



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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August 20, 2007

Proposed Changes to Workers' Compensation Rules

The 2007 Oregon Legislature passed a number of bills affecting workers' compensation laws. The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436 to make these rules consistent with the revised laws. In addition, the department proposes changes to make the rules easier to understand, to streamline regulations, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** September 24, 2007, 2:00 p.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone - (503) 947-7717; Fax - (503) 947-7581
The closing date for written comments is September 27, 2007.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –
<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>
Or call (503) 947-7627 to get free paper copies

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services (DCBS),
Workers' Compensation Division

OAD CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns
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(503) 947- 7717
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RULE CAPTION

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

September 24, 2007	2:00 p.m.*	Room 260 (2 nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

***NOTE: The hearing will begin at 2:00 p.m. and end when all present who wish to testify have done so. Written testimony will be accepted through September 27, 2007.**

**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 436-105-0511; 436-105-0512; 436-160-0400; 436-160-0410; 436-160-0420; 436-160-0430

AMEND: OAR 436-040; 436-105; 436-110; 436-120; and

436-009-0005	436-015-0005	436-030-0175	436-050-0100	436-060-0008	436-160-0004
436-009-0010	436-015-0030	436-030-0185	436-050-0175	436-060-0010	436-160-0005
436-009-0020	436-015-0040	436-035-0005	436-050-0200	436-060-0015	436-160-0006
436-009-0030	436-015-0120	436-035-0110	436-050-0400	436-060-0018	436-160-0010
436-009-0040	436-030-0007	436-035-0350	436-050-0410	436-060-0055	436-160-0020
436-010-0005	436-030-0020	436-035-0390	436-050-0420	436-060-0060	436-160-0030
436-010-0210	436-030-0035	436-035-0420	436-050-0440	436-060-0140	436-160-0040
436-010-0220	436-030-0115	436-035-0500	436-050-0450	436-060-0147	436-160-0050
436-010-0230	436-030-0135	436-045-0008	436-050-0455	436-060-0150	436-160-0060
436-010-0240	436-030-0145	436-045-0030	436-050-0460	436-160-0001	436-160-0070
436-010-0265	436-030-0155	436-050-0003	436-050-0470	436-160-0002	436-160-0080
436-010-0280	436-030-0165	436-050-0005	436-050-0480	436-160-0003	436-160-0090

REPEAL: 436-030-0440; 436-030-0450; 436-030-0460; 436-030-0550; 436-030-0570;
436-110-0326; 436-110-0327; 436-110-0380; 436-120-0730

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Stats. Implemented

RULE SUMMARY

Amendments to implement changes in the Workers' Compensation Law, including:

- Replacing the term "Handicapped Workers" with "Workers with Disabilities" (SB 83);
- Updating name of Board of Medical Examiners for the State of Oregon to "Oregon Medical Board" (SB 147);

- Including “administrative law judge” as a person who may approve or disapprove a claims disposition agreement (SB 253);
- Describing restrictions affecting emergency room physicians’ rights to be attending physicians and authorize temporary disability benefits (SB 504);
- Deleting requirement that managed care organizations send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval; deleting related definitions (SB 563);
- Explaining how DCBS will publish the maximum reimbursable amount for medical services for non-disabling claims (SB 762);
- Amending penalty provisions affecting managed care organizations; deleting procedures for temporary rule promulgation to address disability in individual claims (when medical conditions are not addressed by current standards), and addressing such conditions in the director’s order on reconsideration, and providing that penalties will not be assessed if an increase in compensation results from such an order; describing how insurers must process requests for a lump sum payments of permanent partial disability awards (HB 2218);
- Describing the authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians (HB 2756);
- Referring to ORS 656.427 regarding time frames for termination of guaranty contracts; defining “premium” (HB 2783);
- Adopting standards of professional conduct for health care providers who perform independent medical examinations, which apply if the provider’s professional regulatory board has not adopted standards for performing such examinations (HB 2943);

General amendments to OAR chapter 436, including:

- Using plain language to add clarity to a number of rules;
- Shortening some rules by removing unnecessary descriptions of DCBS procedures;

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI), to improve the quality of medical billing data for use by DCBS and its customers, including:

- Requiring hospitals and other health care providers to include sufficient data on their billings so insurers and DCBS can identify the providers;
- Requiring insurers to report medical billing data to DCBS using standards for electronic data interchange adopted by the International Association of Industrial Accident Boards and Commissions;
- Listing the data elements reportable to DCBS; testing procedures for EDI; phase-in dates for EDI and when insurers and self-insured employers are subject; procedures for requesting deferral of EDI reporting;
-

Amendment to OAR 436-010, “Medical Services,” to remove obsolete medical utilization guideline:

- Regarding frequency of treatment in OAR 436-010-0230;

Amendments to OAR 436-030, “Claim Closure and Reconsideration,” to eliminate conflicts between statute and rules, streamline processing, delete obsolete rules, and reduce litigation, including:

- Restricting reconsideration of claim closure to issues raised by the parties plus requirements under ORS 656.268(1);
- Requiring insurers to submit documents related to reconsideration of claim closure in chronological order;
- Removing the limitation on attorney fees from OAR 436-030-0175(4);
- Deleting obsolete rules OAR 436-030-0440, 0450; 0460, 0550, and 0570; the relevant subject matter from these rules has been addressed in other rules in OAR 436-030 and 436-035 (since approximately 1988), but the rules have remained in the Oregon Administrative Rules published by the Secretary of State;

Amendments to OAR 436-035, “Disability Rating Standards,” to clarify or correct certain provisions, and to provide for rating disability for a medical condition not currently addressed by the standards, including:

- Clarifying the definition of “direct medical sequela”;
- Correcting the description of impairment involving angulation or malalignment of the humerus;
- Clarifying how to rate impairment for surgery involving one or more discs or vertebrae;
- Eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed;

- Provide standards for rating impairment for vaginal prolapse;

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility,” to clarify certain provisions and ensure appropriate oversight of worker leasing company licensing and practices, including:

- Clarifying time frames and process for cancellation of self-insurance;
- Revising regulations affecting worker leasing companies, including:
 - Relevant definitions;
 - The application and license renewal process;
 - Reporting and record-keeping;
 - Grounds for disqualification, suspension of license, and revocation of license by the director;
 - Appeal rights for persons refused approval or renewal of a worker leasing license;
 - Reapplication following disqualification for, or revocation of, license;
 - Continuation of a disqualification, suspension, or revocation of a worker leasing license applicable to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person or controlling person;
 - Penalties under ORS 656.990;

Amendments to OAR 436-060, “Claims Administration,” to eliminate inconsistencies in DCBS rules and clarify or streamline certain provisions, including:

- Revising time frame for employers’ first aid record-keeping (to be consistent with Oregon OSHA requirements);
- Reducing the documentation a worker must submit when appealing an insurer’s refusal to reclassify a claim;
- Clarifying conditions under which the insurer must notify health care providers when a workers’ compensation claim is denied or partially denied;

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP), to promote increased use of the EAIP and therefore earlier return to work of injured workers with their employers at injury, by streamlining program administration, setting an appropriate fee payable to insurers for administration of the program, and expanding some incentives, including:

- Providing that a medical release remains in effect until another medical release is issued by the worker’s medical service provider;
- Providing that a worker is eligible for EAIP services while the claim is “deferred” (prior to acceptance or denial);
- Providing insurers greater discretion to determine appropriate EAIP worksite modifications and EAIP purchases;
- Providing insurers greater discretion to determine what is appropriate training; eliminating the requirement that EAIP purchases for training are limited to “accredited” or “licensed” training or courses;
- Increasing maximum reimbursable amount for EAIP purchases for tools and equipment;
- Allowing insurers to submit more than one reimbursement request per EAIP;
- Stating the administrative fee payable to the insurer for its administration of EAIP services (formerly not prescribed by rule);

Amendments to OAR 436-110, “Preferred Worker Program” (PWP) to promote increased use of the PWP and therefore facilitate the return to work of injured workers and improve return-to-work outcomes (wages, tenure, etc.), by streamlining program administration, creating new PWP incentives, and expanding some existing incentives, including:

- Redefining and simplifying “date of hire” and “reimbursable wages”;
- Shortening and simplifying the wording that must appear on notices to workers about potential PWP benefits;
- Issuing PWP identification cards with no expiration date - workers could offer the initial and any subsequent employers three full years of premium exemption and claim cost reimbursement;
- Eliminating the requirement that a modification of regular work be “substantial” in order for a worker to be eligible for PWP benefits other than Worksite Modification;
- Removing the restriction that Wage Subsidies may not be combined with subsidies from other sources, with the exception of subsidies under OAR 436-120;
- Revising the name of “Obtained Employment Purchases” to “Employment Purchases”;

- Allowing Employment Purchases while a worker is receiving vocational assistance under OAR 436-120;
- Allowing replacement of Employment Purchases;
- Increasing the maximum expenditure for an Employment Purchase for tools and equipment;
- Providing Employment Purchases needed to create a new worksite;
- Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment;
- Allowing a second use of Wage Subsidy and a second use of each category of Employment Purchase for a different job with the same employer (formerly two wage subsidies could not be used with the same employer);
- Eliminating forms currently required for Worksite Modifications costing \$2,500 or less;
- Eliminating the general requirement for competitive bids for Worksite Modification;

Amendments to OAR 436-120, “Vocational Assistance to Injured Workers,” to improve sufficiency of certain notices, clarify time frames for submitting information to DCBS, streamline return-to-work plan development process, clarify or define certain provisions, and delete obsolete provisions, including:

- Describing how the Workers’ Compensation Division will determine the timeliness of any document that must be sent to the division in vocational matters;
- Requiring that notices of eligibility for vocational assistance, training, or direct employment services explain the rights of the worker to request a return-to-work plan conference;
- Requiring that notice must be in writing when an insurer notifies a worker that an eligibility determination is postponed while awaiting information about permanent restrictions;
- Requiring that if an insurer ends a worker’s eligibility because lack of suitable employment is not due to the limitations caused by the injury, the insurer must have obtained new information that did not exist or that the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility;
- Including among the reasons a worker would be ineligible for vocational assistance or for which eligibility would end, that the worker is unavailable for vocational assistance due to short-term incarceration;
- Eliminating all time frames related to return-to-work plan development except that a plan must be approved within 45 days (direct employment) or 90 days (training) under OAR 436-120-0500(1) & (2);
- Updating the vocational fee schedule (consistent with changes in state average weekly wage and Bulletin 124);
- Eliminating the requirement that insurers request administrative approval for vocational services when the insurer is entitled to claims cost reimbursement under OAR 436-110;
- Repealing the rule: “Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries”; and
- Defining “show-cause hearing” for the purposes of OAR 436-120-0915(3).

Request for public comment: The Workers’ Compensation Division 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://wcd.oregon.gov/policy/rules/rules.html#proprules>

or from WCD Publications, 503-947-7627 or fax 503-947-7630.

September 27, 2007
Last Day for Public Comment

John L. Shilts
Authorized Signer and Date

8-14-07

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

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

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

Department of Consumer and Business Services,
Workers' Compensation Division
Agency and Division

OAR CHAPTER 436
Administrative Rules Chapter

Number

In the Matter of

The Amendment of OAR:

436-009, Oregon Medical Fee and Payment Rules
436-010, Medical Services
436-015, Managed Care Organizations
436-030, Claim Closure and Reconsideration
436-035, Disability Rating Standards
436-040, Workers with Disabilities Program
436-045, Reopened Claims Program
436-050, Employer/Insurer Coverage Responsibility
436-060, Claims Administration
436-105, Employer-at-Injury Program
436-110, Preferred Worker Program
436-120, Vocational Assistance to Injured Workers
436-160, Electronic Data Interchange

Rule Caption:

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Need for the Rule(s): Chapter 436 must be amended to be consistent with the Workers' Compensation Law, as amended by legislation passed by the 2007 Oregon Legislature. Some of that legislation required the director to make rules to implement revised laws. The department is proposing additional changes to make the rules easier to understand, to streamline regulations affecting stakeholders, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Documents Relied Upon, and where they are available: "Issues" documents as presented to advisory committees; advisory committee meeting minutes; written advice from advisory committee members.

These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 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) 947-7717 to request copies.

Fiscal and Economic Impact, including Statement of Cost of Compliance: The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by proposed rule amendments:

Amendments to implement changes in the Workers' Compensation Law

- Senate Bill 504 restricts emergency room physicians' rights to be attending physicians and authorize temporary disability benefits. Overall emergency-room treatment charges can be substantially higher than charges for visits to primary care physicians. In addition, early referral to primary care physicians should improve insurers' ability to keep track of authorization of temporary disability benefits and to promote return-to-work. The agency estimates that these changes should result in a small reduction in insurers' claims costs.

- Senate Bill 563 eliminates the requirement that managed care organizations (MCOs) send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval. In the “Statement of Need and Fiscal Impact” filed with the Secretary of State on 8/14/06, DCBS estimated reporting costs for such reporting based on advice from MCOs. The low-high range of estimated reporting costs was then \$100 per year to \$50,000 per year per MCO, potentially \$400/year to \$200,000/year for the four active MCOs. The agency projects elimination of these reporting costs for MCOs.
- House Bill 2756 provides authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians. Because we cannot project how many injured workers will choose these providers as their attending physicians, we cannot now project the fiscal impacts. However, DCBS will monitor the effects of HB 2756 to identify impacts over time.
- House Bill 2783 requires insurers to notify the employer of termination of a guaranty contract 45 days in advance instead of the 30 days currently required. In addition, HB 2783 allows for a shorter notice requirement of only 10 days if the termination is based on nonpayment of premium. The agency projects some reductions in costs for insurers, because they can shorten their liability under the 10-day notice provision. The agency projects that these savings will be greater than any increased costs due to the 45-day notice provision, because insurers can adjust notice procedures in order to end liability, in most cases, by a date certain. The agency projects a small positive impact for employers subject to the 45-day notice, as it will give them more time to shop for cost-effective workers’ compensation insurance coverage.

In addition to changes to implement changes in the Workers’ Compensation Law:

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI)

- The agency projects that proposed rule changes will not have a significant fiscal impact on Oregon health care providers, as providers already send sufficient data to insurers on standard billing forms. The agency projects some fiscal impacts for insurers and self-insured employers, smaller for those companies already using EDI in other states and greater for Oregon-only reporters. The advisory committee did not express concerns about implementation costs. However, the agency projects significant costs for some insurers and self-insured employers in order to prepare for EDI, and also projects that these costs will eventually be exceeded by savings due to efficiencies inherent in electronic communication.

Amendments to OAR 436-035, “Disability Rating Standards”

- The agency projects that eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed, will have a positive economic impact on affected workers and an equal increased cost to affected insurers. However, this combination of medical conditions is very rare and the impact is not expected to be significant overall.

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility”

- The agency projects that proposed rules affecting worker leasing companies will add a small cost to submit additional information with the application for initial license or renewal of license.
- Conversely, the purpose of these rule changes is to create a level playing field for leasing companies by preventing or removing unfair competition by companies that cannot or will not comply with worker leasing laws and rules. Successfully preventing unfair competition would have a positive economic effect on leasing companies that do comply with the laws and rules. Relative to taking no action, the agency projects a small positive economic impact on worker leasing companies.

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP) and OAR 436-110, “Preferred Worker Program” (PWP)

- The agency projects that expanded benefits and administrative fees for the EAIP will cost the Workers’ Benefit Fund (maximum/annual):
 - Reimbursement of EAIP costs before the claim is accepted or denied (if ultimately denied)..... \$700,000.00
 - Increased reimbursable amount for EAIP purchases for tools and equipment..... \$300,000.00
 - Proposed fee payable to insurers for administration of the EAIP..... \$480,000.00
 - Total..... \$1,480,000.00

- The agency projects that expanded benefits for the PWP will cost the Workers' Benefit Fund (maximum/annual):
 - Providing Employment Purchases needed to create a new worksite..... \$100,000.00
 - Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment \$100,000.00
 - Total \$200,000.00
- The agency projects that issuing PWP identification cards with no expiration date will increase use of premium exemption and thus increase costs to the Workers' Benefit Fund. However, the impact would be very minor in the near term and increase gradually over time. The agency does not have a basis to project how many workers will use their cards for future employment, but will monitor this closely.
- Additional proposed changes that expand access to reemployment incentives will have lesser impacts on the Workers' Benefit Fund; however, the agency does not have a basis to project how extensively these incentives will be used.
- All moneys paid out of the Workers' Benefit Fund would have a positive economic impact on Oregon employers and insurers. In addition to the direct dollar transfer, by promoting early return to work, the proposed rules may reduce claims costs. In addition, the proposed changes should positively affect injured workers by promoting early return to work, which produces better long-term employment outcomes.
- The Workers' Benefit Fund has adequate reserves to cover any increased costs resulting from proposed rule changes.

Regarding: Additional proposed changes:

- The agency estimates that additional changes will not have any significant negative economic impacts on any persons or businesses, including small businesses. Because a number of the proposed rule changes streamline processes, the agency projects a small overall positive economic impact of proposed rule changes not otherwise described.

How were small businesses involved in the development of this rule?

Representatives from small businesses participated in the stakeholder advisory committees.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

One managed care organization. (Of the four managed care organizations certified and active in the Oregon workers' compensation system, one managed care organization meets the definition of a small business under ORS 183.310.)

Identify the types of businesses and industries with small businesses subject to the proposed rule:

The proposed rule amendments will affect managed care organizations.

Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:

Reporting: Proposed rule changes would require less reporting by managed care organizations, who will no longer have to send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval.

Record-keeping: Proposed rule changes may substantially reduce record keeping by a managed care organization only if organization keeps a running record of updated treatment standards, protocols, and guidelines for the purpose of reporting the updates to the director.

Other administrative activities and costs of professional services: For managed care organizations that contract with companies that specialize in provision of guidelines and protocols, there is the potential for reduced professional services costs.

Extent of economic impact: The agency projects a substantial reduction in reporting costs for MCOs.

Identify equipment, supplies, labor and increased administration required for compliance with the proposed rule:

Equipment: The proposed rule changes do not require the purchase of equipment to achieve compliance.

Supplies: The proposed rule changes do not require the purchase of supplies to achieve compliance.

Labor: The proposed rule changes do not require increased labor costs to achieve compliance.

Administration: The proposed rule changes do not require increased administrative costs to achieve compliance.

Extent of economic impact: No increased costs for these categories.

Administrative Rule Advisory Committee consulted:

Yes. Advisory committees met on 6/21/07, 7/10/07, 7/16/07, 7/17/07, 7/19/07, 7/20/07, 7/23/07, 7/26/07, 7/31/07

The agency asked the advisory committee for advice on the impact of the discussed changes on costs, including any significant adverse impacts on small businesses.

John L. Shilts
Signature and Date

8-14-07

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

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Claim Closure and Reconsideration
Proposed Oregon Administrative Rules
Chapter 436, Division 030

Summer/Fall 2007

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Revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~

Added text is bold and underlined, as in **Added**

HISTORY LINES: These rules include only the most recent "History" lines. The history line shows when the rule was last revised (or "filed" if the rule has never been revised) and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: http://www.wcd.oregon.gov/policy/rules/full_set.html

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed Rules CLAIM CLOSURE AND RECONSIDERATION

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

436-030-0007 Administrative Review

(1) The following matters are subject to dispute resolution before the director:

(a) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through OAR 436-030-0185, except Notices of Closure under section (2)(b) of this rule.

(b) The director may abate, withdraw, or amend the Order on Reconsideration ~~until the Order is final by operation of law~~ **during the 30-day appeal period for the Order on Reconsideration.**

(c) Notices of Refusal to Reclassify issued by insurers are appealable by the worker to the director under ORS 656.273 and 656.277 and OAR 436-060-0018.

(2) The following matters are brought before the Hearings Division of the Workers' Compensation Board:

(a) Director's Review orders and Orders on Reconsideration issued under OAR 436-060-0018 and these rules within the timeframes in OAR 436-060-0018 and 436-030-0145, respectively.

(b) Notices of Closure that rescind permanent total disability under ORS 656.206.

(c) Any other action taken under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS Chapter 656.

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

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

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

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

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(b) The director may require and allow such evidence as is deemed 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: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

436-030-0020 Requirements for Claim Closure

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

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

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

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

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

(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

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

(a) An authorized nurse practitioner's, **podiatrist's, chiropractor's, naturopath's, physician assistant's** or attending physician's written statement that clearly indicates there is no permanent impairment, residuals, or limitations attributable to the accepted condition(s), and there is no reasonable expectation, based on evidence in the record, of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s). If the physician-~~or~~, nurse practitioner, **podiatrist, chiropractor, naturopath, or physician assistant** indicates there is no impairment, but the record reveals otherwise, a closing examination and reports specified under (b) of this section are required; or

(b) A closing medical examination and report when there is a reasonable expectation of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s) based on evidence in the record or the physician's opinion. The closing medical examination report must describe in detail all measurements and findings regarding any permanent impairment, residuals, or limitations attributable to the

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accepted condition(s) under OAR 436-010-0280 and OAR 436-035; and, if there is not clear and convincing evidence that the worker has been released to regular work (for dates of injury on or after January 1, 2006) or returned to regular work at the job held at the time of injury and ORS 656.726(4)(f) does not apply, all of the following:

(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's legal representative, if any, either before closing the claim or at the time the claim is closed;

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

(C) The worker's date of birth;

(D) Except as provided in OAR 436-030-0015(3)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and

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

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

(4) When issuing a Notice of Closure, the insurer must prepare a summary worksheet, "Notice of Closure Worksheet", Form 440-2807 (Form 2807), as described by bulletin of the director.

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

(6) The notice must be in the form and format prescribed by the director in these rules and include only the following:

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

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

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

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

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

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

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

(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;

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

(j) The worker's appeal rights;

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

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

(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury is to be shown on the Notice of Closure;

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

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

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

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

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

(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under section (2)(a) of this rule or it was previously provided under section (2)(b)(A) of this rule;

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

(e) A cover letter that:

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

(B) Lists and describes enclosed documents; and

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

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

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- (a) The worker;
- (b) The employer;
- (c) The director; and
- (d) The worker's attorney, if the worker is represented.

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

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

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

- (a) To recover payments for permanent disability which were made prematurely;
- (b) To recover overpayments for temporary disability; and
- (c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.

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

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

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

- (A) The worker has ended training; and either
- (B) The worker's condition is medically stationary; or
- (C) The claim otherwise qualifies for closure in accordance with these rules.

(b) For claims with dates of injury before January 1, 2005, permanent disability must be redetermined by the insurer when:

- (A) The worker has ended training; and either
- (B) The worker's condition is medically stationary; or
- (C) The claim otherwise qualifies for closure in accordance with these rules., except
- (D) When the worker became medically stationary after June 7, 1995 for a scheduled disability. Then the scheduled disability must remain unchanged from the last award of compensation in that claim unless the condition did not remain medically stationary through training.

(c) For claims with dates of injury before January 1, 2005, if the worker has remained medically stationary throughout training and the closing examination is six months old or older,

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a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's accepted condition since the previous closing examination.

(14) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 440-1502 consistent with the instructions of the director and disperse it within 14 days of the change.

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 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

436-030-0035 Determining Medically Stationary Status

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

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

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

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

(5) The insurer must request the attending physician's, **as defined in ORS 656.005(12)(b)(A), to** 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 **independent** medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on

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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: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05

436-030-0115 Reconsideration of Notices of Closure

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

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

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

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

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

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

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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~~ **those issues raised by the parties and the requirements under ORS 656.268(1)**. 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

Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

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.~~

(31) Within 14 days from the start date of the reconsideration proceeding, the insurer must provide the director and the worker or the worker's attorney, **in chronological order by document date**, all documents pertaining to the claim which include, but are not limited to the complete medical record and all official action and notices on the claim.

(42) 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.~~

(53) The director will issue an order rescinding a Notice of Closure when the director finds, upon reconsideration:

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

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

~~(64)~~ 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.

~~(75)~~ 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.~~

(6) The reconsideration order may affirm, reduce, or increase the compensation awarded by the Notice of Closure.

~~(107)~~ When a party discovers a After the reconsideration order has been issued and before the **end of the 30-day appeal period for the** order on reconsideration ~~has become final by operation of law,~~ **if a party discovers** that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

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

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

Hist: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05

436-030-0145 Reconsideration Time Frames and Postponements

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

(a) For claims with a medically stationary date prior to June 7, 1995, the appeal period is 180 days from the claim closure. The time required to complete the reconsideration proceeding

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pursuant to this rule must not be included in the 180 days from the mailing date of the Notice of Closure to request a hearing.

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

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

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

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

(2) The reconsideration proceeding begins upon:

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

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

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

(a) Evidence received or issues raised subsequent to the 14 day deadline will be considered in the reconsideration proceeding to the extent practicable.

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

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

(4) Medical arbiter panel requests must be received by the department within the 14 day time frame beginning on the date the reconsideration proceeding starts.

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

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(6) ~~When the~~ The reconsideration proceeding ~~has been stayed, the director will notify the parties that it has been~~ may be 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);~~

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

~~(eb)~~ 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

Hist: Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05

436-030-0155 Reconsideration Record

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding.

(a) The record is maintained in the Workers' Compensation Division's claim file and consists of all documents and material received and date stamped by the director prior to the issuance of the Order on Reconsideration, unless the document(s) is an exact duplicate of what is in the file then the director is not required to retain the duplicate document(s).

(b) The insurer or self-insured employer must not send billing information and duplicate documents to the department, unless specifically requested by the director.

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

~~(a3)~~ The director ~~may not submit~~ will send non-medical information, nursing notes, or physical therapy treatment notes to the arbiter ~~unless~~ if:

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

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

~~(Cc)~~ 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".

~~(34)~~ When any surveillance video obtained prior to closure has been submitted to physician(s) involved in the evaluation or treatment of the worker, it must be provided for arbiter review.

(a) Surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker.

(b) All written materials previously forwarded to physician(s) along with the surveillance video, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted.

(c) Surveillance video must be labeled according to the date(s) and total time of the recording(s).

~~(45)~~ When reconsideration is requested, the insurer is required to provide the director and the other parties with a copy of all documents contained in the record at claim closure. For cases involving a medical service provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the medical service provider's authority to act as an attending physician. ~~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

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

Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

436-030-0165 Medical Arbiter Examination Process

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

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

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

~~(21)~~ The director will select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(7)(d).

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

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

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

~~(32)~~ When the director has determined a claim qualifies for medical arbiter deselection, a list of appropriate physicians will be faxed or sent by overnight mail to the parties.

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

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

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

~~(43) The director will notify the parties of the time and place of the medical arbiter examination. This notice will also inform the worker that~~**The worker's** ~~failure to attend the medical arbiter examination or to cooperate with the medical arbiter will result in suspension of all disability benefits effective on the date of the examination unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The appointment letter will instruct the worker must to call the director within 24 hours after failing to attend the examination to provide any "good cause" reason for missing the exam.~~

(a) Notice of the examination 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.

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(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."

(54) 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.

(65) 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's that~~ disability benefits are will be suspended and ~~that the reconsideration proceeding is postponed~~ for 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.~~

(76) ~~As addressed in the Order on Reconsideration, t~~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.

(87) If none of the events which end the suspension under section (76) 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~~ will ~~to~~ remain in effect.

(98) 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 to the director any issues they wish the medical arbiter or panel of medical arbiters to address within 14 days after the date the reconsideration proceeding begins. The parties must not submit issues directly to the medical arbiter or panel of medical arbiters. ~~The director will only submit issues appropriate to the reconsideration proceeding to t~~The medical arbiter or panel of medical arbiters will only consider issues appropriate to the reconsideration proceeding.

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

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

(409) 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,

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where appropriate, send a letter to the parties requesting consent to defer the reconsideration proceeding.

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

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

~~(11)~~ **(10)** All costs related to record review, examinations, tests, and reports of the medical arbiter must be paid under OAR 436-009-0015, 436-009-0040, and 436-009-0070.

~~(11)~~ **(11)** When requested by the Hearings Division, the director may schedule a medical arbiter examination for a worker who has appealed a Notice of Closure rescinding permanent total disability benefits under ORS 656.206.

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

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

Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

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

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155 and 436-030-0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 436-030-0145, 436-030-0155, and 436-030-0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. Penalties will not be assessed if an increase in compensation results from one of the following:

(a) ~~The promulgation of a temporary emergency rule~~ **An order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted under ORS 656.726(4)(f);**

(b) New information is obtained through a medical arbiter examination, for claims with medically stationary dates or statutory closure dates on or after June 7, 1995; or

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(c) ~~For claims closed on or after January 1, 2006, i~~Information that the insurer or self-insured employer demonstrates they could not reasonably have known at the time of claim closure.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, will be found to be at least 20 percent disabled.

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

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the director. ~~The reconsideration order will order the insurer~~ **must** ~~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: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

436-030-0185 Reconsideration: Settlements and Withdrawals

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

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

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

(2) The director will review the stipulation and issue an order approving or denying the stipulation within 18 working days from the director's receipt of the stipulation. Stipulations approved by the director can not be appealed.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the stipulation, as well as a substantial

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determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

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

(a) Address the disapproval, or

(b) Request that the director issue an Order on Reconsideration addressing the substantive issues.

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

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

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

(A) Be made by certified mail;

(B) Be signed by both parties or their representatives;

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

(D) Be accompanied by a copy of the proposed stipulated agreement.

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

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

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

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

(a) No additional information has been submitted by the other parties;

(b) No medical arbiter exam has occurred, and

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

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

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

~~(10) The director will issue an order dismissing the reconsideration under section (7), (8), and (9) 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

Hist: Amended 12/5/05 as WCD Admin. Order 05-073, eff. 1/1/06

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