

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

CLAIM CLOSURE AND RECONSIDERATION

PROPOSED RULES

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

In the Matter of the Amendment of Oregon Administrative Rules, chapter 436, division: 030, Claim Closure and Reconsideration)
)
) **SUMMARY OF**
) **TESTIMONY AND**
) **AGENCY RESPONSES**
)

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 August 1, 2004. On August 23, 2004, a public rulemaking hearing was held as announced at 10:00 a.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 [August 27, 2004] **October 15, 2004**. {Corrected date 1/6/05, Fred Bruyns, Workers’ Compensation Division.}

NOTE: The hearing and public comment listed below addresses both OAR 436-030 and 436-035. The **Testimony** and responses regarding division 035, “Disability Rating Standards,” are contained in a separate document. However, general **Testimony** directed toward both rule divisions is covered in both documents.

Subject Division	Exhibit #	Oral testimony received from:
035	7	George J. Wall, Welch, Bruun & Green, Attorneys at Law
Subject Division	Exhibit #	Written testimony received from:
035	1	Richard A. Hodgson, MD, Otolaryngology
030 & 035	2	Vicki L. Graves, Liberty Northwest Insurance
030 & 035	3	Linda L. Jefferson, Co-Chair, Oregon Self-Insurers Association Legislative Committee
035	4	George J. Wall, Welch, Bruun & Green, Attorneys at Law
030	5	Christopher J.T. Davie, SAIF Corporation
035	6	Christopher J.T. Davie, SAIF Corporation
035	8	David A. Vinson, Starr & Vinson, P.C.
035	9	Robert A. Dobie, M.D., UC-Davis Medical Center
035	10	Joseph H. Eusterman, M.D. Western Occupational/Environmental

		Medicine Services
030 & 035	11	Linda L. Jefferson, Oregon Self-Insurers Association
030 & 035	12	Linda Barno, Schnitzer Steel Industries, Inc.
035	13	Franklin S. Coale, M.D., Marylhurst Ear Nose & Throat Head & Neck Surgery, Inc.
035	14	George J. Wall, Welch, Bruun & Green, Attorneys at Law
030 & 035	15	William Bartel, Special Districts Association of Oregon & Public Risk Consultants
030 & 035	16	Susan Lavier, City County Insurance Services
030 & 035	17	Christopher J.T. Davie, SAIF Corporation

The following is a summary of the **Testimony** received and the agency's responses to that **Testimony**.

OAR 436-030 & 035 (general comment) *Exhibit #3*

Testimony: First and foremost, we ask that you consider postponing adopting these rules until further evaluation is completed. This is probably one of the most significant changes to the workers' compensation system in recent years and it is imperative that implementing these changes result in the intended outcomes.

Response: The closing date for **Testimony** was extended through October 15, 2004.

OAR 436-030, 436-035 (general comment) *Exhibit #15*

Testimony: Both Special Districts Association of Oregon and Public Risk Consultants fully support the October 13th position paper by OSIA.

Response: See responses for Exhibits 3 and 11.

OAR 436-030 & 035 (general comment) *Exhibit #16*

Testimony: We concur with the written **Testimony** provided by OSIA on 10/13/04, and would like to add additional comment. (See **Testimony** for OAR 436-035.)

Response: See responses for Exhibits 3 and 11.

OAR 436-030 and 436-035 *Exhibit #11*

Testimony: It is clear that the increase in permanent partial disability benefits (PPD) resulting from the new work disability benefit will be offset by the reduction in PPD benefits to those workers who have returned to their job at injury/regular work. However, it is also clear that some of the administrative requirements in the proposed Division 030 and 035 rules will result in significant cost increases to employers, both direct and indirect. OSIA continues to support the MLAC agreements and believes the objectives can be accomplished through policy and procedures/administrative rules that are consistent with the agreements, and with the intent of

Senate Bill 757. Specifically, the administrative rules must establish objective evaluation requirements for rating the “work disability” benefit.

Response: Requirements for rating the “work disability” benefit are clearly outlined in the legislation which will become law on 1/1/2005. The administrative rules have been developed with a focus on the most effective methods of gathering the information necessary to derive the social-vocational factors intrinsic to the computation of the work disability benefit. The tools identified in the rules have been in existence for and applied to cases of unscheduled disability for many years. We have expanded their use to include any case where the worker has not returned to regular work (or ORS 656.726(4)(f) doesn’t apply) with the idea that capitalizing on an existing process is going to be more efficient, less confusing, and less complicated than developing a new one, especially if the existing one is adequate to meet the need. Some modifications were made to the proposed rules in response to this concern; however, gathering the data in those cases where it is necessary to compute the “work disability” benefit cannot be left to chance. We believe the Division 030 rules as revised establish the tools by which the objective evaluation requirements outlined in the Division 035 rules can be met. We will be closely monitoring their effectiveness as they are applied to claims filed after the implementation date.

OAR 436-030 and 436-035 *Exhibit #12*

Testimony: We believe the overall fiscal and economic impact of the changes would significantly exceed expectations. We request an extension in the hearing **Testimony** deadline. It is clear that the increase in permanent partial disability benefits (PPD) resulting from the new work disability benefit will be offset by the reduction in PPD benefits to those workers who have returned to their job at injury/regular work. However, it is also clear that some of the administrative requirements in the proposed Division 030 and 035 rules will result in significant cost increases to employers, both direct and indirect. We strongly support the recent October 13, 2004 **Testimony** presented by the Oregon Self-Insurers Association (OSIA) in addition to our previously submitted comments.

Response: See responses for Exhibits 3 and 11.

OAR 436-030-0005(13), 0015(3), 0015(3)(b), 0020(c) *Exhibit #3*

Testimony: There are too many different terms used in referring to the worker’s “regular work”. This will likely lead to inconsistent interpretation of these requirements and to costly disputes. Please include the definition of “Regular Work” in 436-030-0005 from 656.214(1)(c)(B)(d): “Regular work means the job the worker held at injury.”

Response: As has been pointed out here, the statute provides a definition of the term and, consistent with a mandate for regulatory streamlining, we have opted to rely on the statute, rather than repeat it in any—or all—of the rules where it might be applied.

OAR 436-030-0015 *Exhibit #2*

Testimony: Revise this rule such that an Updated Notice of Acceptance at Closure is not required on fatality claims.

Response: ORS 656.262(7)(c) requires that the insurer issue an Updated Notice of Acceptance that specifies which conditions are compensable when the insurer or self-insured employer determines that the claim qualifies for claim closure. There is no exception for claims involving fatalities.

OAR 436-030-0015(1)(c) *Exhibit #5*

Testimony: The rule defining a “timely” Updated Notice of Acceptance conflicts with OAR 436-030-0020(7)(c), which requires the Notice be sent with the Notice of Closure. In any event, the time requirement in this proposed rule is too confusing. We suggest a simple standard that the Updated Notice of Acceptance should be issued at the time the Notice of Closure is mailed to the worker.

Response: We reviewed ORS 656.262(7)(c), OAR 436-030-0015(1)(c), 436-030-0020(7)(c), and 436-060. We find that, although the two rule cites in Division 30 don’t really conflict, the process is confusing and there is no correlating Notice of Acceptance processing requirement in 436-060. The proposed process of providing an Updated Notice of Acceptance (at Closure) only at closure seems more direct and more consistent with the goals of the Notice of Closure document packet. We will not only revise 436-030-0015(1)(c) to incorporate this proposal, but will provide **Testimony** on OAR 436-060 in support of including a complementary requirement. In this way, the pertinent rules will be consistent regarding the UNOA requirement.

OAR 436-030-0015(3) *Exhibit #5*

Testimony: The opening clause appears to be a “shorthand” description of the qualification standards for work disability awards contained in ORS 656.726(4)(f)(E). Because return to work is only one of the criteria, the statutory conditions should either be incorporated by reference or quoted in full.

Response: This is not the only suggestion for a complete recitation of statutory provisions in the Division 30 rules. Consistent with agency policies that direct us to “streamline” our regulations, we have minimized the reiteration of statute in our rules. In this case, however, we reviewed the possibility of incorporating the qualifications for work disability awards contained in ORS 656.726(4)(f) to determine whether doing so can be justified as a customer service. We found that making reference to the statutory provisions which have bearing on work disability awards was a worthwhile addition and makes the rules where it applies more complete.

OAR 436-030-0015(3) and 0023(9)(c) *Exhibit #5*

Testimony: Should the Notice of Closure be referred to as an order? It is not an official government order; it is a notice issued by an insurer or self-insured employer.

Response: We agree with the logic provided here and, since our research did not find a more complete—and non-redundant—term that still clearly communicated the intended procedure, we determined that using the word “notice” adequately met the need. If we find there is confusion about use of the term “notice”, it will be revisited in a future rules review.

OAR 436-030-0015(6), 0015(6)(a), 0020(1) *Exhibit #3*

Testimony: 436-030-0015(6) requires the insurer to notify the worker when the insurer receives information that the worker’s claim “qualifies” for closure. 436-030-0015(6)(a) requires that the

written notice be sent to the worker within three (3) working days from the date the insurer receives the information. 436-030-0020(1) requires the insurer to issue a Notice of Closure within 14 days of the claim meeting specific criteria that “qualifies” the claim for closure. There has been some confusion concerning exactly when to send the written notice to the worker.

Please include a definition of “Qualifies for Closure” in 436-030-0005. Example: “Qualifies for closure” means that sufficient information has been received and all requirements for issuing a Notice of Closure pursuant to these rules has been completed.” Also, Modify 436-030-0015(6)(a) to state: “Once the claim qualifies for closure, the insurer must send the written notice to the worker or the worker’s attorney, if any, if the claim will not be closed within three (3) working days of the claim qualifying for closure.”

Response: There is no statutory definition of “qualifies for closure” and no case law definition yet. We have been getting along without a restrictive definition up to this point and the proposed change in sentence structure was an effort to clarify one step in the process—not narrow by rule definition. When we reviewed the proposed language for other ways to clarify meaning, we determined that returning to the original format and language was the best option.

OAR 436-030-0020(2)(a) Exhibit #5

Testimony: We disagree with the last sentence of this rule, which questions the worker’s physician’s ability to determine whether a worker has permanent impairment. When the system gives deference to the opinion of the attending physician, why should a claims adjuster or WCD representative without medical training, and without ever seeing the worker, be expected to overrule the physician’s findings and require another examination? We can understand the need for such a rule when the physician makes a clear oversight or error, however this rule has been used to invalidate closures based on sketchy evidence of possible impairment that was recorded long before the claim was ready for closure. We suggest that the rule be amended as follows: “. . . but the record reveals otherwise by clear and convincing evidence . . .”

Response: “Clear and convincing evidence” is a legal standard which is difficult to apply to medical records. Since we received similar **Testimony** regarding this language in this rule, we researched other possible terminology which adequately communicates the threshold for rating permanent findings of impairment in claims where the situation(s) identified exist. After evaluating several options, we decided that providing an example of the kind of objective findings we think should be considered was the best alternative.

OAR 436-030-0020(2)(c) Exhibit #2

Testimony: This proposed rule adds a requirement on all claims at closure to develop social and vocational information, and that the worker either agrees to and signs off on the information or that it be sent by certified mail to the worker and the worker’s attorney, if any, for the worker’s review and response. This places a significant monetary and resource burden on insurers, for development of job analyses and for sending certified mail. About 66% of our claims are time-loss with no permanent disability. Workers, employers, and insurers should not be burdened by obtaining or determining information that is not relevant to the claim. This should not be required if the worker is released to regular work or the attending physician/authorized nurse practitioner has stated there is no permanent impairment.

The proposal doesn't include any timeframes for the insurer or the worker, and this could result in litigation and delay in the closure process. The insurer should obtain the information within a certain timeframe and the worker should be obligated to respond/reply to the insurer's request for information.

Generally, we have a concern as to why these steps are necessary. We currently address specific vocational preparation and work status on claims, and to our knowledge the fairness of this process has not been an issue of concern. Please reconsider whether this is a necessary step and why we cannot continue in the manner we do today.

Response: While it is not our intent to impose unnecessary burdens for documentation on insurers, employers, or workers, provisions of SB 757 expanded the need for accurate return to work information. Unlike in past years when claims involving scheduled disability were "exempt" from application of the release/return to work criteria, all claims occurring on or after January 1, 2005 have the potential for the release/return to work criteria to have a substantial impact on the amount of a worker's permanent disability award. For those claims with dates of injury prior to January 1, 2005, application of the release/return to work criteria will differ little from the past.

The issue of what constitutes "regular work" has long been a concern among system participants. Securing an accurate assessment of the worker's job at injury prior to the attending physician opining the worker's ability to perform all tasks as required is integral to promoting system equity and minimizing potential for re-injury. Because insurers have varied internal work processes, we were reluctant to require that insurers obtain job descriptions at a specific point in time or set timelines and consequences for (failed) worker response. Based on the **Testimony**, the recommendations for acquiring this information are inconsistent. Because the description of physical requirements at injury has potential for significant impact on the worker's disability award and some employers may not have descriptions for work at injury until after the worker is hurt, it is important for the worker to be aware of what has been used to determine whether he/she can or has returned to their regular work. Since the proposed language caused confusion and concern regarding response from the worker about the job description and timing of claim closure, we revised the rule to better communicate our intent and changed the requirement. An accurate description of the physical requirements of the worker's job held at the time of injury now must accompany the Notice of Closure when it is sent to the worker, if not provided prior to claim closure.

OAR 436-030-0020(2)(c) *Exhibit #3*

Testimony: Proposed 436-030-0020(2)(c) requires that before a claim "qualifies for closure" a description of the worker's work at injury, including the physical demands and level of specific vocational preparation, has been agreed to and signed by the worker or has been provided by certified mail to the worker and the worker's legal representative, if any, for the worker's review and response. This is a departure from current rules related to unscheduled injuries, which require consideration of the worker's work history, job at injury, and education, but do not require that the worker agree to and sign off on the worker's work description before the claim qualifies for closure. This is a major issue as it will impede the claim closure process and will be an additional expense to the employer.

Many employers have job descriptions that are fairly broad and will include all types of tasks associated with, but not assigned to, every worker in that particular class. In some cases, the employer cannot easily modify a written job description as the work is in a position represented by a collective bargaining unit. If the employer has to develop job analyses for individuals, that will increase claims costs.

Please change this requirement to be consistent with that in the current rules involving unscheduled injuries. The worker would still have an opportunity to question and appeal any rating that he/she disputes.

Response: See response to same rule, Exhibit #2

OAR 436-030-0020(2)(c) *Exhibit #11*

Testimony: (Some of this **Testimony** is equivalent to Exhibit #3, but is more detailed.)

This subsection implies claim closure process cannot commence without the worker being given the opportunity to approve the description of the worker's job at injury. OSIA believes that this requirement is problematic and will add significant cost to the claim, indirect cost to employers, and will likely lead to a significant increase in disputes and litigation. There are two specific problems we wish to express relative to this section.

1) There is no statement of if or when the claim closure can proceed if the worker has not "agreed to and signed", nor provided a response to the job description provided by certified mail. The significance of this requirement is: a) the potential for awards of work disability to workers who have truly returned to their job at injury/regular work, when there has essentially been no change in their individual work assignment, and no loss of income; b) employers being required to develop individualized job descriptions for each employee, a considerable cost to all Oregon employers who do not have individualized job descriptions; c) increased claim costs from an average charge of \$1,200 for a job analysis performed on each claim where work disability is a factor; and d) risk of non-compliance with other statutory or administrative requirement due to conflicting requirements, including:

436-030-0015(5) which states "the insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure." That is assuming "other information" includes that stated in 436-030-0020(2)(c).

436-030-0015(6) "The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules." (a) "Unless the claim can be closed within three working days from the date the insurer receives the information, the insurer must send the written notice to the worker and the worker's attorney, if any."

436-030-0020(1) "Provided the worker is not enrolled and actively engaged in training, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:"

[Suggested language] There is no acknowledgment that the worker has been released to or returned to their job at injury/regular work, if there are permanent restrictions that are included in, but are not the essential functions of the worker's job at injury/ regular work.

We recommend that 436-030-0020(2)(c) be deleted in its entirety. OAR 436-030-0020(2)(f) adequately addresses the need to consider the worker's work at injury. There should be no additional requirement to have the worker's "approval" of the description of their job at injury/regular work before claim closure can proceed. Also, when the employer has returned the worker to the essential functions of the job at injury/regular work and there is no loss of earnings, the worker should not be entitled to a work disability benefit. Note: ORS 656.214(1)(d) defines "Regular work" as the job the worker held at injury. If said "regular work" is deemed as the essential functions of the worker's job at injury, there should be no consideration of work disability benefits. Finally, the worker would still have an opportunity to question and appeal any rating that he/she disputes. In determining this apportionment, the employer at injury must provide a description of the essential functions which the worker no longer is performing due to the compensable injury. These descriptions must either have been agreed to and signed by the worker, or provided to the worker, and the worker's legal representative, if any, by certified mail and they have failed to timely respond.

Response: See response to same rule, Exhibit #2. Additionally, inclusion of the concept of "essential functions" of work at injury will not be considered in these rules, as this was not part of discussions of MLAC, nor part of the legislation passed. We cannot expand the provisions of the statute by writing rules to include such concepts.

OAR 436-030-0020(2)(c) *Exhibit #16*

Testimony: Replace proposed text with:

(Option 1):

Either a description of the essential functions of the worker's job at injury, including physical demands and level of specific vocational preparation (SVP) or a copy of the Dictionary of Occupational Titles, US Department of Labor, 4th Edition Revised 1991 ("DOT") description of the workers' job at injury;

(Option 2):

1) Either a description of the essential functions of the worker's job at injury, including physical demands and level of Specific Vocational Preparation (SVP), which either has been agreed to and signed by the worker or has been sent by certified mail to the worker and the worker's legal representative, if any; or

2) A copy of the Dictionary of Occupational Titles, U.S. Department of Labor, 4th Edition Revised 1991 ("DOT") description of the workers' job at injury which either has been agreed to and signed by the worker or has been sent by certified mail to the worker and the worker's legal representative, if any;

Response: See response to same rule, Exhibits #2 and #11.

OAR 436-030-0020(2)(c), (f) and (g) *Exhibit #5*

Testimony: The proposed addition of subsections (c), (f) and (g) to this rule is an unwarranted expansion of the definition of "sufficient information" and exceeds the statutory requirement in ORS 656.268(1)(a) of "sufficient information to determine permanent impairment." The information is only relevant for workers with permanent impairment who have not returned to regular work. We estimate that only 5% of disabling claims are closed with the worker unable to return to regular work. Under the Proposed rule, the insurer, worker, and employer would have to work together to assemble unnecessary information in 95% of time loss claims, or around

23,000 claims per year. The administrative cost to the insurer could easily exceed \$50 per claim, pushing the cost close to \$1 million per year for insurers alone.

The proposed rule exceeds the division's authority, is an enormous and unnecessary expense, will delay claim closure and thus payment of permanent partial disability awards, and flies in the face of recent attempts to reduce paperwork, streamline the regulatory burden and simplify claim processing for the worker. The rule should be amended to require this information only when it is truly needed for an accurate closure of the claim. Please note also that this rule should apply only to injuries on or after 1/1/2005.

Response: See response to same rule, Exhibits #2 and #11. In addition, the language quoted here for ORS 656.268(1)(a) is as the statute currently reads. The language for ORS 656.268(1)(a) which goes into effect at the same time as these rules (1/1/2005) reads as follows: "...sufficient information to determine permanent disability." This change in terminology provides the division with a different level of authority and responsibility than is presently in effect.

OAR 436-030-0020(2)(c), (f) and (g) *Exhibit #17*

Testimony: Even if the proposed rule is applied only to the 5% of disabling claims where the worker is never released for regular work, we still have concerns about the level of detail that is required. Specifically, we question expansion of the use of specific vocational preparation (SVP). SVP levels are derived from the Dictionary of Occupational Titles (DOT), a volume that has not been published for over a decade. Many jobs performed today didn't exist thirteen years ago or have changed dramatically. The department and its stakeholders should form a committee to discuss alternatives to the DOT, for implementation when the rules are next revised, preferably after the 2005 legislative session. Given the obsolescence of the DOT, its use should be phased out, not expanded. Yet the department has proposed a new requirement that insurers match a worker's job to the DOT, assign an SVP level and then seek agreement or review by the worker that the SVP is correct. "SVP" will be meaningless to the vast majority of injured worker. If a worker wishes to research an SVP level, he or she will have to locate an out-of-print DOT and search its thousands of pages for a potential job match. The worker will likely conclude the system is not user-friendly and will seek professional help. We recommend the proposed rule not be adopted and that the department initiate a process to replace the DOT and SVP.

Response: See response to same rule, Exhibits #2 and #11. Additionally, we acknowledge the problems with using the DOT and its designations for determining a worker's "work preparation" level as part of their education factor. At the same time, we realize there is no universally accepted standard to replace it. Given the need for an established standard at the present time, we feel the DOT and the designations it contains is adequate to meet the need until research can establish a suitable replacement.

OAR 436-030-0020(2)(f) *Exhibit #3*

Testimony: This proposed rule requires the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, to include tasks performed or level of specific vocational preparation, and physical demands. This is a significant change from what is currently required for unscheduled injuries under 436-030-0015(3)(b) which is "work history for five years preceding the Notice of Closure with dates or period of time spent at each position. The proposed rule would conceivably account for more than five years in cases where the claim does not qualify for closure for a year or more from the date of injury.

Please change this requirement to be consistent with that in the current rules involving unscheduled injuries. The worker would still have an opportunity to question and appeal any rating that he/she disputes.

Response: In reality, there is virtually no change from what is currently required by the Division 035 rules as part of factoring adaptability. Current rules do not clearly address the matter of past physical demand and SVP, both issues which, as a result of changes made by SB 757, now have increased potential to affect a worker's permanent disability award. Additionally, with the impending demise of the differentiation between scheduled and unscheduled claims and the increased emphasis on return to regular work, the matter of gathering information to determine adaptability needed to be addressed for processing a greater variety of claim situations. Presently, some insurers routinely request this information early in a worker's claim in an effort to facilitate early return to work—whether at a regular or modified job. A worker's work history prior to date of injury is likely to encompass a greater variety of jobs and tasks, which is both a more accurate reflection of their capabilities when considering the extent of their disability and a tool that can be used to facilitate a quicker return to the work force. For this reason, we have placed more specifics regarding gathering this information in the Division 030 rules.

OAR 436-030-0020(2)(f) & 436-035-0012 Exhibit #11

Testimony: For purposes of determining extent of disability, 436-030-0020(2)(f) requires the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, to include tasks performed or level of SVP, and physical demands. This is a significant change from what is currently required for unscheduled injuries under 436-030-0015(3)(b) which is "work history for five years preceding the Notice of Closure with dates or period of time spent at each position."

In the proposed Division 035 Rules, WCD has defined the education factor as the worker's formal education and the worker's SVP at the time of NOC issuance. There is no specific statutory requirement for using the SVP, only the worker's age, "education" and adaptability to perform a given job. There is no way to objectively verify that a worker has "successfully performed" any work other than that with the employer at injury.

Proposed Division 030 Rules, 436-030-0020(2)(f), states that you are to use "the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands" in determining the extent of disability. Proposed Division 035 Rules, 436-035-0012(5) states that you only go back to "five years prior to the date of issuance" of the NOC. What would be the five years of prior work on occupational disease claims that are filed years after the last exposure? If these two provisions be adopted in the permanent rules this would likely result in increased litigation. Employer's premium calculations do not include employees' work in prior years and/or with prior employers. The proposed rule would conceivably account for more than five years in cases where the claim does not qualify for closure for a year or more from the date of injury.

We proposed that the division change this requirement to be consistent with that in the current rules involving unscheduled injuries. The worker would still have an opportunity to question and appeal any rating that he/she disputes. OSIA also recommends that only the highest strength

factor for the job at injury should be considered in rating the work disability benefit. Education factor should include the highest education level attained by the time of claim closure.

Response:

See response to same rule for Exhibit #3

OAR 436-030-0020(6)(b) Exhibit #2

Testimony: The proposed rule requires the dollar value of permanent disability and work disability be included on the Notice of Closure (NOC). The work disability value is based on the worker's average weekly wage, which could change. The dollar value of the award should not be on NOCs post 1/1/05, but only the percentage of "whole person" permanent disability and percentage of work disability. A separate letter could list the dollar value of the awards.

Response: The points made here are worthy of note. ORS 656.268(5)(a)(B) continues to require that the notice of closure inform the "worker of the *amount* of any further compensation, including permanent disability compensation to be awarded". Legal interpretation of the term "amount" is the total dollar value of the award. It is because there is potential for change in value(s) of various aspects of the worker's permanent disability award that we have specifically listed the items that appear on the face of the NOC. Additionally, as there is no statutory requirement for the computation or the individual dollar value(s) of any of the integral factors to appear, those are not permitted on the NOC itself. As in the past, we have opted for the calculation—and each of the pertinent values—to appear on the Form 440-2807, NOC Worksheet.

"Whole person disability" applies only to those claims with DOI on/after 1/1/05. All other claims will continue to be processed and closed consistent with the previous "scheduled" and "unscheduled" benefit structure. Thus, NOCs issued after 1/1/05 will need to be able to accommodate both formats. Additionally, the wage at injury is first used in the determination of worker's timeloss benefits. Insurers already are required to advise the worker of the basis for those calculations by the Division 060 rules. They now also include provisions for the worker to be notified (1) how the wage at injury will be used (including computation of the work disability portion of the permanent disability award), (2) each time the wage used as a basis for such computations changes, and (3) when a wage dispute is settled and changes the amount of benefits the worker is due. The 2807 (NOC Worksheet) for claims with DOI on/after 1/1/05 will display the wages—state average weekly wage and the worker's average weekly wage—used to calculate the worker's permanent disability award.

OAR 436-030-0020(6)(m) Exhibit #5

Testimony: We cannot understand why the rule would require the Notice of Closure to include the relevant statewide weekly wage and forbid including the worker's own wage. Both numbers are required for calculation of awards involving both permanent disability and work disability. The worker is entitled to know the wage that was used to calculate the award and to request reconsideration if he or she disagrees with any aspect of the closure. Failure to show the wage will not prevent it being contested. The worker will be able to find the wage that was used by reversing the formula used to calculate work disability.

The reconsideration process should not be used to resolve wage disputes. The appellate unit should advise the worker that the award value is calculated based on the wage of record in the

claim. A worker's failure to request reconsideration should not be considered to be a waiver of the right to contest the wage. If the worker's wage of record should change at any time through appeal or re-evaluation, the dollar value of the worker's PPD award will be adjusted accordingly. A rule should be adopted consistent with this recommendation.

Response: See response to same rule, Exhibit #2. In addition, it was the division's intent to encourage early resolution of disputes over wage at injury through channels already established for that purpose. We strongly concur with the concept that ARU not be used as a means to resolve wage disputes; however, placement of the worker's wage at injury on the NOC—or not—does not change the responsibility for ARU to complete a “de novo” review of the record should reconsideration be requested and the wage be contested at that point in time. In response to the Testimony, we have added a rule addressing the need for the worker to be advised of the change in their benefit amounts when and/or if the wage at injury is changed through litigation after the claim is closed or the reconsideration process is complete.

OAR 436-030-0034(1)(d) *Exhibit #2*

Testimony: The phrase “”permanent disability apparent in the record” is not clear. We request the department specify that only irreversible findings, such as surgical values, amputation, etc., be rated and not reversible findings, such as loss of strength, ROM, etc.

Response: We agree that there is potential for misunderstanding about the meaning of “permanent disability apparent in the record”. We have made modifications to provide an example of the type of findings we believe are potentially ratable and should be considered when they appear in the medical reports, but are not substantiated by a closing examination because one was not performed.

OAR 436-030-0034(1)(d) *Exhibit #5*

Testimony: The word “apparent” is undefined. In most cases, a worker has not returned for medical treatment because the condition has resolved. Rating “apparent” impairment from the record necessarily means that the rating must be based on an older examination and could result in an award for an impairment that no longer exists. Permanent impairment must be based on objective findings and those findings should be current in order to be objective. We recommend that the rule be amended to rate only “hard” findings granted according to a schedule for specific events, such as surgery, and are awarded regardless of the measurable impairment in a closing exam.

Response: See response to same rule, Exhibit #2

OAR 436-030-0135(3) *Exhibit #2*

Testimony: It is not clear that the “start date of the reconsideration proceeding” is the date DCBS receives the reconsideration request, rather than the date the claimant initiates the request. 436-030-0145(2)(a) states reconsideration begins when the director receives the worker's reconsideration request, but sometimes the reconsideration acknowledgement letter puts the start date as the date the worker mailed the request. This reduces the time we have to provide documents. The rule should specify that the start date of the reconsideration proceeding is the date the department receives the reconsideration request from the worker.

Response: ORS 656.268(6)(e) and OAR 436-030-0145(2) specify when the reconsideration proceeding begins. If an error occurs in the acknowledgement letter sent to the parties, it is appropriate for the party who suspects the error to raise it with the Appellate Review Unit staff. After investigation, if the error is confirmed, a correction letter should be sent to advise the parties of the correct “due” date for submission of evidence and/or the claim records. It does not appear that a change in this rule—OAR 436-030-0135(3)—is necessary for this purpose.

OAR 436-030-0155(4) *Exhibit #5*

Testimony: We believe that this proposed rule is not worded correctly. On its face, it requires documentation of authority for every MCO provider, regardless of the medical degree. We are guessing the intent is to document the authority of every MCO provider who does not otherwise meet the definition of an attending physician. If so, the rule should be corrected accordingly.

Response: This revision was added because evidence indicates there is no assurance that a medical provider authorizing timeloss and/or offering an opinion on impairment is within their authority to do so. Insurers routinely cannot confirm whether a medical care provider treating or reporting closing findings is authorized to do so under the auspices of an MCO contract. Contracts with physicians and other medical practitioners change depending on provider, individual employer, and worker. Circumstances can change at any time. In the absence of documentation that the provider is under contract with the MCO on that date for that worker, the action taken by the medical provider may not be within their authority. Insurers—and reviewers performing reconsideration reviews—need to be certain the disability information on which they base their closure is complete to assure the accuracy and appropriateness of their action(s). This change requires an insurer to document that the provider has the authority to provide findings which can result in claim closure and/or rating of impairment.

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 23rd day of November, 2004.

WORKERS' COMPENSATION DIVISION

/s/ Fred Bruyns

Fred Bruyns, Rules Coordinator

Policy Section

Workers' Compensation Division



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE, Room 27
PO Box 14480
Salem, OR 97309-0405
1-800-452-0288, (503) 947-7810
TTY (503) 947-7993
www.oregonwcd.org

September 22, 2004

TO: Oregon workers, employers, and all interested parties

SUBJECT: **Extension of public comment period through October 15, 2004**
Affecting Oregon Administrative Rules,
Chapter 436, Division 030, "Claim Closure and Reconsideration" and
Chapter 436, Division 035, "Disability Rating Standards"

The Workers' Compensation Division has received a request for an extension of the deadline for written **Testimony**. ORS 183.335(4) states in part:

Upon request of an interested person received before the earliest date that the rule could become effective after the giving of notice pursuant to subsection (1) of this section, the agency shall postpone the date of its intended action no less than 21 nor more than 90 days in order to allow the requesting person an opportunity to submit data, views or arguments concerning the proposed action.

The amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated August 1, 2004. On August 23, 2004 a public rulemaking hearing was held as announced.

- **The original closing date for testimony was August 27, 2004.**
- **The revised closing date for testimony is October 15, 2004.**

Deliver or mail written testimony to:
Workers' Compensation Division
350 Winter Street NE, Rm 27
PO Box 14480
Salem, OR 97309-0405

Fax to: (503) 947-7581

Email to: 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.

A summary of the proposed changes is included with this notice – in the Notice of Proposed Rulemaking Hearing. Please note that this is an extension of the closing date for testimony only; there will not be a second public hearing.

If you have questions, please contact Fred Bruyns, Rules Coordinator, (503) 947-7717.

/s/ John L. Shilts

John L. Shilts, Administrator
Workers' Compensation Division

Distribution: WCD-ID, S, T, U, AT, CE, IA, LU, NM, CI, LL, DC, DO, GR, MD, ND, OT, PA, PY, RN, VR, ML, ME, MC, S0, S1, S4, S5, S7, S8

Attachment: Notice of Proposed Rulemaking; Statement of Need and Fiscal Impact

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services, Workers' Compensation Division		OAR CHAPTER 436	
Agency and Division		Administrative Rules Chapter Number	
Fred Bruyns		(503) 947- 7717 Fax (503) 947-7581	
Rules Coordinator		Telephone	
PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879			
Address			
August 23, 2004	10:00 a.m.	Room 260 (2 nd floor), Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns ^{FB}
Hearing date	Time	Location	Hearings Officer

NOTE: The hearing will convene at 10:00 a.m. and end when all present who have indicated their intention to testify have been called to present testimony. Written testimony will be accepted through August 27, 2004.

**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: OAR 436-035-0008, 436-035-0009, 436-035-0011, 436-035-0012, 436-035-0013, 436-035-0014, 436-035-0015, 436-035-0016, 436-035-0017, 436-035-0018, 436-035-0019, 436-035-0115, 436-035-~~0240~~ 0235^{FB}, 436-035-0255, 436-035-0265

AMEND: OAR chapter 436, divisions 030 & 035

REPEAL: OAR 436-035-0010, 436-035-0170, 436-035-0200, 436-035-0270, 436-035-0280, 436-035-0290, 436-035-0300, 436-035-0310, 436-035-0320

ORS 656.726(4), 656.704, 656.268

Stat. Auth.

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

Other Authority

ORS chapter 656; ch. 657, OL 2003 (Senate Bill 757)

Stats. Implemented

RULE SUMMARY

The agency proposes to amend these rules primarily to implement changes in the law due to legislation passed by the 2003 Oregon Legislature. Senate Bill 757 changed the disability rating standards for claims with dates of injury on or after January 1, 2005. In accordance with the changes, these proposed rules (for dates of injury on or after 1/1/2005):

- Eliminate the distinction between scheduled and unscheduled permanent partial disability awards;
- Provide that all impairment is expressed as a percentage of loss of the whole person, not to exceed 100%; impairment benefits are determined by multiplying the impairment value times 100 times the Oregon average weekly wage; and
- Provide “work disability” for workers who have permanent impairment and who have not returned to or been released for regular work; work disability benefits are determined by multiplying the impairment

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

value, as modified by the factors of age, education, and adaptability to perform a given job, times 150 times the worker's weekly wage for the job at injury, though the factor used for the weekly wage may not be more than 133% nor less than 50% of Oregon's average weekly wage.

In addition, these proposed rules:

- 436-030-0105 Establish a uniform process for the director's review of claim classification (disabling/nondisabling) decisions;
- 436-030-0155 Require that for cases involving a care provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the care provider's authority to act as an attending physician.
- 436-035-0007 Establish uniform standards for the determination of chronic condition impairment (existing rules provide different criteria for scheduled and unscheduled body parts);
- 436-035-0012 For dates of injury on or after January 1, 2005, provide that the worker's adaptability is determined by comparing the adaptability scale and the residual functional capacity scale and using the higher of the two values for adaptability.
- 436-035-0110 Establish standards for determination of permanent impairment due to neurological dysfunction resulting in cold intolerance in the upper extremity (upon reconsideration of a Notice of Closure, this scenario currently requires temporary rule promulgation under ORS 656.726(4)(f)(C));
- 436-035-0110 Prescribe a method for determining sensation impairment in a digit in which the sensation loss does not extend to the distal end of the digit; the value is established by determining the value for loss from the distal end of the digit to the proximal location of the loss, and subtracting the value for loss from the distal end of the digit to the distal location of the loss (upon reconsideration of a Notice of Closure, this scenario currently requires temporary rule promulgation under ORS 656.726(4)(f)(C)); and
- 436-035-0250 Extend the presbycusis tables beyond the age of 60 to "85 or older" and provide that the hearing impairment threshold of 150 decibels is to be subtracted from the presbycusis value.
- 436-035-0390 Supplement the brain injury class descriptions with information intended to assist physicians and disability analysts in determining the relevant class and therefore the appropriate percentage of impairment.

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.

August 27, 2004
Last Day for Public Comment

/s/ John L. Shilts
Authorized Signer and Date

July 15, 2004

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.

Distribution: WCD-ID, S, T, U, AT, CE, IA, LU, NM, CI, LL, DC, DO, GR, MD, ND, OT, PA, PY, RN, VR, ML, ME, MC, S0, S1, S4, S5, S7, S8

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
Agency and Division

OAR CHAPTER 436
Administrative Rules Chapter Number

In the Matter of) Statutory Authority,
The Amendment of:) Statutes Implemented,
OAR 436-030, Claim Closure and Reconsideration) Statement of Need,
OAR 436-035, Disability Rating Standards) Principal Documents Relied Upon,
) Statement of Fiscal Impact

Statutory Authority: ORS 656.704, 656.726(4), 656.268

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

Statutes Implemented: ORS chapter 656; ch. 657, OL 2003 (Senate Bill 757)

Need for the Rule(s): These amendments are proposed primarily to implement changes in the law due to legislation passed by the 2003 Oregon Legislature. Senate Bill 757 changed the disability rating standards for claims with dates of injury on or after January 1, 2005.

Documents Relied Upon: Enrolled Senate Bill 757; fiscal impact statement and bill analysis forms for SB 757; rule advisory committee meeting records; issues documents, "Survey of State Workers' Compensation Agencies Regarding Presbycusis, "Head Injury Impairment Ratings Revision Project" 5/24/2004, by M. Tilson Ph.D. and D. Erb, M.D., and a cost analysis developed by the Department of Consumer and Business Services, Information Management Division. 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:

Overall, the fiscal and economic impact of these rules is estimated to be approximately neutral. Senate Bill 757 indexes permanent impairment benefits to Oregon's average weekly wage. The Bill was analyzed with and without the recent upward adjustment (3.527%) in the weekly wage as published by the Oregon Employment Department. Without the increase, the impact is a -0.12% reduction in overall system costs; with the increase, the impact is estimated to be a 0.57% increase in system costs. However, analysis did not account for the effects of "combining" of impairment values for multiple injured body parts. "Combining," for the purposes of impairment rating, means, for example, that 50% whole-person impairment resulting from a spinal injury combined with 50% whole-person impairment resulting from an arm injury is equal to 75%, i.e. 50% + (50% X 50%). We project that cost reductions due to impairment combining will offset increased costs related to chronic condition impairment, adaptability, presbycusis, cold intolerance due to neurological dysfunction, and provisions for atypical sensation impairment. These rules should not impose any significant burdens on small businesses.

Administrative Rule Advisory Committee consulted: Yes

/s/ John L. Shilts

July 15, 2004

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.

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROPOSED CLAIM CLOSURE AND RECONSIDERATION RULES**

**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) Requests for closure by the worker;
- (2) Claim closure under ORS 656.268(1);
- (3) Determining medically stationary status;
- (4) Determining temporary disability benefits;
- (5) Awards of permanent partial disability;
- (6) Review and determination of the disabling or nondisabling status of a claim;
- (7) Determining permanent total disability awards;
- (8) Review for reduction of permanent total disability awards;
- (9) Review [and determination] of prior [unscheduled] permanent partial disability awards **consistent with the provisions of OAR 436-030-0003**; and
- (10) Reconsideration 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.
Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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.

ORDER NO. 04-XXX

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROPOSED CLAIM CLOSURE AND RECONSIDERATION 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] **February 29**, 200[1] **4**, by Workers' Compensation Division Administrative Order [00-058] **04-052**, and carry out ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.277, 656.278, **and** 656.325[, and section 22(3), chapter 865, Oregon Laws 2001].

(a) [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 (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 OAR 436-030-0020, **436-030-0030**, **and 436-030-0050** as adopted by WCD Administrative Order 13-1987 effective January 1, 1988 will apply.

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

(c) OAR 436-030-0055(3) (b), (3)(d) and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.

[(d) OAR 436-030-0115(4) and 436-030-0165(10)(b) apply to all claims closed on or after 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0005 Definitions

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

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

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

(3) "**Day(s)**" means a calendar day(s) unless otherwise specified (e.g., "**working day(s)**").

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
PROPOSED CLAIM CLOSURE AND RECONSIDERATION RULES**

(4) “Director” means the director of the Department of Consumer and Business Services, or the director’s delegate for the matter.

(5)^[4] “Division” means the Workers’ Compensation Division of the Department of Consumer and Business Services.

(6)^[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.

(7)^[6] “Mailed or Mailing Date,” for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by electronic transmission (by facsimile or “fax”) will be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers’ Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(8)^[7] “Notice of Closure” means a notice to the worker issued by the insurer to

(a) Close an accepted disabling claim;

(b) Correct, rescind, or rescind and reissue a Notice of Closure previously issued; or

(c) ^[to r] Reduce permanent total disability to permanent partial disability.

(9)^[8] “Notice of Refusal to Reclassify” means the insurer’s written response, to a worker’s request, which notifies the worker of the insurer’s decision regarding the nondisabling status of a claim.

(10)^[9] “Reconsideration” means review by the director of an insurer’s Notice of Closure .

(11)^[0] “Statutory closure date” means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).

(12)^[1] “Statutory appeal period” means the time frame for appealing a Notice of Closure or Order on Reconsideration.

(13)^[2] “Work disability”, for purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.

(14) “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

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Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0007 Administrative Review

(1) **The following matters are subject to** [D] **dispute resolution before the director:**

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

(c) Notices of Refusal to Reclassify issued by insurers are appealable by the worker to the director under ORS 656.273 and 656.277 **and processed in accordance with the Director's Review processes described in OAR 436-060-0018.** [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 Refusal to Reclassify is mailed.

(B) The insurer 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 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) **The following matters are** [Cases] brought before the Hearings Division of the Workers' Compensation Board:

(a) **Director's Review orders and** Orders on Reconsideration **issued under the provisions of OAR 436-060-0018 and these rules** are appealable to the Hearings Division of the Workers' Compensation Board **within the timeframes established in OAR 436-060-0018 and 436-030-0145, respectively.** [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) Under OAR 436-030-0145(1)(b) for claims medically stationary on or after June 7, 1995, for the purpose of filing such appeal, the time will be 30 days from the mailing date of the Order.

(C) 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 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 under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS Chapter 656.]

(3) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740 [(§9, ch. 170, OL 2003)], any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

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

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

(c) An Administrative Law Judge from the Hearings Division, acting on behalf of the director, will conduct the hearing in accordance with ORS 656.740 and 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 under these rules, may request administrative review by the director as follows:

(a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is **disputed** [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 is^[t] deemed^[s] 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.

(d) The director may, unless otherwise obligated by statute, at the director's discretion, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.268, 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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 under ORS 656.268(1)(b) or (c)[(ch. 429, OL 2003)], the worker or insurer must first request a reconsideration by the director under these rules. 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.

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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 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0010 Director Responsibility

- (1) The director, when requested by a worker, is responsible for reviewing the disabling/nondisabling status of a claim.
- (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.
- (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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0015 Insurer Responsibility

(1) When an insurer issues a Notice of Closure (**Form 440-1644, 1644c, 1644r**), the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the worksheet (**Form 440-2807**) upon which the Notice is based, a completed "Insurer Notice of Closure Summary" (**Form 440-1503**) and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in 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 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 must be issued:

(A) ^[n] No sooner than **either (whichever occurs closer to actual closure):**

(i) ^[t] The date the claim qualified for closure, or

(ii) **Thirty (30) days** prior to claim closure^[(whichever occurs closer to actual closure)]; ^[, but] **and**

(B) ^[n] Not later than the mailing date of the closure.

(d) The Updated Notice of Acceptance at Closure must contain the following title, information and language:

(A) Title: "Updated Notice of Acceptance at Closure";

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(B) Information: [a] **A list of all** compensable conditions that have been accepted, even if [the] **a** [accepted] condition was **denied**, ordered **accepted** by litigation, and is under appeal[:]; [however, a] **Any conditions under appeal and those which were the basis for this claim opening** must be specifically identified;

(C) Language, in bold print:

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

(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 [u]Updated [n]Notice of [a]Acceptance at [c]Closure, the word “CORRECTED” must appear in capital letters adjacent to the word “[u]Updated”.

(f) In the event that the “[I]Initial [n]Notice of [a]Acceptance” is **issued at** the same **time** as the “[u]Updated [n]Notice of [a]Acceptance at [c]Closure,” both titles must appear near the top of the document.

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

(3) In claims **with a date of injury on or after January 1, 2005 where the worker has not returned to regular work,** [involving unscheduled injuries to, or disease of, body parts or conditions under OAR 436-035-0330 through 436-035-0450,] the insurer must consider the worker’s **age at time the order is issued, adaptability to return to employment,** work history, and education including:

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

(b) **A description of the worker’s job at injury and [T]the worker’s work history [under OAR 436-035-0300 and 436-035-0310 including the job at injury and work history]for the period from five years[preceding] before the date of injury to the mailing date of the Notice of Closure [with] including dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical demands.**

(4) **In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, and the claim involves injury to, or disease of,**

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unscheduled body parts, areas, or systems, the insurer must consider the worker's age at time the order is issued, adaptability to return to employment, work history, and education including:

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

(b) The worker's work history including a description of the job at injury and work history for the period from five years before the date of injury to the mailing date of the Notice of Closure, indicating the dates or period of time spent at each position, tasks performed or level of SVP, and physical demands.

(5) The insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.

(6)^[5] The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) [The insurer must send the written notice] **Unless the claim can be closed** within three working days from the date the insurer receives the information, **the insurer must send the written notice to the worker or the worker's attorney, if any** [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 **of closing the claim**, provide the worker's attorney the same documents relied upon for claim closure.

(7)^[6] The insurer must not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

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

(9)^[8] Denials issued 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 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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

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

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

- (a) Name of the worker;
- (b) Date of injury;
- (c) Insurer's claim number;
- (d) Mailing date of the notice;
- (e) The accepted and denied conditions;
- (f) Rationale for the insurer's decision; and
- (g) The following language, in bold print:

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

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

Stat. Auth.: ORS 656.268, 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0020 Requirements for Claim Closure

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

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

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(b) The accepted injury/condition is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;

(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or

(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending action(s) in accordance with these rules.

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

(a) **An authorized nurse practitioner's or attending physician's written statement that clearly indicates there is no permanent impairment, residuals or limitations attributable to the accepted condition(s), and there is no reasonable expectation, based on evidence in the record, of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s). If the physician or nurse practitioner indicates there is no impairment, but the record reveals otherwise, a closing examination and report under (b) of this section is required** [A closing medical examination and report when there is a reasonable expectation of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s) based on evidence in the record or the physician's opinion. The closing medical examination report must describe in detail all measurements and findings regarding any permanent impairment, residuals or limitations attributable to the accepted condition(s) under OAR 436-010-0280 and OAR 436-035]; **OR**

(b) [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 under (a) of this section is required] **A closing medical examination and report when there is a reasonable expectation of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s) based on evidence in the record or the physician's opinion. The closing medical examination report must describe in detail all measurements and findings regarding any permanent impairment, residuals, or limitations attributable to the accepted condition(s) under OAR 436-010-0280 and OAR 436-035;**

(c) A description of the worker's work at injury, including physical demands and level of specific vocational preparation (SVP), which either has been agreed to and signed by the worker or has been provided by certified mail to the worker and the worker's legal representative, if any, for the worker's review and response;

(d) The worker's wage established consistent with OAR 436-060;

(e) The worker's age on date of injury;

(f) The worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and

(g) The worker's level of formal education .

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(3) When determining disability **and issuing the Notice of Closure**, the insurer must **apply all statutes and rules consistent with their provisions particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, review of permanent partial and total disability.** :

(a) Apply 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) Apply OAR 436-030-0035 regarding medically stationary status;

(c) Apply OAR 436-030-0036 regarding temporary disability;

(d) Apply OAR 436-030-0020, 436-030-0038, and 436-030-0066 regarding permanent partial disability;

(e) Apply OAR 436-030-0055 and 436-030-0065 regarding permanent total disability and review of permanent total disability; and]

(f) **4** **When issuing a Notice of Closure, the insure must** [P] prepare a summary worksheet, "Notice of Closure Worksheet", Form 440-2807 (Form 2807), [which contains all the information **as** described by bulletin of the director.

(4) **5** The "Notice of Closure", Form 440-1644 (Form 1644), is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, regardless of the date on the Notice itself.

6 The notice must be in the form and format [that the director]prescribe[s] **d** by [bulletin] **the director in these rules and** [The notice must] include **only** the following:

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

(b) The appropriate dollar value of any **individual scheduled and/or unscheduled permanent disability based on the [statutory]value [for the]per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;**

(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director[.];

(d) The percentage of loss **of the specific body part(s), [and]including either** the number of degrees that loss represents **as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;**

(d) **e** If there is no permanent disability award for this Notice of Closure, a statement to that effect;

(f) **e** The duration of temporary total and temporary partial disability compensation;

(f) **g** The date the Notice **of Closure** was mailed;

(h) **g** The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034[, respectively];

(i) **h** The date the worker's aggravation rights end;

(i) **i** The worker's appeal rights;

(k) **j** The right of the worker to consult with the Ombudsman for Injured Workers;

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(1)(k) For claims with dates of injury before January 1, 2005, [T]the rate in dollars per degree [schedule (dollars per degree)] at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;

(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury is to be shown on the Notice of Closure; the worker's wage is not to appear;

(1)(n) The worker's return to work status; and

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

(1)(7) The Notice of Closure **(Form 440-1644)** must be accompanied by the following:

(a) The brochure "Understanding Claim Closure and Your Rights";

(b) A copy of [the]summary worksheet **Form 2807** containing information and findings which result in the data appearing on the Notice of Closure;[and]

(c) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal and/or which were the basis for this opening of the claim; and

(d) A cover letter that:

(A) **Specifically [E]explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating, etc.);**

(B) Lists and describes enclosed documents; and

(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(1)(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) The worker;

(b) The employer;

(c) The director; and

(d) The worker's attorney, if the worker is represented.

(1)(9) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

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

(1)(11) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:

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

(b) To recover overpayments for temporary disability; and

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(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.

(1[0]2) 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.

(1[1]3) If after claim closure, the worker became enrolled and actively engaged in an approved training program under OAR 436-120, **a new Notice of Closure must be issued consistent with the following:**

(a) **In claims with dates of injury on or after January 1, 2005, the insurer must redetermine work disability when:**

(A) The worker has ended training; and either

(B) The worker's condition is medically stationary; or

(C) The claim otherwise qualifies for closure in accordance with these rules.

(b) For claims with dates of injury before January 1, 2005, [Unscheduled] p[p]ermanent disability must be redetermined by the insurer when:

(A) [t]The worker has ended training; and either

(B) [t]The worker's condition is medically stationary; or

(C) [t]The claim otherwise qualifies for closure in accordance with these rules, except

(D) When the worker became medically stationary after 6/7/95 for a scheduled disability.

Then the scheduled disability must remain unchanged from the last award of compensation in that claim unless the condition did not remain medically stationary through training.

[(b)] **(c)** 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.]
For claims with dates of injury before January 1, 2005, if the worker has remained medically stationary throughout training and the closing examination is six months old or older, a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's accepted condition since the previous closing examination.

[(c) No redetermination of permanent disability 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 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.

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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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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 the date the correction or rescission is mailed. The mailing date of the Notice of Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(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 **but are not limited to:**

- (a) the worker was not medically stationary at the time the Notice of Closure was issued;
- (b) the closure was otherwise premature;
- (c) 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";

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- (c) Explain the reason the action is being taken;
 - (d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;[,]
 - (e) Establish a new 60-day appeal period;
 - (f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and
 - (g) Be distributed and mailed to the parties consistent with these rules.
- (8) Correcting Notices of Closure, Form 1644c, are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure must not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability. Examples of appropriate uses of Correcting Notices of Closure include **include but are not limited to:**
- (a) permanent disability award computation errors (dollars, degrees, percentages);
 - (b) the “mailing date” was incorrect;
 - (c) return-to-work status errors or omissions;
 - (d) incorrect or []incomplete statement of temporary disability.
- (9) A Correcting Notice of Closure must:
- (a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);
 - (b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;
 - (c) State **in the body of the order** 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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

(1) The insurer must close a claim if a worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner. In order to close a claim under this rule, the insurer must:

(a) [s] Send the worker written notification by certified mail that the claim will be closed unless the worker establishes within 14 days that:

(A) [the worker] **Treatment** has resumed [treatment]by attending **an existing appointment** or scheduling a new appointment, or

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(B) [that t] **T**he reasons for not treating were outside the worker's control.

(b) Wait the 14 day period given in the notification letter to allow the worker to provide evidence that the absence of treatment was either authorized by the physician or beyond the worker's control.

(c) Based on the information provided by the worker or absence thereof, determine whether claim closure is appropriate.

(d) Regardless of receiving a response from the worker, the insurer must rate any permanent disability apparent in the record at the time claim closure is appropriate.

(2) The date the claim qualifies for closure, when a worker fails to seek treatment for a period in excess of 30 days, is the latest (most chronologically recent) of the following which occurs prior to the closure:

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

(b) The date the worker failed to attend a follow-up visit that was recommended by the attending physician or authorized nurse practitioner for reasons within the worker's control;

(c) The date the worker returns to or is released to regular work if it is after the last examination date; or

(d) [The 14th day after the notice required in section (1) of this rule, or] **The date of the worker's response** if the worker responds within th[at] **e 14 day period established by the notification letter, and the worker's response** [, 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 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) **T**he insurer has notified the worker, by certified letter, at least 10 days prior to the mandatory examination, that claim closure will result for failure to attend a mandatory closing examination. The notification letter must inform the worker of the worker's responsibility to attend the mandatory closing examination and of the consequences for failing to do so, including but not limited to claim closure and the possible loss or reduction of a disability award.

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

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

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

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

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

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

(5) When any two of the above occur concurrently, the earliest date the claim qualifies for closure is used to close the claim and noted on the notice.

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

(7) When the director has issued a suspension order, under OAR 436-060-0095 and OAR 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.

(8) When a worker fails to seek treatment with an **authorized** attending physician as defined by ORS 656.005 or [authorized] **authorized** nurse practitioner **as defined in ORS 656.245**, the claim must be closed under section[s] (1) **of this rule.** [And] **Section** (2) of this rule **must be used to determine the effective date of the closure.** All noti[ces] **fication letters issued under this rule** must clearly identify **that** the reason for the **impending** closure is because of **the worker's** failure to treat with an **authorized** attending physician or [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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0035 Determining Medically Stationary Status

(1) A worker's compensable condition is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares the worker either “medically stationary,” “medically stable,” or uses other language meaning the same thing.

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

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

(4) When there is a conflict as to the date upon which a worker's compensable condition became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance

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is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer must request the attending physician'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 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 must arrange for medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of claim closure, the medically stationary date is the date of death.

Stat. Auth.: ORS 656.268, 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.).
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 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0036 Determining Temporary Disability

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

(2) Except as provided [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 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.

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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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0038 Permanent Partial Disability

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

Stat. Auth.: ORS 656.268, 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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

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

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 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 and renumbered to OAR 436-060-0018, 2/17/04 as WCD Admin. Orders 04-051 & 04-052, eff. 2/29/04

436-030-0055 Determining Permanent Total Disability

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

(a) "Incapacitated from regularly performing work" means that the worker does not have the necessary physical and mental capacity and the work skills to perform 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.

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Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

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

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

- (i) The original injury;
- (ii) The worker's last gainful employment;
- (iii) Insurer's determination; or
- (iv) Reconsideration by the director.

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

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

(g) "Normal labor market" means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity, or technology trends in the long-term labor market.

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

(2) All disability which existed before the injury must be included in determining permanent total disability.

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

- (a) Prove permanent and total disability;
- (b) Be willing to seek regular and gainful employment;
- (c) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and
- (d) Not have withdrawn from the workforce during the period for which benefits are being sought.

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

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(a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) Inability to regularly perform work at a gainful and suitable occupation; and

(c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational **Testimony**. Competent written vocational **Testimony** is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.

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

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

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

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

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

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

Stat. Auth.: ORS 656.268, 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

Hist: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88.
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Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95.
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Amended 11/16/01 as WCD Admin. Order 01-060, eff. 1/1/02
Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0065 Review of Permanent Total Disability Awards

(1) The insurer must reexamine each permanent total disability claim at least once every two years or when requested to do so by the director to determine if the worker is capable of regularly performing a suitable and gainful occupation. The insurer must notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's permanent total disability status. Workers who fail to cooperate with the reexamination may have benefits suspended under OAR 436-060-0095.

(2) Any decision by the insurer to reduce permanent total disability must be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation must

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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, 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 may be 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 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 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.
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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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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

(1) **For claims having a date of injury prior to January 1, 2005 which involve unscheduled body parts, areas, or systems as defined by OAR 436-035-0005, and all claims with dates of injury on or after January 1, 2005,** [A]n award **of** [for unscheduled] permanent partial disability is subject to periodic examination and adjustment under ORS 656.268 and 656.325 and in accordance with the following conditions:

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

(b) The party requesting review of permanent disability must send a copy of the request to all [other affected] **involved** 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 must be submitted with the request, including sufficient information to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the director will make any necessary adjustments **allowed** under OAR 436-035[-0270 through 436-035-0450].

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(d) The basis for the request for adjustment in the **permanent** disability award must be **asserted to be** failure of the worker to make a reasonable effort to reduce the disability¹ 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

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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.
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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(6) and **436-030-0145(1)**. The reconsideration proceeding begins as described in OAR 436-030-0145(2).

(2) For the purpose of these rules, “reconsideration proceeding” means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the worker’s condition as of the time of claim closure that should have been but was not submitted by the attending physician or authorized nurse practitioner at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed because the worker’s condition is not medically stationary under OAR 436-030-0165(10), medical evidence submitted may address the worker’s condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

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

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

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

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

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

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

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

Stat. Auth.: ORS 656.726, 1999 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

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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 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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) Worker's name;
- (b) Date of injury;
- (c) Date of the closure being appealed;
- (d) Any specific issues regarding the Notice of Closure;
- (e) The name of the worker's attorney;
- (f) The name of the insurer's attorney;
- (g) Any special language needs;
- (h) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;

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(i) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and

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

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

Stats. Implemented: ORS 656.268, 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 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
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Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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.

(2) Upon starting the reconsideration proceeding, 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.

(3) **Within 14 days from the start date of the reconsideration proceeding,** [T]he insurer must **provide**[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, **which include, but is not limited to, the complete medical record and all official actions and notices on the claim.**

(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 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 [n]Notice of [c]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

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

(6) When a worker has requested and cashed a lump sum payment, under ORS 656.230, of an award granted by a Notice of Closure, the director will not consider the adequacy of that award in a reconsideration proceeding.

(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.

(8) The reconsideration order will address issues raised by the parties and will address compensation as follows:

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

(b) Additional compensation awarded in a reconsideration order 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 will be so stated.

(d) The dollar rate per degree of disability will be listed **if appropriate based on the date of injury or an explanation of the computation method used, including wage, percent of loss of the whole person, and other pertinent factors.**

(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] discovers[until] after the reconsideration order has been issued **and before the order on reconsideration has become final by operation of law,** that additional documents were not provided by the opposing party[,] in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

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

Stats. Implemented: ORS 656.268(6), and 1999 OR Laws Chapter 313

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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.
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436-030-0145 Reconsideration Time Frames and Postponements

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

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

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

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

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

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

(2) The reconsideration proceeding begins upon^[:]:

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

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

(3) **Fourteen**^[Ten working] days after the date the reconsideration proceeding begins, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding.

(a) Evidence received or issues raised subsequent to the **14**^[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.

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

(4) Medical arbiter panel requests must be received by the department within the **14**^[ten (10) working] day time frame beginning on the date the reconsideration proceeding starts.

(5) When the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits, under ORS 656.268(7), the reconsideration proceeding will be postponed for up to 60

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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:

(a) To determine whether temporary rules amending “the standards” are required to properly rate the worker’s impairment, under ORS 656.726(4)(f);

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

(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.

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

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

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

Stats. Implemented: ORS 656.268 (ch. 429, OL 2003), 656.726, and 1999 OR Laws Chapter 313

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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
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436-030-0155 Reconsideration Record

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

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

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

(A) A party requests the director to submit those specific materials to the arbiter;

(B) The party identifies and provides the director with specific dates of those materials requested to be submitted; and

(C) The materials otherwise meet the requirements of this rule.

(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) When any surveillance videotape obtained prior to closure has been submitted to physician(s) involved in the evaluation or treatment of the worker, it must be provided for arbiter review. 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, must also be submitted. Surveillance videotape must be labeled according to the date(s) and total time of the recording(s).

(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. **For cases involving a care provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the care provider's authority to act as an attending physician.** 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 will be included in the record if received prior to completion of the reconsideration proceeding.

(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.

(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 must be returned to the director within two days after the hearing.

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

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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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436-030-0165 Medical Arbitrator 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 will refer the claim to a medical arbitrator or panel of arbitrators.

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

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

(2) The director will select a medical arbitrator physician or a panel of physicians in accordance with ORS 656.268(7)(d).

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

(b) When the worker resides outside the state of Oregon, a medical arbitrator 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) Arbitrators 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 arbitrator 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 arbitrator deselection process once the three⁽³⁾ business day period has expired. No further attempts at deselection will be made when continuing the arbitrator deselection process is not practical.

(4) The director will notify the parties of the time and place of the medical arbitrator examination. This notice will also inform the worker that failure to attend the medical arbitrator examination or to cooperate with the medical arbitrator 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 arbitrator. The appointment letter 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.

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

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

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

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

(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:

(a) 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) Reschedule an examination 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 section (7) of this rule occurred prior to the expiration of the 60-day additional postponement, the director will complete the reconsideration proceeding 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 14^[0 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 **report of the** medical arbiter or panel of medical arbiters must address all questions raised by the director^[in the report].

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(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.

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

(a) If the parties agree to the [postponement] **deferral**, the reconsideration proceeding will be [postpon] **deferred** until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the impairment due to the compensable condition(s) may be submitted at the time the parties notify the director that the medical arbiter exam can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (7).

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

(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

Stats. Implemented: ORS 656.268, 1999 OR Laws Chapter 313, and chapter 349, Oregon Laws 2001

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Amended 12/12/03 as WCD Admin. Order 03-063, eff. 1/1/04 (Temp.)
Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

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, **0155** and 0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 0145, **0155**, and 0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent

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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 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, will be found to be at least 20 percent disabled. **For example:**^[As an illustration, a] **A** worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, will be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the director. The reconsideration order 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 11/13/00 as WCD Admin. Order 00-058, eff. 01/01/01
Amended 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0185 Reconsideration: Settlements and Withdrawals

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

(a) Address only issues that pertain to a claim closure and cannot include any issues of compensability;

(b) List the body part(s) for which any award is made and recite all disability awarded in both degrees and percent of loss **as appropriate based on date of injury** when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement **for claims with dates of injury prior to January 1, 2005**, the stated percent of loss will control^[1].

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(2) The director will review the [S]stipulation and issue an order **approving or denying the stipulation** within 18 working days from **the director's** receipt of the [S]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 [S]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 [S]stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) Address the disapproval, and/or

(b) [To r] **Request** that the director issue an Order on Reconsideration addressing the substantive issues.

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

(6) When the parties desire to enter **into** a stipulated agreement that addresses [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] **made prior to the date an Order on Reconsideration is issued and** in accordance with the following procedure[.]:

(a) A written request for an affirming reconsideration order must:

(A) [b] **Be** made by certified mail; [and]

(B) [b] **Be** signed by both parties or their representatives; [The written request must also]

(C) [s] **State** that the parties waive their right to an arbiter review, and that all matters subject to the mandatory reconsideration process have been resolved; [and]

(D) **Be** [A] **accompanied by a** copy of the proposed stipulated agreement [must accompany the request].

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

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

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

(7) A worker requesting a reconsideration may withdraw the request for reconsideration **without agreement of the other parties only** if:

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(a) ^[n]No additional information has been submitted by the other party(ies).;

(b) ^[n]No medical arbiter exam has occurred, and

(c) ^[t]The insurer has not requested reconsideration under OAR 436-030-0145.

(8) ^[.] If additional information has been submitted by the other party(ies), a medical

arbiter exam] **Notwithstanding (7) above, if additional information has been submitted by the other party(ies), a medical arbiter exam has occurred**, or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless **or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless all parties agree to the withdrawal.**

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

(8⁹) ^[9]The director will issue an order dismissing the reconsideration under section **(7)**, **(8)**, and **(8⁹)** 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 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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0575 Audits

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

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

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 2/17/04 as WCD Admin. Order 04-052, eff. 2/29/04

436-030-0580 Penalties and Sanctions

(1) Under ORS 656.745, the director or designee may assess a civil penalty against an employer or insurer who fails to comply with the 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 these rules may be assessed a civil penalty.

(3) Under OAR 436-010-0340, the director may impose sanctions for any medical service provider where the insurer can provide sufficient documentation to substantiate lack of

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cooperation. The medical service provider will be sent a warning letter about **the reporting requirements and** 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) Copies of letters to the medical service provider;
- (b) Memos to the claim file of follow-up phone calls and/or the lack of response;
- (c) Letters from the medical service provider indicating a lack of cooperation; or
- (d) Medical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

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

Stat. Auth.: ORS 656.268, 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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