001 (OAR 436-001-0155(1), testimony stated that under the existing rule the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. Recent weather-related problems caused many Oregon Post Offices to suspend service and to add a Sunday delivery to clear a backlog. The new rule would cause filings to be deemed untimely for reasons beyond the control of the party making the filing.

The division 001 proposed rule would create different standards for WCD and WCB. The Board uses mailing date, not date of receipt. DCBS should use consistent procedures, so that it is easier for the public to do business with the department.

Furthermore, ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law". The proposed rule is an impermissible deviation from statute.

Response: We agree. Under ORS 656.726(4)(a), "Mailing date" determines timeliness.

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OAR 436-030-0023

Testimony: Exhibit #21

“Rescinding Notice of Closure” is a title understood by regular system participants, but its legalese is likely to confuse an unrepresented worker who receives such a document through the mail. “Withdrawal of Notice of Closure” would be a better title.

Response: The word “rescinding” in the form “Rescinding Notice of Closure” does appear to be legalese but once the worker reads further down the form the intent becomes very clear. The first sentence states, “This is to advise you that your workers’ compensation claim closure has been reversed and your claim returned to open status.” In addition, the insurer has an area on the form to specifically explain why the worker’s closure has been withdrawn and the claim has been reopened. Together, these statements clearly inform the worker what has happened with their claim.

Additionally, the department does not have any evidence that would suggest that “withdrawal” would be a better understood word to use than “rescind”. What is known is that the word “rescind” is the common term within workers’ compensation and what is used on forms and in brochures. To change these terms would require additional costs and time, which cannot be justified and spent without significant supporting evidence. The rule will remain as proposed.

OAR 436-030-0023(3)

Testimony: Exhibit #21

The term “current date” as used in this rule is confusing. We suggest “the date of the correction or withdrawal.”

Response: The director agrees, but with the more general perspective that some modifications are needed to clarify that the “current date” must be the date the document is mailed.

OAR 436-030-0034(1)

Testimony: Exhibit #21

The rule should not require claim closure if there has been no treatment for 30 days. There may be extenuating circumstances, when the best interests of the parties would be served by allowing the claim to remain open. Insurers should have the discretion to make the best judgment in the individual case. We request that the word “may” be left in this rule.

Response: The testimony presents a reasonable argument, but the change in wording from “may” to “must” is required because “may” is in direct conflict with OAR 436-030-0020(1) and ORS 656.268(1). The rule will remain as proposed.

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OAR 436-030-0034(6)

Testimony: Exhibit #21

Copies are routinely sent to medical providers. In the infrequent case where the notice is not sent, this should not be grounds to nullify a closure. We suggest adding the following sentence:

“Failure to send a notice required by this rule may subject an insurer to civil penalties, but will not invalidate the closure”.

Response: The attending physician’s and/or nurse practitioner’s input on their patient’s claim closure has been and will continue to be a critical part of the workers’ compensation system. If the medical providers are not sent the required copies, then the claim closure may be rescinded. How critical the information (on the notification and denial letters) is to claim closure will determine if the closure will be rescinded or not. This is not a new procedure, nor is this a new rule. The rule has just been moved, and nurse practitioner has been added as mandated by House Bill 3669.

The recommendation is not an effective remedy when considering the importance of the medical provider’s participation in the claim closure process. Rather than rewrite the rule, review or revision of internal procedures may be necessary to ensure that all necessary documentation is copied to the medical provider. The rule will remain as proposed.

OAR 436-030-0055(1)(h)

Testimony: Exhibit #21

The last sentence of this rule is redundant, but if the rule is to be retained, “retirement” should be defined. Otherwise, it could be interpreted to mean collecting Social Security, collecting a company pension, collecting IRA or 401(k) distributions, ceasing employment without intent to seek new employment, etc.

Response: The director agrees that the term “retirement” is not clearly defined. The intent of the proposed language was to (1) establish the fact that a worker who is receiving retirement benefits (e.g. Social Security, company pension payments, etc.) is not necessarily withdrawn from the workforce, and (2) require an insurer or self-insured employer to use more than the fact a worker is receiving ‘retirement benefits’ to establish that the worker has withdrawn from the workforce. There are numerous examples of workers who receive such benefits and still are working in the workforce. Individuals may retire from the military, state, or federal government and then get another job in the private sector or return to government work. Individuals may receive Social Security but continue to work. Employees may collect company pensions and return to the workforce to supplement that income. The proposed language will be modified to better reflect such circumstances.

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OAR 436-030-0065(1)

Testimony: Exhibit #21

Two changes in the proposed rule seriously undermine the management of Permanent Total Disability claims.

First, the revised rule suggests that an insurer can only re-examine a PTD claim at two-year intervals, despite intervening events that may make the worker employable. The insurer is responsible for monitoring the worker's condition and, if the insurer determines that the worker's physical condition has improved or the vocational situation has changed, should be able to act on the information as soon as it has been developed, and not wait for an arbitrary schedule of reviews.

Second, the revised rule appears to remove the incentive for a worker to cooperate with any reexamination of a PTD award. Currently, a worker who refuses to attend a medical examination may be subject to benefit suspension. The new rule would allow the worker to ignore a reexamination with impunity. As medical evidence is an essential component in any PTD reexamination, this proposed rule would effectively prevent reversal of PTD awards. This rule violates ORS 656.325(1)(a) which clearly states that benefits will be suspended for failure to submit to an examination. The proposed changes also appear to conflict with ORS 656.325(3), which requires the worker to cooperate in the reduction of disability.

Implementation of these rules would not only affect the system cost to employers and insurers, but would also increase cost to the Worker Benefit Fund. Retroactive Reserve payments are the largest single draw on that Fund.

Response: The director agrees with the first position that the insurer is responsible for monitoring their PTD claims and should be able to act on any information that will change the PTD status as soon as possible. It was not the director's intent to limit the insurer in this respect and the changes that have been proposed have not done so. Statute and rule do not prohibit the insurer from reviewing a PTD claim more frequently than every two years. The purpose of removing this language was to eliminate duplication and reduce rules. Since it appears to have created confusion, the director will modify the language to clarify the insurer's existing right to review a PTD claim more frequently than every two years.

The director does not agree with the second position that the deletion of the suspension rule will remove the incentive for the worker to cooperate with any reexamination of a PTD award. The statutes cited in the testimony have given the insurer the right to suspend a worker who does not cooperate with a reexamination. That right cannot be taken away by rule.

The director's intent was not to eliminate the insurer's right to suspend a worker who has not cooperated with the reexamination, but to eliminate redundancy of rule and statute. The reason that the suspension part of this rule was taken out is because it is addressed in OAR 436-060-0095, OAR 436-030-0055, and statute. But to ensure clarity, the deleted suspension portion will be restored and a reference to OAR 436-060-0095 will be inserted.

OAR 436-030-0135(6)

Testimony: Exhibit #21

The word “accepted” as used in this rule is undefined and ambiguous. It would be more appropriate to use “requested and received.”

Response: The director agrees, but with the suggestion for some modifications to clarify that the fiscal instrument not only has to be received, but also negotiated by the worker. The reason for this terminology is because a worker may receive the money from the insurer but return it after deciding to request reconsideration. The language has been modified to more clearly reflect the intent of the change.

OAR 436-030-0155(3)

Testimony: Exhibit #21

The proposed rule needs to be restructured to more clearly convey the intent. The proposed rule appears to require that the attending physician has viewed the recordings, but the insurer cannot know with certainty whether anything sent to a physician has actually been reviewed. Written reports are routinely sent, but the insurer has no way of knowing whether they have been read. Surveillance material should be treated the same way as any other information. Suggested language:

“The insurer must submit to the director for arbiter review all surveillance documentation (including any materials supplied by the insurer to the physician(s), such as videotape, investigator field notes, summary or narrative reports regarding the worker’s observed activities, cover letters or other forms of recorded documentation) of the injured worker’s activities, that were obtained prior to the closure and that were submitted to the attending physician. Surveillance tapes, compact discs or other forms of electronic storage that reflect the worker’s activities will be accompanied by documentation indicating the dates the information was obtained and the total time of the recording. This information will be supplied to the arbiter to view and consider in conjunction with the arbiter’s medical assessment of the worker’s accepted condition and level of disability.”

Response: The director agrees that the proposed language does need to be clarified because the insurer cannot be sure if material sent to a medical provider has been reviewed by that provider. The director’s intent is to require that the insurer submit to the director any surveillance videotape both obtained prior to claim closure and submitted to any physician(s) involved in the treatment of the injured worker. The proposed language will be modified to clarify the intent.

OAR 436-060-0008(3)(a)

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Testimony: Exhibit #22

The proposed change may be more convenient for the Division, but works to the disadvantage of the stakeholders. Under the existing rule, the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. The proposed rule would create different standards for WCD and the Workers' Compensation Board. DCBS should use consistent procedures, so that it is easier for the public to do business with the Department. ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law." The proposed rule is an impermissible deviation from statute.

Response: The Department of Justice has advised the division that ORS 656.726 controls. The current language will be retained.

OAR 436-060-0010(3)

Testimony: Exhibit #15

The proposed language is extremely vague and too subjective to make it a standard for notice or knowledge of a claim. The worker must retain the responsibility of filing the claim. Suggest modifying the sentence to read, "The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a worker's intent to file a claim, either through written communication from the worker, the worker's representative, or the worker's attending physician. [or of when enough facts exist to lead a reasonable employer to conclude that workers' compensation liability is a possibility.] (Emphasis in original)

Response: This language is not new. It has been moved from 436-060-0010(10) to (3) in connection with the change from reporting claims to the division within 21 days of the employer's knowledge date to 14 days from the decision to accept or deny the claim. When read in conjunction with 436-060-0010(4), it is clear that the worker retains the responsibility of filing a claim. ORS 656.262(3)(a) reads, in relevant part, "Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer." Emphasis added. The possibility exists that a worker would choose not to file a claim for an accident that may result in a compensable injury claim, but according to the statute the employer should still report the incident to the insurer. However, as a result of this testimony we will add clarification to the rule that it is the employer who must know the facts.

OAR 436-060-0010(12) and (13)

Testimony: Exhibit #7

Senate Bill 914 eliminated the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim.

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Proposed OAR 436-060-0010(10) clearly indicates that all disabling claims shall now be reported within 14 days of the insurer's decision to either accept or deny the claim.

To be consistent, it is recommended that the reporting timeframe in OAR 436-060-0010(12) & (13) be changed from 21 days to 14 days. This will eliminate any confusion as to how many days an insurer has to file a form 1502.

Response: Consistency is a valid reason to change all 21-day reporting timeframes to 14 days. In addition to the cites referenced in this testimony, there are also 21 day reporting timeframes in OAR 436-060-0010(14), (15), (16), and 436-060-0018(1). Also, it is not clear in 436-060-0018(1) that this applies only to accepted claims. The language in the proposed rules will be changed to require reporting to the director within 14-days of the action and the language in 436-060-0018(1) will be clarified to apply only to accepted claims.

OAR 436-060-0018(11)

Testimony: Exhibit #22

The rule should be prefaced with the phrase: "Subject to the provisions of subsection (12),..." Exhibit 22. In a follow-up call regarding this testimony, the author stated that (11) implies an insurer can change the classification of the claim anytime. It should be limited to the one year mentioned in (12).

Response: This testimony caused us to look closely at the proposed language and recognize there could be better direction for claim processing in these situations. There have been instances when a claim has been classified as disabling, then closed with a Notice of Closure. When the claim is reopened on aggravation or a new or omitted condition is accepted, the claim status remains disabling even though the aggravation or the new or omitted condition may be non-disabling. We recognize there are times when the original decision to classify the claim as disabling was incorrect because the criteria were never met. Case law (*DeGrauw v. Columbia Knit*) does not clearly establish a process for such circumstances other than the requirement that the worker have access to recourse if they are dissatisfied. The proposed language will be modified.

OAR 436-060-0035(8)

Testimony: Exhibit #22

The proposed revision to this rule is incorrect. The current version of (8) correctly states that TPD for supplemental temporary disability must be calculated on the combined pre- and post-injury earnings, not calculated independently. The proposed rule does not work whenever maximum or minimum TTD rates are involved. You cannot calculate primary and secondary benefits separately to get the correct amount to pay the worker. The benefit has to be figured based on combined earnings. You figure the benefits from the primary job and the difference is the secondary benefit that is reimbursable from WBF.

Response: This change was made to limit the required involvement of insurers who elect not to process and pay supplemental disability. However, this testimony has pointed out the problems

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this change would create. With some modification to incorporate the assigned processing agent, the previous language will be restored.

OAR 436-060-0035(18)

Testimony: Exhibit #22

Disputes concerning the rate of disability should be raised before the first closure of the claim. Allowing them “at any time” means that the issue could be raised many years after the initial rate calculation, when evidence of earnings may no longer be available.

Response: There is no statutory limitation on when an injured worker can raise a wage dispute. Similarly, OAR 436-060-0025 does not limit when a wage dispute may be raised. Regardless of when the wage dispute is raised, it is the worker who must supply the wage records for secondary employment. The proposed language will be retained.

OAR 436-060-0060(2)

Testimony: Exhibit 22

We agree that an insurer should respond promptly to a lump sum request. However, we believe the insurer should be allowed ten business days. This would allow the request to be processed within the regular two-week file review cycle. This would allow an average turnaround of five business days, without disrupting the normal review schedule.

Response: When this issue was discussed in the Internal and External Advisory Committees there was general consensus to add a “reasonable timeframe” to the rules. However, what is reasonable was not specifically discussed. Requiring the insurer to send the form within 10 days to coincide with the regular two-week file review cycle seems reasonable. The rule will be modified accordingly.

OAR 436-060-0095

Testimony: Exhibit #22

A proposed revision of OAR 436-030-0065(1) appears to remove the ability to suspend compensation when a worker with a PTD award refuses to attend a medical examination. For the reasons stated in our Division 030 testimony, we oppose that change. It would be logical to move that rule to Division 060, where all other benefit suspension issues are covered.

Response: Suspension of benefits for any worker who refuses to attend a reasonable requested medical examination is currently contained in OAR 436-060-0095. However, the last sentence of OAR 436-030-0065(1) will be added back with a cross-reference to OAR 436-060-0095. This will make it clear that if a worker with a PTD award refuses to attend a medical examination, the process for requesting suspension is under OAR 436-060-0095.

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OAR 436-060-0140(9)

Testimony: Exhibit #22

Since claims that have been resolved by a claim disposition agreement are not subject to reopening under any circumstances, the rule should be prefaced with the phrase: “Except for claims resolved by claim disposition agreement under ORS 656.236,…”

Response: Claims that have been resolved by a claim disposition agreement are subject to reopening if a new or omitted condition is later accepted. The rule will remain as proposed.

OAR 436-060-0155(2)

Testimony: Exhibit 8

The right to the penalty is in ORS 656.262(11). The rule terminates claimant’s rights after 180 days of the alleged violation. The rule is in direct conflict with ORS 656.319(6), which provides claimant a right to a hearing on this issue for a period of two years after the alleged action or inaction. There is adequate case law that explains when the two-year period begins and ends. There is also adequate case law to support the position that the Director cannot promulgate a rule that takes away a right or limits a statutory right.

Response: This language has existed in these rules for many years. In *Kathryn R. Cook v. Liberty Northwest Insurance Corporation*, 150 Or App 597 (1997), the Court of Appeals held this rule is reasonably required for the director to carry out the performance of his duties. The case also considered the issue the testimony presented concerning ORS 656.319(6). The current language will remain.

OAR 436-060-0180(8)

Testimony: Exhibit #22

The requirement that an insurer’s response to WCD be “adequate” is reasonable, but the insurer cannot know what WCD may perceive to be adequate. We suggest rewording to say that the insurer must respond “in good faith”.

Response: This language was patterned after OAR 436-060-0155(4) where it’s clear that inadequate means failing to answer specific questions or provide requested documents. The language in this rule will be modified to make it clear what the director considers inadequate by more closely mirroring the language in OAR 436-060-0155(4).

OAR 436-120-0004(2)(d)

Testimony: Exhibit # 13

Regarding the statement in the notice text in (d), “If you disagree with this decision, you should contact (person’s name and insurer) within five days of receiving this letter to discuss your

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concerns,” if the injured worker is required to contact the insurer to remain eligible, the time allowed should be longer.

Regarding the remaining notice text, add a reference to the worker’s attorney, as in “If you are still dissatisfied, you or your attorney must contact . . .”

Response: The changes recommended were not included in the proposed rules. The division can not take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

OAR 436-120-0008(2)

Testimony: Exhibit # 13

Regarding statements of services for attorney fees, in addition to the hours spent on the case, consideration should be given to the difficulty involved as well as the likelihood of prevailing, because attorneys are only paid if they win.

The rule should be consistent with awards made by the Workers’ Compensation Board, and not start a trend of requiring a statement of services.

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

OAR 436-120-0008(2)

Testimony: Exhibit # 23

Two additional factors should be considered in determining attorney fees:

- ‘ “Professional hours devoted” shall be limited to those hours that a reasonable attorney, well-trained in workers’ compensation law, would expend on the matter at issue.’
- ‘Proof of “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.’

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

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The division believes the proposed rule accomplishes those goals.

With regard to the proof of “extraordinary circumstances” the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of \$10,000.

OAR 436-120-0008(4)(b)

Testimony: Exhibit #23

The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers’ Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): “. . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law.”

Response: The division agrees that the standard should be the one described in ORS 656.726(4)(a). The proposed rule will be changes to reflect agreement with ORS 656.726 (45)(a).

OAR 436-120-0340(2)(g)

Testimony: Exhibit #23

Regarding the Oregon Wage Information publication [of the Oregon Employment Department], the rules should require reference to the fifth percentile rather than the 10th percentile as proposed. The 5th percentile is better aligned with the standard now in use.

Response: The division compared the Oregon Wage Information (OWI) 5th and 10th percentile to the current use of the Oregon Automated Reporting System (OARS) median wage (Q2). A review by the Information Management Division of DCBS found the 10th percentile to be the closest to the Q2 statistic. In addition, the Oregon Department of Employment which publishes the OWI will only publish for general circulation statistics starting with the 10th percentile.

Given the divisions analysis of the 5th and 10th percentiles and in order to make the statistics as readily available as possible, the 10th percentile will be the standard.

OAR 436-120-0360(7)

Testimony: Exhibit # 14

Regarding proposed language for this section, “The worker returned to work prior to the worker becoming medically stationary, and the physician **later** [emphasis added] rescinded the release.” This section should include a time limit for rescission; otherwise, insurers could be compelled to complete an eligibility evaluation 12 months after the return to work if a physician later rescinds

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a release – even if the worker has not perfected a claim for aggravation. Recommended replacement language: “The worker returned to work prior to becoming medically stationary, and the physician *rescinds the release within 60 days of the date of the Notice of Closure.*”

Response: This rule is being moved from its present location as 436-120-0360 (9) to 436-120-0360(7). The only other change was change the word rescinds to rescinded. Time frames were not recommended for this rule and no discussions on the effect of adding time frames was part of the internal or external advisory committees. The present wording of this rule has not generated requests for reconsideration under the scenario presented in the testimony. While the recommendation may have merit, the division could not consider implementation of the recommended wording without further public input. The division will file the proposed wording for consideration future rule changes.

OAR 436-120-0710(7)

Testimony: Exhibit #23

This section should not provide for prepayment of the last month’s rent, as this is not generally required in today’s market and is inconsistent with OAR 436-110.

Response: This rule was not proposed for any changes and as such has not had any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

The current wording does not require the payment of last months rent but does state it is only payable . . .” if required prior to moving in.”

OAR 436-120-0720

Testimony: Exhibit # 13

The advisory committee discussed increasing the dollar amount for direct worker purchases for training programs. The need was acknowledged by some of the insurer representative’s. The proposed rules do not address this need.

Response: The division is proposing an increase in OAR 436-120-0720(3) for direct worker purchases in training programs. The increase in from \$14,256 to \$16,157, which is a 10% increase.

OAR 436-120-0720(2)

Testimony: Exhibit # 23

As proposed, this section, a worker may qualify as having an exceptional loss of earning capacity if additional services would yield just a 10% greater wage than a shorter program. For a 21-

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month training program, the TTD benefit alone may exceed \$80,000. The analysis to authorize extended benefits should include whether the program will result in significantly improved earning capacity over the likely period of post-training employment.

Response: The proposed rule recommends changes to the fee schedule for workers found to have an exceptional disability or exceptional loss of earning capacity and the percentage increase to be applied. The change recommended in the testimony proposes a change in how exceptional loss of wage earning capacity is determined, which is in OAR 436-120-0440(2)(b).

No changes were proposed for OAR 436-120-0440 and as such there has not been any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 12th day of March, 2004.

WORKERS' COMPENSATION DIVISION

/s/ Fred Bruyns

Fred Bruyns, Rules Coordinator

Policy Section

Workers' Compensation Division

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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 001**

436-001-0000 Notice of Agency Action Concerning Rules

(1) Except when [acting in an emergency to] adopting a temporary rule, [pursuant to ORS 183.335] the [director] division will give prior notice of the adoption, amendment, or repeal of [administrative] any rule(s), as provided in ORS 183.335 and this rule.

(2) The division will publish notice of [the] a proposed action [will be published] in the Secretary of State's Oregon Bulletin [referred to in ORS 183.360] at least [15] 21 days prior to the effective date of the [adoption, amendment or repeal of the rule] action.

(3) [Upon request, t] The division will notify interested persons and organizations on the division's notification lists of proposed rulemaking actions under ORS 183.335. [mail copies of all notices of proposed action to any party making such a request. Such parties may also be added to the division's mailing list.]

(4) [As a matter of routine practice, depending on the subject matter of the proposed action, copies of the notice will be provided to the following persons and organizations on the division's mailing list, including:

- (a) Workers' compensation insurers;
- (b) Self-insured employers;
- (c) Third-party administrators;
- (d) Insurance adjusters and adjusting firms;
- (e) Workers' compensation attorneys;
- (f) Medical providers and managed care organizations;
- (g) News reporting organizations;
- (h) Vocational rehabilitation organizations;
- (i) Labor unions;
- (j) Employer groups and associations;
- (k) Management-Labor Advisory Committee;
- (l) Employers and employees;
- (m) Oregon Chambers of Commerce;
- (n) State Advisory Council on Occupational Safety and Health; and
- (o) Other interested parties.]

A person or organization may be included on the division's notification list as follows:

(a) To receive electronic notification through the division's e-mail notification service, by subscribing through the division's web board at www.oregonwcd.org. The on-line subscription form requires a first name, last name, password, e-mail address, and phone number.

(b) To receive hard-copy notification, by submitting a written request, including the person or organization's full name and address.

(5) The division's notification list includes persons and organizations receiving electronic and hard-copy notification of proposed actions. The list complies with the

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requirements of the mailing list as required by ORS 183.335(8), and the Uniform Electronic Transactions Act, ORS 84.001 to 84.061.

Stat. Auth.: ORS 656.704(2), 656.726(4[3])
Stats. Implemented: ORS 183.335 **and 84.022**
Hist: WCB 16-1975, f. & eff. 10-20-75
WCD 4-1977 (Admin) (Temp f. & eff. 11-7-77;
WCD 4-1978 (Admin) f. 7 eff. 3-6-78;
Renumbered from 436-90-505, 5-1-85;
WCD 3-1986 f. & eff. 5-15-86;
Amended 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0001 Authority

The[se rules are adopted] **director adopts these rules** under the [director's] general rulemaking authority [under] **in** ORS 656.726, and the director's specific authority and responsibility under ORS [chapter] **chapters** 183 and **656**[ORS 656.245, 656.248, 656.260, 656.262, 656.268, 656.283, 656.327, 656.385, 656.388, 656.447, and 656.704].

Stat. Auth.: ORS 656.704(2), 656.726(4[3])
Stats. Implemented: ORS Chapter 183, ORS 656.245, 656.248, 656.260, 656.262, 656.268, 656.283, 656.327, 656.385, 656.388, 656.447
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 02/12/96 as WCD Admin. Order 96-055 eff. 02/12/96
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0003 Applicability and Purpose

(1) This [e rules] **rule division** [contained in OAR 436, Division 001] establishes **supplemental** procedures governing rulemaking and contested case hearings, and [carry] **carries** out the provisions of ORS [Chapter] **chapters** 183 and [Chapter] 656.

(2) These rules apply to all **contested case** hearings **and rulemaking** [before the director] ON OR after the effective date [of these rules].

(3) [Applicable to these rules, the director may, u] **Unless** otherwise obligated by statute, **the director may** waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4[3])
Stats. Implemented: ORS 656.704(2) and 183.310 through 183.550
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 02/12/96 as WCD Admin. Order 96-055 eff. 02/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

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 assigned by the Office of Administrative Hearings.

([1]2) "Administrator" means the administrator of the Workers' Compensation Division [and designated representatives of the director for administration of the division, ORS chapter 656 and OAR chapter 436] **or the administrator's designee.**

([2]3) "Delivered[y]" means physical delivery to the division's Salem office [or delivery by facsimile transmission].

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([3]4) "Department" means the Department of Consumer and Business Services[, the director and all employees].

([4]5) "Director" means the director of the Department of Consumer and Business Services or the director's designee[for the particular contested case matter].

([5]6) "Division" means the **department's** Workers' Compensation Division[of the Department of Consumer and Business Services].

([6]7) "[Filing] **Filed**" means mailed, **electronically transmitted by telephonic facsimile or e-mail**, [faxed] or [physically] delivered **to the division**.

([7]8) "Final order" means a final action by the director, expressed in writing.

([8]9) "Good cause" includes, but is not limited to, mistake, inadvertence, surprise, or excusable neglect.

(10[9]) "Mailed" means correctly addressed, with sufficient postage and placed in the custody of the U. S. Postal Service.

(11[0]) "Party" includes, but is not limited to, a worker, an employer, an insurer, a self-insured employer, a managed care organization, or a medical provider.

(12[1]) "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.

[(12) "Presiding officer" means a person designated by the director to conduct hearings on the director's behalf.]

(13) [The o] **Other** words and phrases[used in OAR 436-001] have the same meaning as given in ORS 183.310, where applicable.

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 656.704(2), ORS 183.310 through 183.550

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 02/12/96 as WCD Admin. Order 96-055 eff. 02/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0005 Model Rules of Procedure Governing Rulemaking

[Pursuant to ORS 656.726(3), and in accordance with ORS 183.341, t] **The director adopts**[, by reference, OAR chapter 137, Division 01.] **the Attorney General's Model Rules** [of Procedure] **for Rulemaking**[under the Administrative Procedures Act, which became effective September 15, 1997, except OAR 137-01-007(2) and (3)], **OAR 137-001-0005 to 137-001-0085, by reference.**

Stat. Auth.: ORS 656.726(4[3])

Stats. Implemented: ORS 183.325 through 183.410 and ORS 656.704 (2)

Hist: Filed 5/15/86 as WCD Admin. Order 3-1986, eff. 5/15/86
Amended 5/22/92 as WCD Admin. Order 9-1992, eff. 5-22-92
Amended 2/12/96 as WCD Admin Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0007 Designation of Proposed or Final Order

(1) Unless provided otherwise by statute or administrative rule, an order issued by [a presiding officer] **an administrative law judge** [on behalf of the director] is a proposed and final order subject

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to revision by the director.

(2) [Any order of suspension or revocation of an insurer's authority to issue guaranty contracts pursuant to ORS 656.447 by the director's designee is a proposed and final order subject to revision by the director.] **An order suspending or revoking the insurer's authority to issue guaranty contracts under ORS 656.447 is a proposed and final order subject to revision by the director.**

Stat. Auth.: ORS 656.726(4)[3]

Stats. Implemented: ORS 656.704(2) and 656.447

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin Order 96-055 eff. 2/12/96
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0008 Model Rules of Procedure in Contested Cases

[Pursuant to ORS 656.726(3) and in accordance with ORS 183.341, the director adopts, by reference, OAR chapter 137, Division 03, Attorney General's Model Rules of Procedure under the Administrative Procedures Act that became effective September 15, 1997, except as modified by ORS chapter 656 and these procedural rules.] **These rules supplement the Attorney General's Model Rules of Procedure for Contested Cases, OAR 137-003-0501 to 137-003-0700, which govern the procedures for a contested-case hearing before the Office of Administrative Hearings. If there is a conflict between these rules and the model rules, the provisions of the model rules will control.**

Stat. Auth: ORS 656.726(4)[3]

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2) (and §7, ch. 75, OL 2003)

Hist: Filed 12/2/91 as WCD Admin. Order 9-1991, eff. 12/2/91 (Temporary)
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0025 Contested Case Notice

In addition to the requirement of ORS 183.415(2), a contested case notice may include a statement that the record of the proceeding to date, including information in the division file or files on the subject of the contested case, automatically becomes part of the contested case record upon default for the purpose of proving a prima facie case.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

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

(1) In any **contested-case** proceeding [under these rules], the director['s designee, the WCD], [is entitled] **may request** to:

(a) Receive notice of all matters;

(b) [.] Receive copies of all documents; **and**

(c) [and to present] Present evidence, testimony, and argument.

(2) The director['s designee, the WCD.] may appear **by providing the administrative law judge and parties with an entry of appearance in the contested-case hearing. The director may** [and] be represented by a contested-case 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 dispute must be provided to the director's representative.**

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(3) In every contested-case proceeding the administrative law judge must copy the director with all:

(a) Notices and reset notices of hearing;

(b) Substitution of Counsel notices;

(c) Addition of a party notices; and

(d) All orders.

[(3) If necessary, the presiding officer shall continue the hearing to allow the presentation of oral or written legal argument by the Department of Justice.

(4) In any proceeding where the director's designee, the WCD, chooses to be represented, the director's representative shall be served with notice of hearing and all documents provided to and by the parties.]

Stat. Auth.: ORS 656.726(~~4~~[3])

Stats. Implemented: ORS 180.220(2), 180.235, [183.450(7)], and 656.704(2)

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0045 Rights of Parties in Contested Cases

(1) The presiding officer shall explain the issues and the matters the party must prove or disprove. The presiding officer shall also inform a party, if the party is an agency, corporation, or an unincorporated association, that such party must be represented by an attorney licensed in Oregon, unless statutes applicable to the contested case proceeding specifically provide otherwise. This information may be given in writing or orally before the commencement of the hearing.

(2) Upon the agreement of the division and the parties, and unless otherwise precluded by law, alternative methods of dispute resolution may be used in contested case matters. Such alternative methods of resolution may include non-binding arbitration, modified contested case proceedings, non-record abbreviated hearings or any collaborative method designed to encourage the division and the parties to work together to develop a mutually agreeable solution, such as negotiation, mediation, use of a neutral facilitator or settlement conferences, but may not include binding arbitration.

(3) Final disposition of contested cases may be by a final hearing order or, unless precluded by law, by stipulation, agreed settlement, consent order or final order by default. Informal settlement may be made in license revocation proceedings by written agreement of the parties and the director consenting to a suspension, fine or other form of intermediate sanction.]

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0055 Request by a Person to Participate as a Party or Limited Party

(1) When the division gives notice that it intends to hold a contested case hearing, persons who have an interest in the outcome of the proceeding or who represent a public interest in such result may request to participate as parties or limited parties.

(2) A person requesting to participate as a party or limited party shall file a notice of appearance with the presiding officer at least 14 days before the hearing and shall copy all other parties with the notice.

(3) The notice of appearance shall include the following:

(a) Name and address of the party;

(b) Name and address of the party's attorney, if any;

(c) If the party wishes to limit its participation to that of a limited party, the notice should so indicate and state the precise area in which participation is sought;

(d) If the party seeks to protect a personal interest in the outcome of the proceeding, a detailed statement of the party's interest economic or otherwise, and how such interest may be affected by the results of the proceeding;

(e) If the party seeks to represent a public interest in the results of the proceeding, a detailed statement of such public interest, the manner in which such public interest will be affected by the results of the proceeding, and the party's qualifications to represent such public

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interest; and

(f) A statement of the reasons why existing parties to the proceeding cannot adequately represent the interests identified in subsections (3)(d) or (e) of this rule.

(4) Each party shall have seven days from the date of mailing to file a response to the notice of appearance.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0065 Request by Agency to Participate as a Party or an Interested Agency

(1) When the division gives notice that it intends to hold a contested case hearing, it may also notify the parties that it intends to name any other agency that has an interest in the outcome of that proceeding as a party or as an interested agency, either on its own initiative or upon request by that other agency.

(2) Each party shall have seven days from the date of personal service or mailing of the notice to file objections.

(3) The division's decision to name an agency as a party or as an interested agency shall be by written order and served promptly on the parties and the named agency.

(4) An agency named as a party or as an interested agency has the same procedural rights and shall be given the same notices, as any party in the proceeding. An interested agency, unlike a party, has no right to judicial review.

(5) An agency may not be named as a party under this rule without written authorization of the Attorney General.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0090 Postponement and Continuances

(1) The presiding officer may postpone or continue the hearing for good cause.

(2) A party requesting postponement of a hearing do so as soon as the party is aware of the need for postponement. The request may be in writing or orally.

(3) If one or more of the parties objects to the postponement, the presiding officer may schedule a conference call with the parties.

(4) When a continuance is necessary, additional hearing dates shall be scheduled .]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92

Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96

Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0105 Pre-hearing Conference

(1) Prior to hearing, the presiding officer may conduct one or more prehearing conferences to facilitate the conduct and resolution of the case. At the presiding officer's own initiative or at a party's request, the presiding officer may convene the conference.

(2) The purposes of a prehearing conference may include, but are not limited to, one or more of the following:

(a) to facilitate discovery and to resolve disagreements about discovery;

(b) to identify, simplify and clarify issues, as well as eliminate irrelevant issues;

(c) to obtain stipulations of fact;

(d) to discuss settlement or other resolution or partial resolution of the case;

(e) for any other good cause determined by the presiding officer.

(3) The prehearing conference may be conducted in person or by telephone.

(4) The presiding officer shall make a record, either audio or stenographic, of any stipulations, rulings and agreements. Stipulations to facts and to the authenticity of documents and agreements to narrow issues shall be binding upon the parties unless good cause is shown for rescinding a stipulation or agreement. Settlement discussions are not a part of the record.]

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Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.415 and 656.704(2)
Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0110 Consolidation or Separation

(1) The [presiding officer] **administrative law judge** may consolidate cases in which there are common parties or common issues of law and fact.

(2) The [presiding officer] **administrative law judge** may separate cases which will promote efficient disposition of the matters.

Stat. Auth.: ORS 656.726([3]4)
Stats. Implemented: ORS 183.310 through 183.508 and 656.704(2)
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0120 Motions

(1) At the discretion of the presiding officer, pre-hearing and post-hearing motions shall be filed in writing. Motions shall contain a clear and plain statement of the relief sought. The moving party shall serve all parties with a copy of any written motion.

(2) The other parties shall have seven days from the date of service of the motion, or such greater or lesser time as the presiding officer may allow, to file a response to the motion.]

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0135 Discovery

(1) At the discretion of the presiding officer, discovery may be ordered in appropriate cases. If the presiding officer does authorize discovery, the presiding officer shall control the methods, timing and extent of discovery. Nothing, however, in this rule prevents informal exchanges of information.

(2) Discovery may include, but is not limited to, one or more of the following:

- (a) depositions;
- (b) disclosure of names and addresses of witnesses expected to testify at the hearing;
- (c) production of documents, which may but need not be limited to documents that the party producing the documents plans to offer as evidence;
- (d) production of objects for inspection or permission to enter upon land to inspect land or other property;
- (e) requests for admissions;
- (f) written interrogatories;
- (g) prehearing conferences, as provided in OAR 436-001-0105.

(3) Before requesting a discovery order, a party shall seek the discovery through an informal exchange of information.

(4)(a) A party that seeks to take the testimony of a material witness by deposition shall file a written request with the presiding officer. The request shall set forth the name and address of the witness, an explanation of the materiality of the witness's testimony, an explanation of why a deposition rather than informal or other means of discovery is necessary, and a request that the witness's testimony be taken before an officer named in the request for the purpose of recording testimony.

(b) For all other forms of discovery, a request for discovery order shall be in writing and shall include a description of the attempts to obtain the requested discovery informally. The request shall be mailed or delivered to the presiding officer, with a copy to the other parties. The presiding officer shall consider any objections by the party from whom discovery is sought.

(5) Any discovery request shall be reasonably likely to produce information that is generally relevant to the case. If the relevance of the requested discovery is not apparent, the presiding officer may require the party requesting discovery to explain how the request is likely to

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produce relevant information. If the request appears to be unduly burdensome, the presiding officer may require an explanation of why the requested information is necessary or is likely to facilitate resolution of the case.

(6) The presiding officer may issue an order granting a discovery request in whole or in part.

(7) The presiding officer may refuse to admit evidence which has not been disclosed in response to a discovery order, unless the party that failed to provide discovery offers a satisfactory reason for having failed to do so or unless excluding the evidence would violate the duty to conduct a full and fair inquiry under ORS 183.415(10). If the presiding officer admits evidence which was not disclosed as ordered, the presiding officer may grant a continuance to allow an opportunity for the other parties to respond.]

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.415 and 656.704(2)
Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0140 Subpoenas

(1) The attendance and testimony of witnesses, and the production of documents or physical evidence under the witnesses' control or possession, may be compelled by subpoena.

(2) Subpoenas may be issued by the director, the presiding officer, other designees of the director any party authorized by the presiding officer, or the attorney of the party in whose behalf the witnesses are required to appear.

(3) If the hearing is by telephone, at least two days before hearing, the party who subpoenaed the witness shall provide to the presiding officer, the name of the witness and telephone number where the witness can be reached at the time of the hearing.

(4) Witnesses appearing by subpoena, unless a party, or an officer or employee of the department, shall be paid the fees and mileage required by ORS 44.415(2) by the party who subpoenas them, other than employers, their officers and representatives subpoenaed by the director.]

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.310 through 183.550 and 656.704
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0150 Change of [Presiding Officer] Administrative Law Judge

[(1) **The director adopts OAR 471-060-0005, by reference.** [If the presiding officer has a potential conflict of interest as defined in ORS 244.020, the presiding officer shall withdraw from the case or advise the parties of the nature of the conflict.

(2) Any party may request, by motion, that the presiding officer be removed from a case on the grounds of personal bias or conflict of interest by filing with the director, promptly upon discovery of the alleged facts, an affidavit which sets forth the grounds for disqualification.

(a) The presiding officer may withdraw from the case.

(b) If the director finds the request for disqualification is filed with due diligence, and the supporting affidavit is sufficient on its face, the director shall either disqualify the presiding officer and assign another presiding officer to the case, or order a hearing on the allegation in the affidavit.

(c) If the director does not disqualify the presiding officer, the director shall state the grounds and so rule on the record.]

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.310 through 183.550, 656.704(2)
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0155 Manner of Filing a Contested-Case Hearing Request

(1) **A [Requests] request for hearing[, motions and other hearing documents may be filed by mail, facsimile transmission or delivery to the division.] must be received by the division no later than 5 p.m. on the filing deadline. The date and time of receipt for electronic filings is determined under ORS 84.043. Parties are responsible for submitting a request timely, which will not be extended except as provided in section (6) of this rule. The request should be copied to all known parties and their legal representatives, if any.**

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(2) A contested case hearing request must be in writing. A party may use the division's Form 2839. If filing by electronic mail and attaching a word processing document, the document must be in Microsoft Word 97 format. A request for hearing must include:

- (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;**
 - (h) The reason for requesting review; and**
 - (i) If applicable, the justification for holding an in-person hearing.**
- (3) A request for hearing may be mailed or delivered to the division.**

(4) A request for hearing may be electronically transmitted to "wcd.hearings@state.or.us", the division's contested-case hearing electronic mail address. The division will acknowledge receipt of the transmission by electronic response. A party submitting a request for hearing under this section consents and agrees to conduct the transaction electronically. The party's electronic mailing address qualifies as its electronic signature.

(5) A telephonic facsimile [copy of a document] request for hearing will be accepted [for filing] provided the document transmitted indicates [at the top] that it has been delivered by FAX, uses the division's facsimile transmission number [is used], and the original signed document is simultaneously mailed [addressed] to the [Division] division. The complete facsimile copy must be received by [the Division by 5 p.m. on] the filing deadline. When reception of a document begins after 5 p.m., the receipt date [of filing of that document, for purposes of these rules, shall] will be the date of the next regular workday. [Persons filing documents by facsimile copy accept all responsibility for timely filings. Delays in transmission shall not extend filing deadlines.]

(6) The director will deny requests for hearing if the request is submitted or received after the filing deadline. The party may request a show-cause hearing within 30 days after the date of the denial notice. The administrative law judge may only consider whether:

- (a) The request for contested case hearing was filed timely; or**
- (b) If good cause existed that prevented the party from timely requesting a hearing on the merits.**

Stat. Auth.: ORS 656.726([3]4) and ORS 84.013
Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)
Hist: Filed 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

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436-001-0160 Extension of Time for Filing

Requests for extension of time for filing documents other than a request for hearing [shall] must be received by the director, or the administrative law judge if the contested case has been referred to the Office of Administrative Hearings, on or before the document's [date] filing deadline. [on which the document is due].

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
 Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
 Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
 Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0170 Duties and Powers of the [Presiding Officer] Administrative Law Judge

(1) The [presiding officer shall conduct a fair and impartial hearing. The presiding officer] administrative law judge [has authority to] may [.]

[(1) Administer oaths and affirmations;

(2) Regulate the course of the hearing and exclude persons from the hearings;

(3) Require a party to state their position on any issue and the basis for that position;

(4) Order a party to produce a witness or other evidence;

(5) Call and examine any party or witness;

(6) Close and reopen the hearing record as justice so requires;

(7) R] remand a dispute to the director for further administrative [unit;] action. [and

(8) Take any other action necessary, in the presiding officer's reasonable judgment, for a full and fair disposition of the case.]

(2) Unless otherwise provided in writing, the director delegates to an administrative law judge conducting a contested case hearing on the director's behalf the authority to:

(a) Rule on a petition to participate as a party or as a limited party under OAR 137-003-0535;

(b) Issue subpoenas in support of a discovery order, and manage discovery motions, under OAR 137-003-0572(10) when a motion for an order requiring discovery has been filed with the administrative law judge under OAR 137-003-0520(2);

(c) Issue a written order granting or denying a deposition, or issue a subpoena to compel a deposition, of persons other than department employees under OAR 137-003-0572;

(d) Determine whether a party is unable to pay for a qualified interpreter under OAR 137-003-0590;

(e) Execute and issue final orders of dismissal when the requesting party has withdrawn the request, and no cross-request for hearing was filed; and

(f) Execute and issue final orders by default under OAR 137-003-0670.

(3) If necessary, the administrative law judge shall continue a hearing to allow the presentation of oral or written legal argument by the Department of Justice.

Stat. Auth.: ORS 656.726(4[3])

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Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)
Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0171 Hearings Security

(1) Any party or representative, having knowledge or reasonable belief that any person participating in the hearing may present a danger or may be a threat to anyone involved in the hearing, shall immediately notify the assigned presiding officer and the opposing parties or representatives of the potentially dangerous situation.

(2) All decisions involving security at the hearing shall be within the discretion of the presiding officer.]

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.415 and 656.704(2)
Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0175 Conducting a Contested Case Hearing

(1) The contested case hearing shall be conducted by and under the control of the presiding officer, so as to include the following:

- (a) The statement and evidence of the petitioner in support of its action;
- (b) The statement and evidence of respondent, interested agencies, and other parties, except that subject areas of the limited parties shall be confined to the area of participation granted by the presiding officer;
- (c) Any rebuttal evidence; and
- (d) Any closing arguments.

(2) Presiding officers, interested agencies and parties shall have the right to question witnesses. However, questions of witnesses by limited parties shall be confined to the area of participation granted by the presiding officer.]

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 183.415 and 656.704(2)
Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0185 Hearings

(1) At the discretion of the [presiding officer] **administrative law judge**, hearings may be conducted either by telephone or in-person.

(2) [A party desiring an in-person hearing shall make a written request.] In-person contested case hearings are held in Salem, Oregon except when the **administrative law judge**[presiding officer] authorizes a hearing outside of Salem.

(3) Upon prior arrangement and approval of the [presiding officer] **administrative law judge**, a party or witness for an in-person hearing may appear by telephone.

(4) The [presiding officer] **administrative law judge** shall make an audio recording of [any] **all** hearings.

(5) Prior to [commencement of a hearing] **the hearing**, each party and the division [shall] **must** provide **copies of documentary evidence that it will seek to introduce into the record** to all other parties, **the director's representative under OAR 436-001-0030(2), [presiding officer] and the administrative law judge**[and to the division, copies of documentary evidence that it will seek to introduce into the record].

(6) Nothing in this rule precludes any party or the division from seeking to introduce documentary evidence in addition to evidence described in [sub]section (5) during the hearing. The [presiding officer] **administrative law judge** may receive such evidence, subject to the applicable

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rules of evidence, if inclusion of the evidence in the record is necessary to conduct a full and fair hearing. When new evidence is introduced, the other parties may request an opportunity to submit rebuttal evidence. The [presiding officer] **administrative law judge** may allow the admission of rebuttal evidence. If any evidence introduced during the hearing has not previously been provided to the [presiding officer] **administrative law judge**, [to]the [division] **director's representative**, and to the other parties, the hearing may be continued for sufficient time to allow the party or the division to obtain and review the evidence.

[(7) The presiding officer may recess the hearing to discuss any of the matters listed in OAR 436-001-0105(2).]

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)

Hist: Filed 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0191 Evidence

- (1) Evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible.
- (2) Irrelevant, immaterial or unduly repetitious evidence shall be excluded.
- (3) Subject to the presiding officer's discretion to exclude irrelevant, immaterial or unduly repetitious matter, all offered evidence, not objected to, will be received.
- (4) Evidence objected to may be received by the presiding officer. Rulings on its admissibility or exclusion, if not made at the hearing, shall be made on the record at or before the time a final order is issued.
- (5) The presiding officer shall accept an offer of proof made for excluded evidence. The offer of proof shall contain sufficient detail to allow the reviewing agency or court to determine whether the evidence was properly excluded. The presiding officer has discretion to decide whether the offer of proof is to be oral or written and at what stage in the proceeding it will be made. The presiding officer may place reasonable limits on the offer of proof, including the time to be devoted to an oral offer or the number of pages in a written offer.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0195 Medical Evidence

The following does not constitute "new medical evidence" and, if relevant, may be admissible in a contested case:

- (1) Supplemental cross-examination of medical professionals whose reports or work products are included in the medical evidence gathered by the Medical Review Unit's staff, provided the scope of the cross-examination deals with events occurring on or before the date the Medical Review Unit's record was closed.
- (2) Supplemental reports, corrections and clarifications by medical professionals whose reports or work products are in the medical evidence gathered by the Medical Review Unit's staff provided the scope of the additional items deals with events occurring on or before the date the Medical Review Unit's record was closed.
- (3) Supplemental cross-examination of those providing data under subsection (2), provided the scope of the cross-examination is limited to what is under subsection (2).
- (4) Relevant testimony.]

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 656.260, 656.327, and 656.704(2)

Hist: Filed 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0201 Failure to Appear

(1) If the petitioner fails to appear at the hearing, the [presiding officer] **administrative law judge** may issue an order of dismissal or an order to show cause. An order to show cause shall

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allow the petitioner ten days to present argument establishing good cause reason for the failure to appear.

(2) If the respondent does not appear, the [presiding officer] **administrative law judge** has the discretion to proceed with the hearing.

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0205 Withdrawal of Attorney from Contested Case

If an attorney is withdrawing from representing a party, the attorney shall provide written notice of the withdrawal to all parties and the presiding officer.]

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0210 Record and Transcript of Hearing

(1) A verbatim record shall be made of [the] **all** hearings, including all motions, rulings and testimony. The record shall be made by audio tape or reporter, at the discretion of the [presiding officer] **administrative law judge**.

(2) At any time before the decision becomes final, the [presiding officer] **administrative law judge** or director may order a full or partial transcript of the record.

(3) At any time before the reporter's notes or recordings of the hearing are destroyed, any party may order a transcript at that party's expense.

(4) Audio tapes, reporters' notes or records of a hearing may be destroyed six months after final disposition of the case.

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92

Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96

Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

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

(1) Review of medical service (ORS 656.245 and 656.247(3)(a)) and treatment (ORS 656.327 and 656.260) disputes is for substantial evidence or error of law. New medical evidence or issues may not be considered at the contested-case hearing.

(2) In vocational assistance (ORS 656.340) disputes, new evidence may be admitted. The standard of review is to determine whether the director's order:

(a) Violates a statute or rule;

(b) Exceeds the statutory authority of the agency;

(c) Was made upon unlawful procedure; or

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

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discretion.

(3) The scope of review for medical fee (ORS 656.248 and 656.247(3)(b)) disputes is *de novo*.

(4) The scope of review in all other contested-case hearing disputes is *de novo*, unless otherwise prescribed by statute or administrative rule.

[The scope of review shall be as follows:

- (1) Medical services disputes arising under ORS 656.245 shall be reviewed *de novo*.
- (2) Medical fee disputes arising under ORS 656.248 shall be reviewed *de novo*.
- (3) Medical treatment disputes arising under ORS 656.327 shall be reviewed pursuant to the substantial evidence standard. In such disputes, no new medical evidence or medical issues, as defined by OAR 436-001-0195, shall be admitted at the contested hearing.
- (4) Medical treatment disputes arising within a managed care organization certified under ORS 656.260 shall be reviewed pursuant to the substantial evidence standard. In such disputes, no new medical evidence or medical issues, as defined by OAR 436-001-0195, shall be admitted at the contested case hearing.
- (5) Vocational assistance disputes arising under ORS 656.340 shall be reviewed pursuant to the limited scope of review in ORS 656.283, as follows:
 - (a) Violates a statute or rule;
 - (b) Exceeds the statutory authority of the agency;
 - (c) Was made upon unlawful procedure; or
 - (d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.
- (A) At the hearing, the presiding officer may admit new evidence to determine if any of the above occurred.
- (B) Review of any new evidence is *de novo*.
- (6) All other disputes shall be reviewed *de novo* unless otherwise prescribed by statute or administrative rule.]

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 656.260, 656.283, 656.327, 656.704(2)

Hist: Filed 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0226 Notice of Expert Testimony

At least 14 days before the hearing, a party shall provide **written notice** to the [presiding officer] **administrative law judge, all** [and] other parties, **and the director's representative** [in writing, the identity of] **identifying** each expert witness the party will call to testify at hearing. **If a party fails to provide 14 days notice, the contested-case hearing will be continued to allow sufficient time for the parties to prepare.**

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0231 Official Notice

(1) The presiding officers may take official notice of a fact, if it is a fact not subject to reasonable dispute because it is generally known or can be accurately and readily determined by resort to sources whose accuracy cannot reasonably be questioned.

(2) The presiding officers may also take official notice of general, technical or scientific facts within their specialized knowledge.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

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436-001-0240 Exhibits and Exchange of Exhibits

(1) The division [shall] **will** provide the parties and the [presiding officer] **administrative law judge** legible copies of all documents that were relied upon in the underlying administrative review, together with an index. The index [shall] **will** include a description of each document, author, number of pages, and date of the document. The documents [shall] **will** be arranged in chronological order and designated by numbers in the lower right corner of each page, beginning with the document of earliest date. Pagination of multiple-page documents [shall] **will** be designated by the document number, followed by the page number. For example, page two of document five may be marked as "Exhibit 5, page 2" or "Ex. 5-2," etc.

(2[a]) Not less than [fourteen] **14** days before the hearing, or within seven days of receipt of the division's document index and documents, whichever is later, the petitioner(s) [shall] **must** provide the other parties, **the director's representative**, and the [presiding officer] **administrative law judge** legible copies of any additional documents [that they will offer at] **to be relied upon at** hearing. The additional documents [shall] **must** be marked and accompanied by a supplemental document index, numbered to coincide in chronological order with the division's [documents] **exhibits and exhibit list**. For example, a document which is chronologically between documents [five] **5** and [six] **6** of the division's [documents] **exhibit list** may be marked as "Exhibit 5a," "Ex. 5a," etc.

(3[b]) Not less than seven days before the hearing, the respondent(s)/cross-petitioner(s) [shall] **must** provide to the other parties, **the director's representative**, and the [presiding officer] **administrative law judge** legible copies of any additional documents that they will offer at hearing in the same manner as provided by the petitioner(s).

(4[2]) [If photographs are used as exhibits, each party and the presiding officer shall be provided with a set of the photos.] **Any party using photographs as exhibits must provide each party, the director's representative, and the administrative law judge with a set of the photographs.**

(3)(5) All exhibits offered, whether or not admitted into evidence, unless withdrawn, [shall] **will** be part of the record in the case.

(6[4]) At the discretion of the [presiding officer] **administrative law judge**, [to accompany the record,] an accurate description or photograph of an object or real evidence may be substituted for such object or real evidence. The party offering such evidence shall be responsible for providing the description or photograph, and for retaining custody of the object until the case is closed.

(7) If any party, in the regular course of the party's business or activity, had kept or recorded any memorandum, writing, entry, print, reproduction, or a combination thereof, of any act, transaction, occurrence, or event, and in the regular course of the party's business or activity has caused any or all of the same to be recorded, copied, or reproduced by any photographic, photostatic, microfilm, micro-card, miniature photographic, optical imaging, or other process that accurately reproduces or forms a durable medium for so reproducing the original, the original may be destroyed in the regular course of business. Such reproduction, when satisfactorily identified, is as admissible in evidence as the original itself whether the original is in existence or not at the time a party introduces into evidence such reproduction. The introduction of a reproduced record, enlargement, or facsimile does not preclude admission of the original.

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(8) If a party introduces into evidence a reproduction described in section (7), the exhibit index described in this rule must include the following certification: "The attached exhibits contain reproductions as described in OAR 436-001-0240. I hereby certify that the reproductions were created in the regular course of business or activity, and are a true and accurate representation of the original."

[(5) The presiding officer has discretion to admit evidence as otherwise provided under these rules.]

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.310 through 183.550, 656.260, 656.327, 656.283 and 656.704(2)

Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0255 Ex Parte Communication

(1) An ex parte communication is an oral or written communication to the presiding officer or administrator not made in the presence of all parties to the hearing, concerning a fact in issue in the proceeding, but does not include communication from agency staff or counsel about facts in the record.

(2) If the presiding officer or administrator receives an ex parte communication during the pendency of the proceeding, the individual shall:

(a) Give all parties notice of the substance of the communication, if oral, or a copy of the communication, if written; and

(b) Provide any party who did not present the ex parte communication an opportunity to rebut the substance of the ex parte communication at the hearing, at a separate hearing for the limited purpose of receiving evidence relating to the ex parte communication, or in writing.

(3) The division's record of a contested case proceeding shall include:

(a) The ex parte communication, if in writing;

(b) A statement of the substance of the ex parte communication, if oral;

(c) The presiding officer's or administrator's notice to the parties of the ex parte communication; and

(d) Rebuttal evidence.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0260 Unacceptable Conduct

(1) Contested case hearings [before the director] are not public meetings and are not open to the public, except with the consent of the parties and as authorized by the [presiding officer]**administrative law judge**.

(2) The [presiding officer]**administrative law judge** may [have]**expel** a person [removed]from a contested case hearing if that person disrupts the proceeding.

(3) The [presiding officer]**administrative law judge** may prohibit broadcasting, television, sound or video recording, and the taking of photographs of proceedings in the hearing room. These prohibitions, in the [presiding officer's discretion]**administrative law judge's discretion**, may be applied to areas immediately adjacent to the hearing room where the activities may interrupt or interfere with entry or exit from the hearing room and distract or disturb the proceedings or interfere with the conduct of the hearing.

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)

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Hist: Filed 5/22/92 as WCD Admin. Order 9-1992, eff. 5/25/92
Amended 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0265 Attorney Fees

(1) In cases where the director is required to assess an attorney fee under ORS 656.385(1) (§2, ch. 756, OL 2003):

(a) The fee must be based on the factors listed in ORS 656.385(1) (§2, ch. 756, OL 2003).

(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:

<u>Estimated Results Achieved</u>	<u>Attorney Time Devoted</u>				
	<u>1-2 hours</u>	<u>2.1-4 hours</u>	<u>4.1-6 hours</u>	<u>6.1-8 hours</u>	<u>8.1-12 hours</u>
<u>\$1-\$2000</u>	<u>\$100-400</u>	<u>\$200-700</u>	<u>\$300-750</u>	<u>\$600-1000</u>	<u>\$800-1250</u>
<u>\$2001-\$4000</u>	<u>\$200-500</u>	<u>\$400-800</u>	<u>\$600-900</u>	<u>\$800-1300</u>	<u>\$1050-1500</u>
<u>\$4001-\$6000</u>	<u>\$300-700</u>	<u>\$600-1000</u>	<u>\$800-1250</u>	<u>\$1000-1450</u>	<u>\$1300-1750</u>
<u>\$6001-\$10000</u>	<u>\$400-900</u>	<u>\$800-1300</u>	<u>\$1050-1600</u>	<u>\$1350-1800</u>	<u>\$1550-2000</u>

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

(d) 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] in cases where the administrative law judge or director [is authorized to] assesses an [reasonable] attorney fee [by statute], the following factors may also be considered:

- (a) [The time devoted to the case;
- (b) The complexity of the issue(s) involved;
- (c) **(b)** The quality of the legal representation;
- (d) **(c)** The value of the interest involved;
- (e) **(d)** The nature of the proceedings;
- (f) [The benefit secured for the claimant;]
- (g) **(e)** The risk in a particular case that an attorney's efforts may go uncompensated;
- (h) **(f)** The assertion of frivolous issues or defenses;
- (i) **(g)** A statement of services, if submitted within seven days of the hearing date, unless the [presiding officer] **administrative law judge** instructs otherwise; and

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[(j)] **(h)** Any other relevant consideration deemed appropriate by the [presiding officer] **administrative law judge or director.**

(2) If the attorney representing a claimant is instrumental in obtaining a settlement of the dispute, after a hearing request is filed but prior to the director's decision, the presiding officer or director may, where authorized by law, approve an assessed fee agreed to by the parties or may assess a fee considering the factors set forth in subsection (1).

(3) Attorney fees may only be authorized if an executed attorney retainer agreement has been filed.]

(3) In cases under ORS 656.262(11) (§1, ch. 756, OL 2003) where the issue is solely the assessment and payment of a penalty and attorney fee, OAR 438-015-0110 applies.

(4) [Once the] **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 [pursuant to] **under** OAR 436-001-0275.

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS **656.262**, 656.385, 656.388 and 656.704(2) (**and ch. 756, OL 2003**)

Hist: Filed 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0275 Proposed and Final Orders, Filing Exceptions

(1) When the [division] **administrative law judge** serves a proposed and final order on the parties, the [division] **Office of Administrative Hearings** shall notify the parties[:

(a) T]that[, in order to be considered by the division,] written exceptions [shall] **must** be filed within 30 days of the date of service of the proposed and final order[; and].

[(b) When and in what form argument may be made to the administrator who will render the final order.]

[(c)] **2** [That w] **Written responses** [by other parties] **to exceptions** [shall] **must** be filed within 20 days of service of the exceptions and a reply, if any, [shall] **must** be filed within 10 days of service of the responses.

[(2)] **3** If no exceptions are filed, the proposed and final order becomes final 30 days after the date of service of the order[, subject to subsection (4)].

[(3) If exceptions are filed, the administrator may adopt the proposed order or prepare a new order.]

(4) [Nothing in this rule prohibits the staff of a non-party agency from commenting on the proposed order or] **Notwithstanding section (3) of this rule**, the administrator [from revising] **may revise** the proposed and final order[, even if no exceptions are filed by the parties.] **under OAR 137-003-0501 to 137-003-0700, or these rules.**

(5) "Date of service" means the date [of mailing or delivery.] **mailed or delivered.**

Stat. Auth.: ORS 656.726([3]4)

Stats. Implemented: ORS 183.310 through 183.550 and 656.704(2)

Hist: Filed 2/12/96 as WCD Admin. Order 96-055 eff. 2/12/96
Amended 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0285 Final Orders

(1) Final orders in contested cases shall comply with all of the requirements prescribed in ORS 183.470.

(2) The date of service of the order to the parties shall be specified in writing and be part of or be attached to the order.

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(3) Review of final orders shall be pursuant to ORS 183.480 et. seq.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

[436-001-0295 Immediate Suspension or Refusal to Renew a License, Notice of Opportunity for Hearing, Service

(1) Upon finding there is a serious danger to the public health or safety, the director may immediately suspend or refuse to renew a license. For purposes of this rule, such a decision is referred to as an emergency suspension order. An emergency suspension order shall be in writing and may be issued without prior notice to the licensee or an opportunity for a hearing as required for contested cases under ORS chapter 183.

(2)(a) Except when the danger to the public health or safety is so imminent that opportunity for the licensee to object under subsection (3) of this rule is not practicable as determined by the director, the director shall provide the licensee with notice and opportunity to object prior to issuing the emergency suspension order. For purposes of this rule, this notice is referred to as a pre-suspension notice.

(b) The pre-suspension notice shall:

(A) Describe generally the acts of the licensee and the circumstances that would be grounds for revocation, suspension or refusal to renew the license under the director's usual procedures;

(B) Describe generally the reasons why the acts of the licensee and the circumstances seriously and immediately endanger the public's health or safety; and

(C) Identify a person who the licensee may contact and who is authorized to issue the emergency suspension order or to make recommendations regarding the issuance of the emergency suspension order.

(c) The director may provide the pre-suspension notice to the licensee in writing, orally or by any other means available.

(3) Following the pre-suspension notice, the director shall provide the licensee an immediate opportunity to respond to the pre-suspension notice before a person authorized to issue the emergency suspension order or to make recommendations regarding the issuance of the emergency suspension order. An emergency suspension order may be issued anytime thereafter.

(4)(a) When the director issues an emergency suspension order, the director shall serve the order on the licensee either personally or by registered or certified mail.

(b) The order shall include the following statements:

(A) Those required under ORS 183.415(2) and (3);

(B) That the licensee has the right to demand a hearing to be held as soon as practicable to contest the emergency suspension order;

(C) That if the demand for hearing is not received by the division within 90 days of the date of notice of the emergency suspension order the licensee shall have waived its right to a hearing under ORS chapter 183;

(D) The effective date of the emergency suspension order;

(E) Findings of the specific acts or omissions of the licensee that are grounds for revocation, suspension or refusal to renew the license, and the reasons these acts or omissions seriously and immediately endanger the public's health or safety; and

(F) That the director may combine the hearing on the emergency suspension order with any other proceedings before the director affecting the license. The procedures for a combined proceeding shall be those applicable to the other proceeding affecting the license.

(5)(a) If timely requested by the licensee, the director shall hold a hearing on the emergency suspension order as soon as practicable.

(b) At the hearing, the division shall consider the facts and circumstances including, but not limited to:

(A) Whether the acts or omissions of the licensee pose a serious danger to the public's health or safety; and

(B) Whether circumstances at the time of the hearing justify confirmation, alteration or revocation of the order.]

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.415 and 656.704(2)

Hist: Filed 08/10/98 as WCD Admin. Order 98-057, eff. 9-15-98

Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. 4/1/04

436-001-0300 Alternative Dispute Resolution

(1) The director may contact the parties to a contested case dispute for the purposes of offering a resolution alternative to a contested-case hearing.

(2) The parties must voluntarily consent to participate in an alternative dispute

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resolution process.

(3) If consent to attempt alternative dispute resolution is received prior to referral of the dispute to the Office of Administrative Hearings, the director will stay the referral. Once the dispute is settled, or it becomes clear that no resolution can be reached, the director will refer it.

(4) If consent to attempt alternative dispute resolution is received after referral of the dispute to the Office of Administrative Hearings, the director will notify the administrative law judge that the parties have agreed to use an alternative dispute resolution process, and that the hearing should be suspended until the process is complete. Once the dispute is settled, or it becomes clear that no resolution can be reached, the director will notify the administrative law judge to resume the hearing.

(5) If the parties resolve only the issues under the director's jurisdiction related to the contested case notice, then the director will incorporate the agreement into a final order under OAR 137-003-0665.

(6) If the parties resolve any or all matters regarding the claim under ORS 656.236, or issues resolving disputes over compensability of a claim under ORS 656.289(4), the disposition must be submitted to the Workers' Compensation Board for approval.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 183.415, 183.502 (§16, ch. 75, OL 2003)

Hist: Adopted xx/xx/xx asWCD Admin. Order xx-xxx, eff. 4/1/04