DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROPOSED OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030

CLAIM CLOSURE AND RECONSIDERATION

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Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

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

Rules Coordinator	Telephone
Fred Bruyns	(503) 947- 7717 Fax (503) 947-7581

PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879
Address

Hearing date	Time	Location	Hearings Officer
January 22, 2004	2:00 p.m..	Room 260 (2nd floor), Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns

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

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 <u>director</u> to request an examination to determine the extent of impairment.

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%.

- 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

The Amendment of:
OAR 436-001, Procedural Rules Governing Rulemaking and Hearings
OAR 436-009, Oregon Medical Fee and Payment Rules
OAR 436-010, Medical Services
OAR 436-030, Claims Evaluation, Determination, and Reconsideration
OAR 436-060, Claims Administration
OAR 436-120, Vocational Assistance to Injured Workers

Statutory Authority,
Statutes Implemented,
Statement of Need,
Principal Documents Relied Upon,
Statement of Fiscal Impact

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.

Oregon Administrative Rules, Chapter 436
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

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<tr>
<td>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
010, Medical Services
030, Claim Closure and Reconsideration
060, Claims Administration
120, Vocational Assistance to Injured Workers</td>
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<td>SUMMARY OF
TESTIMONY AND
AGENCY RESPONSES</td>
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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

The following written testimony was received:

Subject Division	Exhibit #	Testimony received from:
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
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.

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 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 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 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.

OAR 436-009-0030(9)(d)
Testimony: Exhibit #10
Revise the following sentence as shown: ~~Only i~~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.

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.**

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.

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 carbamazapine 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.

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.

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.

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.

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 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)
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.

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 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 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 <u>medical</u>

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
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.

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.

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.

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.

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.

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)
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. 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 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.

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 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.

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 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-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

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 030

436-030-0001 Authority for Rules

These rules are promulgated under the director's authority contained in ORS 656.726(4) and ORS 656.268.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 2/6/75 as WCB Admin. Order 5-1975, eff. 2/26/75.
Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
Renumbered from OAR 436-65-000, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.

436-030-0002 Purpose of Rules

The purpose of these rules is to provide standards, conditions, procedures and reporting requirements for:

(1) [r]**R**equests for closure by the worker;

(2) [c]**C**laim closure [in accordance with] **under** ORS 656.268(1);

(3) [d]**D**etermining medically stationary status;

(4) [d]**D**etermining temporary disability benefits;

(5) [a]**A**wards of permanent partial disability;

(6) [r]**R**eview and determination of the disabling or nondisabling status of a claim;

(7) [d]**D**etermining permanent total disability awards;

(8) [r]**R**eview for reduction of permanent total disability awards;

(9) [r]**R**eview and determination of prior unscheduled permanent partial disability awards; and

(10) [r]**R**econsideration of notices of closure.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.206, ORS 656.210, ORS 656.212, ORS 656.262, ORS 656.268, ORS 273, ORS 277, ORS 656.325, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-002, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.

436-030-0003 Applicability of Rules

(1) Except as provided in section (3) of this rule, these rules apply to all accepted claims for workers' compensation benefits and all requests for reconsideration received by the department on or after the effective date of these rules.

(2) All orders issued by the division to carry out the statute and these rules are considered an order of the director.

(3) These rules take the place of the rules adopted on January 1, 2001, by Workers' Compensation Division Administrative Order 00-058, and carry out [the provisions of] ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.277, 656.278, 656.325, and section 22(3), chapter 865, Oregon Laws 2001.

(a) [The provisions of] OAR 436-030-0009, 030-0020, 030-0030, 030-0115 (except section (4)), 030-0125, 030-0135, 030-0145, 030-0155, 030-0165 (except subsection [(9)]**(10)**(b)), 030-0175**,** and 030-0185 apply to all determinations or claims for workers who become medically stationary after July 1, 1990. For claims in which the worker became medically stationary prior to July 2, 1990 [the provisions of] OAR 436-030-0020, 030-0030, 030-0050 as [contained in] **adopted by** WCD Administrative Order 13-1987 [shall apply] **effective January 1, 1988**.

[(b) The provisions of OAR 436-030-0045 apply to requests for reclassification made on or after January 1, 2002.]

[(c)]**(b)** OAR 436-030-0017(1) applies to all requests for closure made on or after January 1, 2002.

[(d)]**(c)** [The provisions of] OAR 436-030-0055(3)[(c)]**(b), (3)(d)** and (4)(a) apply to all claims with dates of injury on or after [the effective date of these rules,] January 1, 2002.

[(e)]**(d)** [The provisions of] OAR 436-030-0115(4) and 436-030-0165[(9)]**(10)**(b) apply to all claims closed on or after [the effective date of these rules,] January 1, 2002.

(e) The changes to the following rules effective January 1, 2004, apply to all claims closed on or after January 1, 2004: OAR 436-030-0009, 030-0010, 030-0115, 030-0125, 030-0135, 030-0145, 030-0165, and 030-0185.

Stat. Auth.: ORS 656.268 **(ch. 429, OL 2003)**, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.206, ORS 656.210, ORS 656.212, ORS 656.262, ORS 656.268 **(ch. 429, OL 2003)**, ORS 656.273, ORS 656.277, ORS 656.325, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313; chapters 349, 350, 377, and 865, Oregon Laws 2001
Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
Renumbered from OAR 436-65-030, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058 , eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02.
Amended 1/15/02 as WCD Admin. Order 02-051, eff. 1/15/02 (Temp.)
Amended 4/5/02 as WCD Admin. Order 02-054, eff. 4/8/02
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0005 Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrator" means the [A]**a**dministrator of the Workers' Compensation Division, Department of Consumer and Business Services, or the administrator's delegate for the matter.

(2) "Authorized Nurse Practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 (§3, ch. 811, OL 2003) and OAR 436-010.

[(2)]**(3)** "Director" means the [D]**d**irector of the Department of Consumer and Business Services, or the director's delegate for the matter.

[(3)]**(4)** "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

[(4)]**(5)** "Insurer" means the State Accident Insurance Fund, or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer or a self-insured employer group.

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

[(6) "Notice of Classification" means the insurer's written response, to a worker's request, which notifies the worker of the insurer's decision regarding the nondisabling status of a claim.]

(7) "Notice of Closure" means a notice to the worker issued by the insurer to close an accepted disabling claim or to reduce permanent total disability to permanent partial disability.

(8) "Notice of [Classification] **Refusal to Reclassify**" means the insurer's written response, to a worker's request, which notifies the worker of the insurer's decision regarding the nondisabling status of a claim.

[(8)]**(9)** "Reconsideration" means review by the director of an insurer's Notice of Closure.

[(9)]**(10)** "Statutory closure date" means the date the claim [can be] **satisfies the criteria for** clos[ed]**ure** [pursuant to] **under** ORS 656.268(1)(b) and (c).

[(10)]**(11)** "Statutory appeal period" means the time frame for appealing a Notice of Closure or Order on Reconsideration.

[(a) For closures where the worker is medically stationary prior to June 7, 1995, the appeal period is 180 days from the mailing date of the order.]

[(b) For closures where the worker is medically stationary on or after June 7, 1995, the appeal period is 60 days from the date the order is mailed to the worker and to the worker's attorney if the worker is represented. The appeal period for an Order on Reconsideration is 30 days from the mailing date of the order.]

[(c) Former ORS 656.268(1)(a) and (b) became effective June 7, 1995. For workers whose claims are closed pursuant to that statute, the medically stationary date will be at some point in the future after June 7, 1995. Therefore, the appeal period for claims closed pursuant to former ORS 656.268(1)(a) and (b) is 60 days from the date the order is mailed to the worker and to the worker's attorney if the worker is represented.]

[(11)]**(12)** "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.005, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82.
Renumbered from OAR 436-65-004, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058 eff. 01/01/01
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0007 Administrative Review

(1) Dispute Resolution [B]**b**efore the director:

(a) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through OAR 436-030-0185.

(b) Abating, withdrawing or amending an Order on Reconsideration: The director may abate, withdraw, and/or amend the Order on Reconsideration until [a hearing is requested or] the Order is final by operation of law.

(c) Notices of [Classification] **Refusal to Reclassify** issued by insurers are appealable by the worker to the director [in accordance with] **under** ORS 656.273 and 656.277. A worker need not be represented in the administrative review process to make a request for review of the insurer's classification decision.

(A) The worker's request for review must be made to the director no later than the 60th day after the date the Notice of [Classification] **Refusal to Reclassify** is mailed.

(B) The insurer [shall] **must** provide the director with the complete medical record used and all other relevant documents within 14 days of notification by the director of the request for review. The insurer may be subject to penalties under OAR 436-030-0580 for failure to provide the claim documents in a timely manner. The worker may also submit, within the same 14 days, any additional evidence the worker wishes the director to consider.

(C) When providing information to the director, the submitting party [shall] **must** also provide copies to all other parties at the same time.

(D) After receiving the relevant documents, the director will issue an order. The parties will have 30 days from the date of the order to appeal to the Hearings Division of the Workers' Compensation Board.

(E) The director may reconsider, abate, or withdraw any order before a hearing on that order has been requested and before the order becomes final by operation of law.

(2) Cases brought before the Hearings Division of the Workers' Compensation Board:

(a) Orders on Reconsideration [and Director's Review of Claim Classification] are appealable to the Hearings Division of the Workers' Compensation Board as follows:

(A) The party must send the request for hearing in writing to the Hearings Division in accordance with ORS 656.283 and the rules of procedure adopted by the Workers' Compensation Board.

(B) [Pursuant to] **Under** OAR 436-030-0145[(2)]**(1)(b)** for claims medically stationary on or after June 7, 1995, for the purpose of filing such appeal, the time [shall] **will** be 30 days from the mailing date of the Order.

(C) [Pursuant to] **Under** OAR 436-030-0145(1)**(a)** for claims medically stationary before June 7, 1995, for the purpose of filing such appeal, the time required to complete the reconsideration proceeding [shall] **will** not be included in the time limit. The request for hearing must be filed within the statutory appeal period.

(b) A party may request a hearing before the Hearings Division of the Workers' Compensation Board on any other action taken [pursuant to] **under** these rules where a worker's right to compensation or the amount thereof is directly an issue [in accordance with the provisions of] **under** ORS Chapter 656.

(3) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.7[04]**40 (§9, ch. 170, OL 2003)**, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director [pursuant to] **under** ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

(a) The party must send the request for hearing in writing to the director within [20 calendar days] **60 days** after [service of] **the mailing date of** the **proposed** order or [notice of] assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The Workers' Compensation Division [shall] **will** forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(c) An Administrative Law Judge from the Hearings Division, acting on behalf of the director, [shall] **will** conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(4) Director's Administrative Review of other actions: Except as covered under sections (1) through (3) of this rule, any party seeking an action or decision by the director or aggrieved by an action taken by any other party [pursuant to] **under** these rules, may request administrative review by the director as follows:

(a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is taken, unless the director determines that there was good cause for delay or that substantial injustice may result otherwise.

(b) The director may require and allow such evidence as it deems appropriate to complete the review.

(c) A director's order will be issued and will specify if the order is final or if it may be appealed.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313**, (§9, ch. 170, OL 2003)**

Stats. Implemented: ORS 656.268, ORS 656.277, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 350, Oregon Laws 2001
Hist: Filed 06/30/78 as WCD Admin. Order 8-1978, eff. 07/10/78.
Amended 03/20/80 as WCD Admin. Order 4-1980, eff. 04/01/80.
Renumbered from OAR 436-65-998, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 01/01/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Renumbered from OAR 436-030-0020.
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0009 Appeals of Notices of Closure

If the worker **or insurer** disagrees with a Notice of Closure and the worker was determined medically stationary after July 1, 1990, or the worker is not medically stationary and the claim is closed [pursuant to] **under** ORS 656.268(1)**(b) or (c) (ch. 429, OL 2003)**, the worker **or insurer** must first request a reconsideration by the director [pursuant to] **under** these rules. [An insurer may not request reconsideration of its own Notice of Closure.] If the worker was determined medically stationary on or before July 1, 1990, WCD Admin. Order 13-1987 rules apply.

Stat. Auth.: ORS 656.268 **(ch. 429, OL 2003)**, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268 **(ch. 429, OL 2003)**, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Renumbered from OAR 436-030-0020.
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0010 Director Responsibility

(1) The director, when requested by a worker, is responsible for[:

(a)] reviewing the disabling/nondisabling status of a claim**.**[; and

(b)]**(2) The director, when requested by a worker or insurer, is responsible for** conducting the reconsideration proceeding when the worker **or insurer** is dissatisfied with a Notice of Closure, and assessing penalties and attorney fees where appropriate.

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

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.206, ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.268, ORS 656.277, ORS 656.325, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 2/6/75 as WCB Admin. Order 5-1975, eff. 2/26/75.
Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82.
Renumbered from OAR 436-65-005, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.

Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0015 Insurer Responsibility

(1) When an insurer issues a Notice of Closure, the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the worksheet upon which the Notice is based, a completed "Insurer Notice of Closure Summary" and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in section (2) of this rule;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes [in accordance to] **under** OAR 436-050; and

(c) Providing the Updated Notice of Acceptance at Closure in a timely manner. For purposes of this rule, a timely Updated Notice of Acceptance at Closure [shall] **must** be issued no sooner than the date the claim qualified for closure, or 30 days prior to claim closure (whichever occurs closer to actual closure), but not later than the mailing date of the closure. The Updated Notice of Acceptance at Closure [shall] **must** contain the following title, information and language:

(A) [t]**T**itle: "Updated Notice of Acceptance at Closure";

(B) [i]**I**nformation: all compensable conditions that have been accepted, even if the accepted condition was ordered by litigation and is under appeal; however, any conditions under appeal must be specifically identified;

(C) [l]**L**anguage, in bold print:

"Notice to Worker: This notice restates and includes all prior acceptances for the current claim opening only, but does not include conditions which have been denied. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal unless and until the condition is found to be compensable after all litigation is complete. These are the only conditions considered at the time of claim closure. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(d) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(e) In the event an omission or error requires a corrected updated notice of acceptance at closure, the word "CORRECTED" [shall] **must** appear in capital letters adjacent to the word "updated".

(f) In the event that the "initial notice of acceptance" is the same as the "updated notice of acceptance at closure," both titles [shall] **must** appear near the top of the document.

(2) Copies of Notices of Refusal to Close [shall] **must** be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(3) In claims involving unscheduled injuries to, or disease of, body parts or conditions [pursuant to] **under** OAR 436-035-0330 through 436-035-0450, the insurer [shall] **must** consider the worker's work history and education including:

(a) The worker's level of education; and

(b) The worker's work history [pursuant to] **under** OAR 436-035-0300 and 436-035-0310 including the job at injury and work history for five years preceding the Notice of Closure with dates or period of time spent at each position.

(4) The insurer [shall] **must** consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.

(5) The insurer [shall] **must** notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure [pursuant to] **under** these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of his or her impending claim closure and that any time loss disability payments will end soon.

(c) The insurer must, within 14 days, provide the worker's attorney the same documents relied upon for claim closure.

(6) The insurer [shall] **must** not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

[(7) Failure to meet the requirements and timeframes of this rule may result in civil penalties pursuant to OAR 436-030-0580.]

[(8)]**(7)** When a condition is accepted after a closure **and the claim has been reopened under ORS 656.262**, the insurer [shall] **must** issue a Notice of Closure, considering only the newly accepted condition.

[(9)]**(8)** Denials issued [pursuant to] **under** ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

[(10)]**(9)** When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure [shall] **must** send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.331, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 377, Oregon Laws 2001
Hist: Amended and Renumbered 11/18/94 from 436-030-0020 and 030 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.

Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0017 Requests for Claim Closure by the Worker

(1) A worker may request closure from the insurer. The insurer [shall respond] **must issue a Notice of Closure or Notice of Refusal to Close** within 10 days of receipt of a written request.

(2) If an insurer issues a notice of refusal to close the claim, the notice [shall] **must** be identified in capital letters as a "NOTICE OF REFUSAL TO CLOSE" and [shall] **must** include the following information and appeal language:

(a) [n]**N**ame of the worker;

(b) [d]**D**ate of injury;

(c) [i]**I**nsurer's claim number;

(d) [m]**M**ailing date of the notice;

(e) [t]**T**he accepted and denied conditions;

(f) [r]**R**ationale for the insurer's decision; and

(g) [t]**T**he following language, in bold print:

"If you disagree with this Notice of Refusal to Close your claim, you must file a letter of disagreement with the Workers' Compensation Board within sixty (60) days from the date of this notice. Your letter must state that you want a hearing, note your address and the date of your accident, if you know the date. You must mail your letter of disagreement to the Workers' Compensation Board, [INSURER: Insert current address of Workers' Compensation Board here]. If your claim qualifies and you request it, you may receive an expedited hearing (within 30 days). Your request cannot, by law, affect your employment. If you do not file your letter of disagreement within sixty (60) days from the date of this notice, your hearing will be denied as the appeal time has passed. You may be represented by an attorney if you so choose."

(3) If the worker disagrees with the Notice of Refusal to Close, the worker may request a hearing from the Workers' Compensation Board.

[(4) Failure by the insurer to meet the requirements of this rule may result in civil penalties against the insurer pursuant to OAR 436-030-0580.]

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.319, ORS 656.726, ORS 656.745, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 349, Oregon Laws 2001
Hist: Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff/ 1/1/02
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0020 Requirements for Claim Closure

(1) **Provided the worker is not enrolled and actively engaged in training,** [T]**t**he insurer [shall] **must** issue a Notice of Closure on an accepted disabling claim within 14 days when:

(a) [m]**M**edical information **establishes there is sufficient information to determine the extent of permanent disability under ORS 656.245(2)(b)(B), and** indicates the worker's compensable condition is medically stationary [and there is sufficient information to determine the extent of permanent disability];

(b) [t]**T**he accepted injury/condition is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, **and** there is sufficient information to determine the extent of permanent disability [and the worker is not enrolled and actively engaged in training];

(c) [t]**T**he worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or

(d) [t]**T**he worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending action(s) in accordance with these rules.

(2) For purposes of determining the extent of disability, "sufficient information" requires the following:

(a) [a]**A** closing medical examination and report when there is a reasonable expectation of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s) based on evidence in the record or the physician's opinion. The closing medical examination report [shall] **must** describe in detail all measurements and findings regarding any permanent impairment, residuals or limitations attributable to the accepted condition(s) [pursuant to] **under** OAR 436-010-**0**280 and OAR 436-035; or

(b) [a]**A** physician's written statement that clearly indicates there is no permanent impairment, residuals or limitations attributable to the accepted condition(s), and there is no reasonable expectation, based on evidence in the record, of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s). If the physician indicates there is no impairment, but the record reveals otherwise, a closing examination and report [pursuant to] **under** (a) of this section is required.

(3) When determining disability, the insurer [shall] **must**:

(a) [a]**A**pply OAR 436-030-0034 regarding major contributing cause denials, worker's failure to seek treatment, and worker's failure to attend a mandatory examination;

(b) [a]**A**pply OAR 436-030-0035 regarding medically stationary status;

(c) [a]**A**pply OAR 436-030-0036 regarding temporary disability;

(d) [a]**A**pply OAR 436-030-0020, 436-030-0038, and 436-030-0066 regarding permanent partial disability;

(e) [a]**A**pply OAR 436-030-0055 and 436-030-0065 regarding permanent total disability and review of permanent total disability; and

(f) [p]**P**repare a summary worksheet**, "Notice of Closure Worksheet", Form 440-2807 (Form 2807),** which contains all the information[, and is in the form and format,] prescribed by bulletin of the director.

(4) The **"**Notice of Closure**", Form 440-1644 (Form 1644),** [shall be] **is** effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, regardless of the date on the Notice itself. The notice [shall] **must** be in the form and format that the director prescribes by bulletin. The notice [shall] **must** include[, but need not be limited to,] the following:

(a) The worker's name, address, and claim identification information;

[(a)]**(b)** [t]**T**he appropriate dollar value of any permanent disability based on the statutory value for the degree;

[(b)]**(c)** [t]**T**he body part(s) awarded disability, coded to the table of body part codes as prescribed by the director, the percentage of loss, and the number of degrees that loss represents;

[(c)]**(d)** [i]**I**f there is no permanent disability award for this Notice of Closure, a statement to that effect;

[(d)]**(e)** [t]**T**he duration of temporary total and temporary partial disability compensation;

[(e)]**(f)** [t]**T**he date the Notice was mailed;

[(f)]**(g)** [t]**T**he medically stationary date or the date the claim statutorily qualifies for closure [pursuant to] **under** OAR 436-030-0035 or 436-030-0034, respectively;

[(g)]**(h)** [t]**T**he **date the** worker's aggravation rights **end**;

[(h)]**(i)** [t]**T**he worker's appeal rights;

[(i)]**(j)** [t]**T**he right of the worker to consult with the Ombudsman for Injured Workers;

[(j)]**(k)** [t]**T**he rate schedule (dollars per degree) at which permanent disability, if any, will be paid based on date of injury; [and]

[(k)]**(l)** [t]**T**he worker's return to work status[.]**; and**

(m) A general statement that the insurer has the authority to recover an overpayment.

(5) The Notice of Closure [shall] **must** be accompanied by the following:

(a) [t]**T**he brochure "Understanding Claim Closure and Your Rights"; [and]

(b) A copy of the summary worksheet containing information and findings which result in the data appearing on the Notice of Closure; and

[(b)]**(c)** [a]**A** cover letter that:

(A) [e]**E**xplains why the claim has been closed;

(B) [l]**L**ists and describes enclosed documents; and

(C) [n]**N**otifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(6) A copy of the Notice of Closure [shall] **must** be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) [t]**T**he worker;

(b) [t]**T**he employer;

(c) [t]**T**he director; and

(d) [t]**T**he worker's attorney, if the worker is represented.

(7) The worker's copy of the Notice of Closure [shall] **must** be mailed by both regular mail and certified mail return receipt requested.

(8) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.

[(9) An insurer who fails to comply with section (6) of this rule may be assessed a civil penalty pursuant to OAR 436-030-0580.]

[(10) These rules do not prohibit an insurer from rescinding or correcting its Notice of Closure or Notice of Refusal to Close prior to the expiration of the appeal period for that Notice and prior to receipt of a request for reconsideration of the Notice of Closure by the director. A Notice of Closure shall be corrected or rescinded when:]

[(a) the insurer has been instructed to correct or rescind a Notice of Closure in the course of a department audit of insurer claim files; or]

[(b) the director has instructed the insurer to correct a Notice of Closure because it did not contain the information required by section (4) of this rule.]

[(11) Requests for reconsideration of a corrected Notice of Closure must be received within the statutory appeal period for the Corrected Notice of Closure. Requests for reconsideration of a Corrected Notice of Closure must be limited to those areas changed by the corrected Notice.]

[(12)]**(9)** Insurers may allow adjustments of benefits awarded to the worker [pursuant to] **under** the documentation requirements of OAR 436-060-0170 for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability; and

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements or other benefits payable under ORS 656.001 to 656.794.

[(13)]**(10)** The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

[(14)]**(11)** If after claim closure, the worker became enrolled and actively engaged in an approved training program [pursuant to] **under** OAR 436-120:

(a) Unscheduled permanent disability [shall] **must** be redetermined by the insurer when the worker has ended training and the worker's condition is medically stationary or the claim otherwise qualifies for closure in accordance with these rules.

(b) If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's accepted condition since the previous closing examination.

(c) No redetermination of permanent disability [shall] **will** be made for a scheduled condition or a scheduled direct medical sequela if the worker became medically stationary on or after June 7, 1995. The scheduled permanent disability [shall] **must** remain unchanged from the last award of compensation in that claim.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.268, ORS 656.270, ORS 656.726, ORS 656.745, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80.
Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82.
Renumbered from OAR 436-65-006, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0023 Correcting and Rescinding Notices of Closure

(1) An insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that Notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure.

(2) The form, format, and completion of the Correcting and Rescinding Notices of Closure are the same as those of the Notice of Closure except that, to correct a Notice of Closure, a Form 440-1644c (Form 1644c) must be used and, to rescind a Notice of Closure, a Form 440-1644r (Form 1644r) must be used.

(3) The "Date of closure (mailing date)" on the Correcting or Rescinding Notice of Closure must be a current date. The mailing date of the Notice of Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(6) and (7).

(5) Rescinding Notices of Closure, Form 1644r, are used to rescind the Notice of Closure and return the claim to open status. Examples of appropriate uses of Rescinding Notices of Closure include: the worker was not medically stationary at the time the Notice of Closure was issued; the closure was otherwise premature; to grant PPD when the Notice of Closure being rescinded granted TTD only.

(6) The Rescinding Notice of Closure must:

(a) Advise the worker that the claim remains open and no aggravation rights end date has been established, if it is rescinding the first closure of the claim;

(b) Initiate a 60-day appeal period during which any request for reconsideration must be received by the director;

(c) Explain the reason for the action being taken; and

(d) Be distributed and mailed to the parties consistent with these rules.

(7) When a Notice of Closure granting only timeloss has been issued, if the insurer determines the worker's medically stationary status is unchanged and the worker is entitled to an award of permanent disability, the insurer must use a Notice of Closure, Form 1644, to rescind and reissue the closure. In such cases, the Notice of Closure must:

(a) Contain all required information consistent with these rules;

(b) Bear the heading "Rescind and Reissue;

(c) Explain the reason the action being taken;

(d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;,

(e) Establish a new 60-day appeal period;

(f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and

(g) Be distributed and mailed to the parties consistent with these rules.

(8) Correcting Notices of Closure, Form 1644c, are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure must not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability. Examples of appropriate uses of Correcting Notices of Closure include: permanent disability award computation errors (dollars, degrees, percentages); the "mailing date" was incorrect; return-to-work status errors or omissions; incorrect/incomplete statement of temporary disability.

(9) A Correcting Notice of Closure must:

(a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);

(b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;

(c) State only the information being corrected on the Notice of Closure and the basis for the correction in the body of the order;

(d) Not change the appeal period for the Notice of Closure being corrected; and

(e) Initiate a new 60-day appeal period during which any request for reconsideration must be received, but only for those items being corrected.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.268, ORS 656.270, ORS 656.726, ORS 656.745, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: **Adopted XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX**

436-030-0034 Claim Closure When the Worker is Not Medically Stationary

(1) [A claim may] **The insurer must** [be] close[d] [by the insurer]**a claim if a** [when the] worker [is not medically stationary and when the worker has not sought medical care for a period in excess of] **fails to seek treatment for more than** 30 days[,] without the instruction or approval of the attending physician **or authorized nurse practitioner. In order to close a claim under this rule, the insurer must send the worker written notification by certified mail that the claim will be closed unless the worker establishes within 14 days that the worker has resumed treatment by attending or scheduling a new appointment, or that the** [, for] reasons **for not treating were outside** [within] the worker's control**.**[; and]

[(a) The insurer has notified the worker after the close of that 30-day period, by certified letter, that claim closure may result for failure to seek medical treatment for a period of 30 days. The notification letter shall inform the worker of the worker's responsibility to seek medical treatment in a timely manner, and [shall] inform the worker of the consequences for failing to do so, including claim closure.]

[(b) Workers shall be given 14 days from the mailing date to respond to the notification letter before any further action is taken by the insurer towards claim closure.]

(2) [When a worker fails to seek treatment for a period in excess of 30 days, t] **T**he date the claim qualifies for closure**, when a worker fails to seek treatment for a period in excess of 30 days,** [shall be] **is** the latest (most chronologically recent) of the following which occurs prior to the closure:

(a) 30 days from the last treatment provided or authorized by the attending physician **or authorized nurse practitioner**;

(b) [t]**T**he date the **worker failed to attend a follow-up visit that was recommended by the** attending physician **or authorized nurse practitioner** [recommended a follow-up visit] and [the worker failed to attend] for reasons within the worker's control;

(c) [t]**T**he date the worker returns to or is released to regular work if it is after the last examination date; or

(d) [t]**T**he [date the insurer receives, prior to the] 14th day after the [notification letter was sent by certified mail, a written response from the worker regarding the notification letter and failure to treat]**notice required in section (1) of this rule, or if the worker responds within that 14 day period, the date of the response if it fails to establish that the worker has resumed treatment or that the reasons for not treating were outside the worker's control**.

(3) A claim [may] **must** be closed when the worker is not medically stationary, and the worker fails to attend a mandatory closing examination for reasons within the worker's control, and

(a) The insurer has notified the worker, by certified letter, at least 10 days prior to the mandatory examination, that claim closure [may] **will** result for failure to attend a mandatory

closing examination. The notification letter [shall] **must** inform the worker of the worker's responsibility to attend the mandatory closing examination and of the consequences for failing to do so**, including but not limited to claim closure and the possible loss or reduction of a disability award**.

(b) Workers have 7 days from the date of exam to demonstrate good cause for failing to attend, before any further action is taken by the insurer toward claim closure.

(c) Where the worker fails to attend a mandatory closing examination for reasons within the worker's control, the date the claim qualifies for closure [shall be] **is** the date of the failed mandatory closing examination.

(d) Where a closing exam has been scheduled between a worker and attending physician directly, insurers may close [pursuant to] **under** (1) of this section.

(4) A claim may be closed when the worker is not medically stationary, and a major contributing cause denial has been issued **on an accepted combined condition**.

(a) The major contributing cause denial [shall] **must** inform the worker that claim closure may result from the issuance of the denial and **provide all** other information required by these rules.

(b) When a "major contributing cause" denial has been issued **following the acceptance of a combined condition**, the date the claim qualifies for closure [shall be] **is** the date the insurer receives sufficient information to determine the extent of any permanent disability [pursuant to] **under** OAR 436-035-0007(5) and 436-030-0020(2) or the date of the denial, whichever is later.

(5) [The attending physician shall be copied on all notification and denial letters applicable to this rule.

(6)] When [(1), (2) or (3)] **any two of the above** occur concurrently, the earliest date the claim qualifies for closure [shall be] **is** used to close the claim and noted on the notice.

(6) The attending physician or authorized nurse practitioner must be copied on all notification and denial letters applicable to this rule.

(7) When **the director has issued** a suspension order, [pursuant to] **under** OAR 436-060-0095 and OAR 436-060-0105, [has been issued by the Department,] the date the claim qualifies for closure is the date of the suspension order.

(8) When a worker fails to seek treatment with an attending physician as defined by ORS 656.005[(12)] **or authorized nurse practitioner**, the claim [may] **must** be closed [pursuant to] **under** sections (1) and (2) of this rule. All notices must clearly identify the reason for the closure is because of failure to treat with an attending physician **or authorized nurse practitioner**.

Stat. Auth.: ORS 656.262, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0035 Determining Medically Stationary Status

(1) A worker's compensable condition [shall be determined to be] **is** medically stationary when the attending physician**, authorized nurse practitioner,** or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether or not a worker's compensable condition is medically stationary, more weight [shall be] **is** given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

(3) Where there is not a preponderance of medical opinion stating a worker's compensable condition is or is not medically stationary, deference [shall] **will** generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference [shall be] **is** given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's condition.

(4) When there is a conflict as to the date upon which a worker's compensable condition became medically stationary, the following conditions [shall] govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established [pursuant to] **under** sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer [shall] **must** request the attending physician's concurrence or comments when the attending physician arranges, or refers the worker for, a closing examination with another physician to determine the extent of impairment, or when the insurer refers a worker for an insurer medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence [shall] **can** not be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer [shall] **must** arrange for medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.).
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0036 Determining Temporary Disability

(1) Temporary disability [shall] **must** be determined [pursuant to] **under** ORS Chapter 656, OAR 436-060 and this rule, less time worked. Beginning and ending dates of each authorized period of temporary total disability and temporary partial disability [shall] **must** be noted on the Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law."

(2) Except as provided for in section (3) of this rule and ORS 656.268(9), a worker is not entitled to any award for temporary disability for any period of time in which the worker is medically stationary.

(3) Awards of temporary disability [shall] **must** include the day the worker is medically stationary or the date the claim otherwise qualifies for closure, unless temporary disability is not authorized for another reason at that time.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.005, ORS 656.160, ORS 656.210, ORS 656.212, ORS 656.236, ORS 656.245, ORS 656. 262, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0038 Permanent Partial Disability

The standards developed [pursuant to] **under** ORS 656.726(4) and contained in OAR 436-035 [shall] **must** be applied when evaluating a worker's permanent partial disability.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.214, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0045 Disabling/Nondisabling Reporting Requirements and Change in Status Determinations

[(1) When the insurer determines that a nondisabling injury has become disabling, the insurer shall submit to the director an "Insurer's Report," Form 440-1502, indicating a change in status within 21 days from the date of the determination of classification. A notice of change of status to disabling and/or a Notice of Classification in accordance with subsection (2) of this rule shall be sent to the director, the worker, and to the worker's attorney if the worker is represented, explaining the change in status. If the claim qualifies for closure, the insurer shall close the claim in accordance with ORS 656.268(5).]

[(2) When a claim has been classified as nondisabling for less than one year after the date of acceptance, a worker who believes the claim was or has become disabling may request reclassification by the insurer.]

[(a) The worker may seek reclassification by submitting a written request for review

to the insurer.]

[(b) Within 14 days of the worker's request, the insurer shall review the claim and

notify the worker of the decision by mailing a Notice of Classification to the worker and the worker's attorney if the worker is represented.]

[(c) The insurer's Notice of Classification must include the following statement, in bold print:]

["If you disagree with this Notice of Classification, you must appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing of this notice, or you will lose your right to appeal. The address and telephone number of the Workers' Compensation Division are: [INSURER: Insert current address and telephone number of the Workers' Compensation Division, Appellate Review Unit, here.]."]

[(d) A worker dissatisfied with the decision in the Notice of Classification may appeal to the director within 60 days of the mailing date of the Notice.]

[(e) The appeal must be accompanied by copies of the worker's request for reclassification and the insurer's Notice of Classification in response.]

[(3) When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation.]

[(4) Failure of the insurer or self-insured employer to respond timely to a request may result in penalties pursuant to OAR 436-030-0580.]

[(5) A claim is disabling if any of the following conditions apply:]

[(a) temporary disability is due and payable;]

[(b) the worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or]

[(c) the worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary.]

[(6) Examples of when temporary disability is due and payable as in subsection (5)(a) of this rule include:]

[(a) when the worker is released to and doing a modified job at reduced wages from the job at injury; or]

[(b) when the modified job the worker is released to and/or has been doing for the same wage as the job at injury no longer exists or a job offer is withdrawn for reasons including termination of temporary employment, layoff, or plant closure.]

[(7) For claims that are reclassified, the aggravation rights begin with the first valid closure. For claims that are not reclassified, the aggravation rights continue to run from the date of injury.]

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.262, ORS 656.268, ORS 656. 273, ORS 656.277, ORS 656.745, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 350, Oregon Laws 2001
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Amended as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Repealed XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0055 Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule and OAR 436-030-0065:

(a) "Incapacitated from regularly performing work" means that the worker does not have the necessary physical and mental capacity and the work skills to perform work **on a regular basis. Employment in a sheltered workshop is not considered regular employment unless this was the worker's job at the time of injury**.

(b) "Suitable occupation" means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

(c) "Gainful occupation" means those types of general occupations that pay wages equivalent to, or greater than, the state mandated hourly minimum wage. Those types of general occupations that pay on a commission or piece-work basis, as opposed to a wage or salary basis, may not be "gainful employment" depending upon the facts of the individual situation.

(d) "Work skills" means those skills acquired through experience or training that are necessary to gain and adequately perform skilled, semi-skilled or unskilled occupations. Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

(e) A "reasonable geographic distance" means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 50-mile radius of [claimant's] **the worker's** place of residence at the time of:

(i) [t]**T**he original injury;

(ii) [claimant's] **The worker's** last gainful employment;

(iii) [i]**I**nsurer's determination; or

(iv) [r]**R**econsideration by the director.

(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills and financial obligations as [claimant] **the worker** does at the time of his rating of disability, would go to seek work.

(f) "Types of general occupations" means groups of jobs which **actually** exist in a [theoretically] normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening [currently] **may** exist[s] **in the future**.

(g) "[Theoretically n] **N**ormal labor market" means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity or technology trends in the long-term labor market.

(h) "Withdrawn from the workforce" means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. Retirement alone does not establish a worker has withdrawn from the workforce.

(2) **All** [D]**d**isability which existed before the injury [shall] **must** be included in determining permanent total disability.

(3) In order for a worker to be determined permanently and totally disabled, a worker must:

(a) [p]**P**rove permanent and total disability;

(b) Be willing to seek regular and gainful employment;

[(b)]**(c)** [m]**M**ake reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and

[(c)]**(d)** [n]**N**ot have withdrawn from the workforce during the period for which benefits are being sought [and be willing to seek regular and gainful employment].

(4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:

(a) [t]**T**he worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) [i]**I**nability to regularly perform work at a gainful and suitable occupation; and

(c) [t]**T**he futility of seeking work if [claimant] **the worker** has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services. [It does not include opinions by claimants, physicians or others not certified.]

(5) Notices of Closure and Orders on Reconsideration which grant permanent total disability [shall] **must** notify the worker that:

(a) The claim [shall] **must** be reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker [shall] **must** make the statement on a form provided by the insurer in accordance with the requirements under section (6) of this rule.

(6) If asked to provide a statement under subsection (5)(b) of this rule, the worker is allowed 30 days to respond. Such statements are subject to the following:

(a) If the worker fails to provide the requested statement, the director may suspend the worker's permanent total disability benefits. Benefits [shall] **must** be resumed when the statement is provided. Benefits not paid for the period the statement was withheld [shall] **must** be recoverable for no more than one year from the date of suspension.

(b) If the worker provides a report which is false, incomplete or inaccurate, the insurer [shall] **must** investigate. The investigation may result in suspension of permanent total disability benefits.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.005, ORS 656.206, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 865, Oregon Laws 2001
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Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0065 Review of Permanent Total Disability Awards

(1) The insurer [shall] **must** reexamine each permanent total disability claim every two years or when requested to do so by the director to [see] **determine** if the worker is capable of regularly performing a suitable and gainful occupation. [Reexamination of a PTD claim may be performed by the insurer whenever the insurer considers it necessary.] The insurer [shall] **must** notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's [PTD] **permanent total disability** status. [Once an insurer has obtained the statutory three medical examinations for an open period and wants an additional medical examination on a PTD claim more frequently than every two years, the insurer is required to notify and request authorization from the director for the additional medical examination. Workers who fail to cooperate with the reexamination may have benefits suspended until such time as the worker cooperates with the reexamination.]

(2) Any decision by the insurer to reduce permanent total disability [shall] **must** be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation [shall] **must** include: medical reports, including sufficient information necessary to determine the extent of permanent partial disability, vocational and/or investigation reports (including visual records, if available) which demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence.

(3) An award of permanent total disability for scheduled injuries before July 1, 1975, [shall] **must** be considered for reduction only when the insurer has evidence that the medical condition has improved.

(4) Except for section (3) of this rule, an award of permanent total disability [shall] **may** be [considered for reduction] **reduced** only when the insurer has **a preponderance of** evidence that the worker is regularly working at a suitable and gainful occupation or is **currently** capable of doing so. **Preexisting disability must be included in redetermination of the worker's permanent total disability status.**

(5) When the insurer reduces a permanent total disability claim, the insurer [shall] **must**, based upon sufficient information to determine the extent of permanent partial disability, issue a Notice of Closure which reduces the permanent total disability and awards permanent partial disability, if any.

(6) Any party to the claim who does not agree with the Notice of Closure may, within the statutory period, appeal the order [pursuant to] **under** OAR 436-030-0007(1)(a). **Appeal is to the Hearings Division for workers that were medically stationary on or before July 1, 1990.**

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.206, ORS 656.214, ORS 656.268, ORS 656.283, ORS 656.319, ORS 656.325, ORS 656.331, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
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Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
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Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0066 Review of Prior Unscheduled Permanent Partial Disability Awards

(1) An award for unscheduled permanent partial disability is subject to periodic examination and adjustment [pursuant to] **under** ORS 656.268 and 656.325 and in accordance with the following conditions:

(a) Requests for review and adjustment [shall] **must** be made in writing to the Workers' Compensation Division.

(b) The party requesting review of permanent disability [shall] **must** send a copy of the request to all other affected parties at the time the request is made. The worker may submit any information in rebuttal.

(c) All pertinent medical, vocational, and other applicable evidence [shall] **must** be submitted with the request, including sufficient information to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the director [shall] **will** make any necessary adjustments [pursuant to] **under** OAR 436-035-0270 through 436-035-0450.

(d) The basis for the request for adjustment in the disability award [shall] **must** be failure of the worker to make a reasonable effort to reduce the disability and be so stated in the request for adjustment.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.325, ORS 656.331, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.).
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Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0115 Reconsideration of Notices of Closure

(1) A worker **or insurer** may request reconsideration of a Notice of Closure by mailing or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005[(5)]**(6)** and [(9)] **030-0145(1)**. The reconsideration proceeding begins [upon receipt of the request] **as described in OAR 436-030-0145(2).**

(2) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All

information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician **or authorized nurse practitioner** at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed because the worker's condition is not medically stationary under OAR 436-030-0165[(9)]**(10)**, medical evidence submitted may address the worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

(3) All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record [pursuant to] **under** ORS 656.268(6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments, written statements and sworn affidavits from the parties.

(4) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:

(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.

(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but [shall] **must** not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.

(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter and the costs for the original transcript and its copies. An original transcript of the deposition [shall] **must** be sent to the department and each party [shall] **must** be sent a copy of the transcript.

(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.

(5) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will do a complete review of that notice. Once the reconsideration proceeding is initiated**,** [by the worker, the insurer must raise] any additional issues **must be raised and further evidence submitted** [and submit any evidence for review by the director] within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed [pursuant to] **under** ORS 656.268(6).

Stat. Auth.: ORS 656.726, 1999 OR Laws Chapter 313, and section 12 (6)(a)(A), chapter 865, Oregon Laws 2001
Stats. Implemented: ORS 656.268, 1999 OR Laws Chapter 313, and section 12 (6)(a)(A), chapter 865, Oregon Laws 2001
Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
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Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
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Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01.
Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0125 Reconsideration Form and Format

(1) A request for reconsideration may be in the form and format the director provides by bulletin. A reconsideration request should include at least the following:

(a) [w]**W**orker's name;

(b) [d]**D**ate of injury;

(c) [d]**D**ate of the closure being appealed;

(d) [a]**A**ny specific issues [the worker wishes to raise] regarding the Notice of Closure;

(e) [t]**T**he name of the worker's attorney;

(f) [t]**T**he name of the insurer's attorney;

(g) [a]**A**ny special language needs;

(h) [w]**W**hether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;

(i) [a]**A**ny information and documentation deemed necessary to correct or clarify any part of the claim record [the worker] believe[s]**d** to be erroneous; and

(j) [a]**A**ny medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at, before, or pertaining to claim closure**.**

[(2) The reconsideration proceeding begins with the director's receipt of the request for reconsideration. The director will send a letter of acknowledgment to all parties notifying them a request has been received and the proceeding has begun.]

Stat. Auth.: ORS 656.726, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, and 1999 OR Laws Chapter 313
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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0135 Reconsideration Procedure

(1) If the director assists the worker in completing the request for reconsideration, the director will notify the worker that the proceeding may result in an increase, decrease, or no change in entitlement to benefits.

[(1)]**(2)** [When] **Upon starting the reconsideration proceeding ,** [requesting reconsideration of a Notice of Closure,] **the director will send the parties a letter of acknowledgement which includes:**

(a) The proceeding's start date;

(b) The timelines for submitting additional information to be included in the record;

(c) A certification that the letter has been mailed to the listed parties; and

(d) The last date an Order on Reconsideration can be issued or the proceeding postponed, and the status of the request if the director fails to issue an Order on Reconsideration or postponement under the time limits specified in ORS 656.268.

[(a) A worker may ask the director for assistance in completing the request for reconsideration. The director will notify the worker the proceeding may result in an increase or a decrease in entitlement to benefits.]

[(b) After receipt of the request, the director will notify all parties of the date of the request and of the timelines for submitting additional information to be included in the record. The acknowledgment letter shall include a certification that the letter has been mailed to the listed parties. The acknowledgment letter will notify the parties of the last date an Order on Reconsideration can be issued or the proceeding postponed, and the status of the request if the director fails to issue an Order on Reconsideration or postponement pursuant to the time limits specified in ORS 656.268(6).]

(3) The insurer must furnish, to the director and the worker or the worker's attorney, within 10 working days from the beginning of the reconsideration proceeding, all documents pertaining to the claim.

[(c)]**(4)** The request for reconsideration and all other information submitted to the director by any party during the reconsideration process must be copied to all interested parties. Failure to comply with this requirement [will] **may** result in the information not being included as part of the record on reconsideration. The director may assist a worker in meeting this requirement.

(5) The director will issue an order rescinding a notice of closure when the director finds, upon reconsideration:

(a) The claim was closed prematurely because the worker's accepted condition(s) was not medically stationary and the claim did not qualify for closure under ORS 656.268(1)(a); or

(b) The claim was not closed according to the requirements of these rules and ORS 656.268(1)(b) or (c).

[(d) When a party does not discover until after the reconsideration order has issued that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.]

[(2) The insurer shall furnish within 10 working days of the beginning of the reconsideration proceeding all documents pertaining to the claim that have not been previously submitted to the director and the worker or the worker's representative. The insurer may be subject to penalties under OAR 436-030-0175 for failure to provide the claim documents in a timely manner.]

[(3)]**(6)** When a worker has **requested and accepted** [received] a lump sum payment, [pursuant to] **under** ORS 656.230, of an award granted by a Notice of Closure, the director [shall] **will** not consider the adequacy of that award in a reconsideration proceeding.

[(4) The director will issue an order rescinding the Notice of Closure when the director finds, upon reconsideration:]

[(a) the claim was closed prematurely because the worker's accepted condition was not medically stationary and the claim did not qualify for closure pursuant to ORS 656.268(1)(a); or]

[(b) the claim was not closed in accordance with the requirements of ORS 656.268(1)(b) and (c) and OAR 436-030-0020.]

[(5)]**(7)** When a new condition is accepted after a prior claim closure, and the newly accepted condition is subsequently closed, the director and the parties may mutually agree to consolidate requests for review of the closures into one reconsideration proceeding, provided the director has jurisdiction and neither of the closures have become final by operation of law.

[(6)]**(8)** The reconsideration order [shall] **will** address issues raised by the parties and [shall] **will** address compensation as follows:

(a) Compensation reduced in a reconsideration order [shall] **will** be "in lieu of" any compensation awarded by the Notice of Closure.

(b) Additional compensation awarded in a reconsideration order [shall] **will** be "in addition to" any compensation awarded by the Notice of Closure. The reconsideration order may award total compensation due less any compensation previously ordered.

(c) Any compensation affirmed in a reconsideration order [shall] **will** be so stated.

(d) The dollar rate per degree of disability [shall] **will** be listed.

[(7)]**(9)** A copy of the reconsideration order will be sent to the worker, employer(s), insurer(s), worker's attorney if the worker is represented, and the insurer's attorney(s), if the insurer is represented.

(10) When a party does not discover until after the reconsideration order has been issued that additional documents were not provided by the opposing party, in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
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Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
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436-030-0145 Reconsideration Time Frames and Postponements

(1) Statutory time frames for appealing a Notice of Closure:

[(1)]**(a)** For claims with a medically stationary date prior to June 7, 1995, the **appeal period is 180 days from the claim closure. The** time required to complete the reconsideration proceeding pursuant to this rule [shall] **must** not be included in the 180 days from the mailing date of the Notice of Closure to request a hearing.

[(a)]**(A)** The 180-day time limit will be tolled upon receipt of the request for reconsideration from the mailing date of the request for reconsideration until the reconsideration request is either dismissed or an Order on Reconsideration is issued.

[(b)]**(B)** The 180-day time limit will not be tolled when a request for reconsideration is withdrawn [pursuant to] **under** OAR 436-030-0185.

[(2)]**(b)** For claims with a medically stationary date, or date the claim statutorily qualifies for closure, on or after June 7, 1995, a request for reconsideration [shall] **must** be mailed within 60 days of the mailing date of the Notice of Closure. A request for hearing must be made within 30 days of the mailing date of the Order on Reconsideration.

(c) For claims closed on or after January 1, 2004, the insurer's request for reconsideration is limited to the findings used to rate impairment and must be mailed within seven days of the mailing date of the Notice of Closure.

(2) The reconsideration proceeding begins upon;

(a) The director's receipt of the worker's request for reconsideration, if the insurer has not previously requested reconsideration consistent with subsection (1)(c) of this rule; or

(b) The 61st day after the closure of the claim, if the insurer has requested reconsideration consistent with subsection (1)(c) of this rule; unless the director receives, within the appeal time frames in section (1) of this rule, a request for reconsideration or a statement by the worker instructing the director to start the reconsideration proceeding.

(3) Ten working days after the date the reconsideration proceeding begins, the reconsideration request and all other appropriate information submitted by the parties [shall] **will** become part of the record used in the reconsideration proceeding. [The insurer may be subject to penalties under OAR 436-030-0175 for failure to provide the claim documents within ten working days without good cause.]

(a) Evidence received or issues raised subsequent to the tenth working day deadline will be considered in the reconsideration proceeding to the extent practicable.

(b) Upon review of the record the director may request, in accordance with ORS 656.268(6), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

[(c) When the reconsideration proceeding has been postponed in accordance with OAR 436-030-0165(9) because the worker's condition is not medically stationary, interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the impairment due to the compensable condition(s) may be submitted at the time the parties notify the director that the medical arbiter can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (7).]

(d) Except as provided in section [(4)]**(5) and (6)** of this rule, the director will either mail an Order on Reconsideration within 18 working days from the date the reconsideration proceeding begins or notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days in accordance with the provisions of ORS 656.268(6).

(4) Medical arbiter panel requests must be received by the department within the ten (10) working day time frame beginning on the date the reconsideration proceeding starts.

[(4)]**(5)** [Pursuant to ORS 656.268(7), w]**W**hen the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits, **under ORS 656.268(7),** the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(6) When the reconsideration proceeding has been stayed, the director will notify the parties that it has been stayed for one of the following reasons:

[(5)]**(a)** [Pursuant to ORS 656.726(4)(f), the reconsideration proceeding may be stayed t] **T**o determine whether temporary rules amending "the standards" are required to properly rate the worker's impairment**, under ORS 656.726(4)(f);** [The director will notify the parties that the proceeding has been stayed for this purpose.]

(b) The parties consent to postponing the reconsideration proceeding, under ORS 656.268(7)(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

[(6)]**(c)** When a Claim Disposition Agreement (CDA) is filed with the Workers' Compensation Board, the reconsideration proceeding is stayed until the CDA is either approved by a final order of the Board or the Board sets aside the disposition. [The director will notify the parties that the proceeding has been stayed for this purpose.]

(7) If the director fails to mail an Order on Reconsideration or a Notice of Postponement [pursuant to] **under** the time frames specified in ORS 656.268[(6)], the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the director had issued an Order on Reconsideration affirming the Notice of Closure. [In accordance with] **Under** section (1) of this rule, the counting of the 180-day time limit for requesting a hearing under former ORS 656.268(6)(b) [shall] **will** resume on the date after the director should have issued an Order on Reconsideration.

(8) Notwithstanding any other provision regarding the reconsideration proceeding, the director may extend nonstatutory time frames to allow the parties sufficient time to present evidence and address their issues and concerns.

Stat. Auth.: ORS 656.726, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268 **(ch. 429, OL 2003)**, 656.726, and 1999 OR Laws Chapter 313
Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
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Renumbered from OAR 436-65-100, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.

Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0155 Reconsideration Record

(1) The record for the reconsideration proceeding [shall] include**s** all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding. The record [shall be] **is** maintained in the Workers' Compensation Division's claim file and [shall] consist**s** of all documents and material received and date stamped by the director prior to the issuance of the Order on Reconsideration**, unless the document(s) is an exact duplicate of what is in the file then the director is not required to retain the duplicate document(s)**.

(2) Except as noted below, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.

(a) The director [will] **may** not submit non-medical information, [handwritten] nursing notes, or [handwritten] physical therapy treatment notes to the arbiter unless:

(A) [a]**A** party requests the director to submit those specific materials to the arbiter;

(B) [t]**T**he party identifies and provides the director with specific dates of those materials requested to be submitted; and

(C) [t]**T**he materials otherwise meet the requirements of this rule.

(b) All medical documents and other medical materials not submitted by the director to the medical arbiter will be stamped in the lower right hand corner "not sent to arbiter".

(3) The insurer must submit to the director for arbiter review all surveillance videotape obtained prior to closure, if previously viewed by physician(s) involved in the evaluation or treatment of the worker. The insurer must also submit for arbiter review all written materials previously forwarded to physician(s) along with the surveillance videotape, such as investigator field notes, summary or narrative reports, and cover letters. Surveillance videotape must be labeled according to the date(s) and total time of the recording(s).

[(3)]**(4)** When reconsideration is requested, the insurer is required to provide the director and the other party(ies) with a copy of all documents contained in the record at claim closure. Any information the director adds to the record, such as the medical arbiter report, will be copied to all parties. Responses of the parties to the medical arbiter report [shall] **will** be included in the record if received prior to completion of the reconsideration proceeding.

[(4)]**(5)** Since all parties will have a complete copy of the record at reconsideration prior to the issuance of a reconsideration order, additional certified copies of the record will be made at a charge to the requesting party.

[(5)]**(6)** When a hearing is scheduled following the appeal of a reconsideration order and the parties or the administrative law judge requests the director to provide the record at

reconsideration, either the original claim file or a certified copy of the claim file will be delivered to the Hearings Division two days prior to the hearing. The original claim file [shall] **must** be returned to the director within two days after the hearing.

Stat. Auth.: ORS 656.726, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268(6), and 1999 OR Laws Chapter 313
Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78.
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Renumbered from OAR 436-65-100, May 1985.
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.).
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0165 Medical Arbiter Examination Process

(1) When a worker **or insurer** requests reconsideration and disagrees with the impairment findings used in rating the worker's disability at the time of claim closure, the director [shall] **will** refer the claim to a medical arbiter or panel of arbiters.

(a) When the director determines that sufficient medical information is not available to rate disability, the director may refer the claim to a medical arbiter or panel of arbiters.

(b) The director will notify the parties within 18 working days from the date the reconsideration proceeding begins that a medical arbiter review will be scheduled.

[(c) The costs related to record review, examinations, tests and reports of the medical arbiter shall be paid pursuant to OAR 436-009-0015, 436-009-0040, and 436-009-0070.]

(2) The director [shall] **will** select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(7)(d). [Arbiters or panel members shall not include any medical service providers whose examination or treatment is the subject of the review.]

(a) Any party that objects to a physician on the basis that the physician is not qualified under ORS 656.005(12)(b) must notify the director prior to the examination of the specific objection. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician. All costs related to the completion of the medical arbiter process in this rule [shall] **must** be paid by the insurer.

(b) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(7).

(c) Arbiters or panel members will not include any medical service providers whose examination or treatment is the subject of the review.

(3) When the director has determined a claim qualifies for medical arbiter deselection, a list of appropriate physicians will be faxed or sent by overnight mail to the parties.

(a) Each party may eliminate one physician from the list by crossing out the physician's name.

(b) The parties may agree to one physician from the list by responding in writing. The parties must also deselect one physician from the list in case the agreed upon physician is unavailable.

(c) All responses must be signed and received by the director within three (3) business days. No further opportunity will be given for the parties to provide input regarding the arbiter deselection process once the three (3) business day period has expired. No further attempts at deselection will be made when continuing the arbiter deselection process is not practical.

[(3) The medical arbiter or panel of medical arbiters shall perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment. The director shall provide notice of the examination of the worker to all parties.

(a) Any issues the parties wish the medical arbiter or panel of medical arbiters to address must be submitted to the director within 10 working days after the date the reconsideration proceeding begins. Issues shall not be submitted to the medical arbiter or panel of medical arbiters directly by the parties. Only issues appropriate to the reconsideration proceeding will be submitted by the director to the medical arbiter or panel of medical arbiters.

(b) The medical arbiter or panel of medical arbiters shall address all questions raised by the director in the report.

(c) The director shall instruct the medical arbiter to provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer(s) within five (5) working days after completion of the arbiter review. The cost of providing copies of such additional reports shall be reimbursed according to OAR 436-009-0070 and shall be paid by the insurer.]

(4) The director [shall] **will** notify the parties of the time and place of the medical arbiter examination. This notice [shall] **will** also inform the worker that failure to attend the medical arbiter examination or to cooperate with the medical arbiter will result in suspension of all disability benefits effective on the date of the examination unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The appointment letter [shall] **will** instruct the worker to call the director within 24 hours after failing to attend the examination to provide any "good cause" reason for missing the exam.

(a) Notice of the examination [shall] **will** be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney if the worker is represented.

(b) For the purposes of this rule, non-cooperation includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the physician reports the findings as medically invalid.

(c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause."

(5) If a worker misses the medical arbiter examination, the director [shall] **will** determine whether or not there was a "good cause" reason for missing the examination.

(6) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with the arbiter, the director will**:** [issue a notice to

the worker that disability benefits are suspended and that the reconsideration proceeding is postponed up to an additional 60 days. A rescheduled examination will be made for the worker to complete the medical arbiter review within the additional 60-day postponement period.]

(a) [i]**Issue** a notice to the worker that disability benefits are suspended and that the reconsideration proceeding is postponed up to an additional 60 days, and

(b) [r]**R**eschedule[d] **an** examination [will be made] for the worker to complete the medical arbiter review within the additional 60-day postponement period.

(7) As addressed in the Order on Reconsideration, the suspension will be lifted if any of the following occurred during the additional 60-day postponement period:

(a) The worker established a "good cause" reason for missing or failing to cooperate with the examination;

(b) The request for reconsideration was withdrawn by the worker; or

(c) The worker attended and cooperated with a rescheduled arbiter examination.

(8) If none of the events which end the suspension **under** [pursuant to sub]section (7) of this rule occurred prior to the expiration of the 60-day additional postponement, the director [shall] **will** complete the reconsideration proceeding [pursuant to] **under** ORS 656.268(7) and the Order on Reconsideration will order the suspension of benefits to remain in effect.

(9) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment. The director will provide notice of the examination of the worker to all parties.

(a) The parties must submit any issues they wish the medical arbiter or panel of medical arbiters to address within 10 working days after the date the reconsideration proceeding begins. The parties must not submit issues directly to the medical arbiter or panel of medical arbiters. The director will only submit issues appropriate to the reconsideration proceeding to the medical arbiter or panel of medical arbiters.

(b) The medical arbiter or panel of medical arbiters must address all questions raised by the director in the report.

(c) The director will instruct the medical arbiter to provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer(s) within five (5) working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0070 and must be paid by the insurer.

[(9)]**(10)** When [a medical arbiter examination is not medically appropriate because] the worker's medical condition is not stationary **on reconsideration which may result in difficulties in obtaining findings of impairment** [and impairment cannot be accurately evaluated] by the **arbiter** [physician], the director will**, where appropriate,** send a letter to the parties requesting consent to postpone the reconsideration proceeding.

(a) If the parties agree to the postponement, the reconsideration proceeding will be postponed until the **medical record reflects the** worker's condition has **stabilized sufficiently**

[medically resolved] to allow for examination **to obtain the impairment findings**. The parties must notify the director when it is appropriate to schedule the medical arbiter examination **and provide the necessary medical records when requested**. **Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the impairment due to the compensable condition(s) may be submitted at the time the parties notify the director that the medical arbiter exam can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (7).]**

(b) If [the parties do not agree to the] postponement **is not appropriate**, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).

(11) All costs related to record review, examinations, tests, and reports of the medical arbiter must be paid under OAR 436-009-0015, 436-009-0040, and 436-009-0070.

Stat. Auth.: ORS 656.726, 1999 OR Laws Chapter 313
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Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 8/23/95 as WCD Admin. Order 95-059, eff. 8/23/95 (temp).
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
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Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0175 Fees and Penalties within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 0145 and 0165 may be assessed civil penalties [pursuant to] **under** OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 0145 and 0165 may also be grounds for extending the reconsideration proceeding [pursuant to] **under** ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer [shall] **will** be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. If an increase in compensation results from the promulgation of a temporary emergency rule, penalties will not be assessed. For claims with medically stationary dates or statutory closure dates on or after June 7, 1995, if the increase in compensation results from new information obtained through a medical arbiter examination, the penalty [shall] **will** not be assessed.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, [shall] **will** be found to be at least 20 percent disabled. As an illustration, a worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe

is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, [shall] **will** be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the director. The reconsideration order [shall] **will** order the insurer to pay the attorney 10 percent out of any additional compensation awarded but not more than the maximum attorney fee allowed in OAR 438-015-0040(1) and (2) and OAR 438-015-0045, effective February 1, 1999. "Additional compensation" includes an increase in a permanent or temporary disability award.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268
Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.).
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-030-0050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 8/23/95 as WCD Admin. Order 95-059, eff. 8/23/95 (temp).
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 4/28/99 as WCD Admin. Order 99-054, eff. 4/28/99
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0185 Reconsideration: Settlements and Withdrawals

(1) Contested matters arising out of a claim closure may be resolved by mutual agreement of the parties at any time after the claim has been closed under ORS 656.268 but before that claim closure has become final by operation of law. If the parties have reached such an agreement prior to the completion of the reconsideration proceeding, the parties [shall] **must** submit the stipulation agreement to the director for approval as part of the reconsideration proceeding. The Stipulation for review at the reconsideration proceeding must:

(a) [a]**A**ddress only issues that pertain to a claim closure and cannot include any issues of compensability;

(b) [l]**L**ist the body part(s) for which any award is made and [shall] recite all disability awarded in both degrees and percent of loss when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement, the stated percent of loss [shall be] **will** controll[ing].

(2) The director [shall] **will** review the Stipulation and issue an order within 18 working days from receipt of the Stipulation by the director. Stipulations approved by the director are not appealable.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the Stipulation as well as a substantial determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

(4) If the Stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) [a]**A**ddress the disapproval, and/or

(b) [t]**T**o request that the director issue an Order on Reconsideration addressing the substantive issues.

(5) When the parties desire to enter into a stipulated agreement to resolve disputed issues relating to the claim closure but are unable to reach an agreement, the parties may request the assistance of the director to mediate an agreement.

(6) When the parties desire to enter a stipulated agreement that addresses issues including all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the director of their resolution and request the director enter an Order on Reconsideration affirming the Notice of Closure. The request for an affirming order must be made prior to the date an Order on Reconsideration is issued and in accordance with the following procedure:

(a) A written request for an affirming reconsideration order must be made by certified mail and be signed by both parties or their representatives. The written request must also state that the parties waive their right to an arbiter review, and that all matters subject to the mandatory reconsideration process have been resolved. A copy of the proposed stipulated agreement must accompany the request.

(b) After the affirming Order on Reconsideration has issued, the parties will submit their stipulation to a referee of the Hearings Division, Workers' Compensation Board, for approval in accordance with the provisions of ORS 656.289 and the Board's rules of practice and procedure.

(c) An Order on Reconsideration issued [pursuant to] **under** this rule is final and is subject to review [pursuant to] **under** ORS 656.283.

(d) This provision does not apply to Claims Disposition Agreements filed [pursuant to] **under** ORS 656.236.

(7) A worker requesting a reconsideration may withdraw the request for reconsideration if no additional information has been submitted by the other party(ies)**,** [and] no medical arbiter exam has occurred**, and the insurer has not requested reconsideration under OAR 436-030-0145**. If additional information has been submitted by the other party(ies), [or] a medical arbiter exam has occurred, **or the insurer has requested reconsideration,** the reconsideration request will not be dismissed unless all parties agree. [When appropriate, an order dismissing the reconsideration will be issued.]

(8) If the insurer has requested reconsideration, either the worker or the insurer may initiate the withdrawal request but both must agree to the withdrawal.

(9) The director will issue an order dismissing the reconsideration under section (7) and (8) of this rule, when appropriate.

Stat. Auth.: ORS 656.726, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268(6), and 1999 OR Laws Chapter 313
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92

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Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0575 Audits

(1) Notices of Closure issued by insurers and supporting documentation including, but not limited to, the worksheet upon which the Notice of Closure is based, [shall] **will** be subject to periodic audit by the director. Supporting documentation and records [shall] **must** be maintained in accordance with OAR 436-050.

(2) The director reserves the right to visit the worksite to determine compliance with these rules.

Stat. Auth.: ORS 656.268, ORS 656.726, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.455, ORS 656.726, ORS 656.750, and 1999 OR Laws Chapter 313
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Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

436-030-0580 Penalties and Sanctions

(1) [Pursuant to] **Under** ORS 656.745, the director or designee may assess a civil penalty against an employer or insurer who fails to comply with the rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(2) An insurer or medical service provider failing to meet the requirements set forth in [OAR 436-030-0015, 436-030-0017, 436-030-0020, 436-030-0038, 436-030-0045, and 436-030-0125 through 436-030-0185] **these rules** may be assessed a civil penalty.

(3) [Pursuant to] **Under** OAR 436-010-0340, the director may impose sanctions for any medical service provider where the insurer can provide sufficient documentation to substantiate lack of cooperation. The medical service provider will be sent a warning letter about possible penalties and the reporting requirements. Failure by the medical service provider to submit the requested information within the specified period may result in civil penalties.

(4) Sufficient documentation to substantiate lack of cooperation by the medical service provider includes:

(a) [c]**C**opies of letters to the medical service provider;

(b) [m]**M**emos to the claim file of follow-up phone calls and/or the lack of response;

(c) [l]**L**etters from the medical service provider indicating a lack of cooperation; or

(d) [m]**M**edical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

(5) In arriving at the amount of penalty, the director or designee may assess a penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations in any three-month period.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313

Stats. Implemented: ORS 656.268, ORS 656.726, ORS 656.745, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
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Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92.
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX

[**436-030-0581 Issuance/Service of Penalty Orders**

(1) When a penalty is assessed as provided in OAR 436-030-0580, the director or designee shall serve an order on the party with a notice of the party's appeal rights provided under ORS 656.704.

(2) The Order shall be served by:

(a) mailing a copy of the Order to the party by certified mail return receipt requested. If the employer is a corporation, the certified mail may be addressed to any one of the persons named in Rule 7 of Oregon Rules of Civil Procedure subsection (D)(3)(b)(i); or

(b) delivering a copy to the party in the manner provided by Rule 7 of Oregon Rules of Civil Procedure, subsection (D)(2).

(3) Orders issued in accordance with these rules shall contain the following notice in bold print:

"If you disagree with this Order, you are entitled to a hearing as provided by ORS 656.704(2), OAR 436-030-0007, and the contested case provisions of the Administrative Procedures Act (ORS Chapter 183). You must request a hearing in writing within sixty (60) days of the date you receive this notice. Your request must be mailed to the Department of Consumer and Business Services, Workers' Compensation Division, [INSERT CURRENT ADDRESS HERE]. You will be notified of the time and place of hearing. If you request a hearing, you will be given information on procedures, right of representation, and the rights of parties relating to the conduct of the hearing. If you fail to request a hearing within sixty (60) days, this Order will become final."]

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Stats. Implemented: ORS 656.268, ORS 656.704, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Hist: Filed 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90.
Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92.
Amended 2/14/96 as WCD Admin. Order 96-052, eff. 2/17/96.
Amended 12/22/97 as WCD Admin. Order 97-065, eff. 1/15/98.
Amended 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Repealed XX/XX/XX as WCD Admin. Order 04-XXX, eff. XX/XX/XX