



# Oregon

John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
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Sept. 21, 2011

## Proposed Changes to Workers' Compensation Rules

The Workers' Compensation Division proposes changes to the Oregon Administrative Rules (OAR):

- 436-009, Oregon Medical Fee and Payment Rules
- 436-010, Medical Services
- 436-015, Managed Care Organizations
- 436-030, Claim Closure and Reconsideration

The purpose of the proposed changes is primarily to implement legislation passed by the 2011 Oregon Legislature. Please review the attached documents for more information about proposed rule changes and projected fiscal impacts.

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

**When is the hearing?** Oct. 24, 2011, 10:00 a.m.

**Where is the hearing?** Labor & Industries Building, Room 260  
350 Winter Street NE, 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](mailto:fred.h.bruyns@state.or.us)  
Phone – 503-947-7717; Fax – 503-947-7514

**The closing date for written comments is Oct. 27, 2011.**

**How can I get copies of the proposed rules?**

On the Workers' Compensation Division's website –

[www.wcd.oregon.gov/policy/rules/rules.html#proprules](http://www.wcd.oregon.gov/policy/rules/rules.html#proprules)

Or call 503-947-7717 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.

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	503-947-7717
Rules Coordinator	Telephone

350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405

Address

**RULE CAPTION**

Medical fee schedule; managing care; attending physicians; delay of reconsideration of claim closure pending settlement

**Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.**

Oct. 24, 2011	10:00 a.m.*	Room 260 Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing Date	Time	Location	Hearings Officer

\*NOTE: The hearing will begin at 10:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through **Oct. 27, 2011**.

***Auxiliary aids for persons with disabilities are available upon advance request.***

**RULEMAKING ACTION**

**AMEND:** OAR 436-009-0080, 436-010-0210, 436-010-0230, 436-010-0280, 436-015-0008, 436-030-0003, 436-030-0036, 436-030-0145, 436-030-0165

**Stat. Auth.:** ORS 656.726(4), 656.248, 656.260, 656.268

**Other Auth.:**

**Stats. Implemented:** ORS chapter 656, primarily 656.005(12) [OL 2011, ch. 117, HB 2743], 656.245, 656.248, 656.260 [OL 2011, ch. 98, HB 2093], 656.268 [OL 2011, ch. 99, HB 2094]

**RULE SUMMARY**

NOTE: "Insurer" in this summary includes self-insured employers. The agency proposes to amend OAR chapter 436 to improve organization, clarity and consistency, and to eliminate obsolete information. More specifically:

**The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules," limited to rule 0080, affecting payment for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). These proposed rules:** Establish maximum payments for DMEPOS Healthcare Common Procedure Coding System (HCPCS) codes published by the Centers for Medicare and Medicaid Services. These codes are commonly used by health care providers and payers. The rule also lists maximum percentages for services and items that have no HCPCS codes, and for equipment that is used or rented.

**The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules:** Implement House Bill 2743 by including podiatric physicians and surgeons among those health care providers who may serve as attending physicians, without limitation, in the workers' compensation system. In addition, the agency proposes to correct the term, "lumbar spondylosis," to "lumbar spondylolysis" (upon advice from the Medical Advisory Committee).

**The agency proposes to amend OAR chapter 436, division 015, "Managed Care Organizations." These proposed rules:** Implement House Bill 2093 by referring to civil penalties and to cease and desist orders that may be issued under ORS 656.260(20).

**The agency proposes to amend OAR chapter 436, division 030, "Claim Closure and Reconsideration." These proposed rules:** Implement House Bill 2094 by describing the process for the director to delay the reconsideration proceeding and toll the reconsideration timeline for up to 45 days when both parties request the delay for settlement negotiations. The proposed rules also more fully describe the arbiter selection process, including options for participation by the parties in the selection, and align rule with statute regarding the effective suspension date if a worker fails to attend or cooperate with a medical arbiter examination.

Notice of Proposed Rulemaking Hearing

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

Address questions or requests for paper copies of the rules to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7514; e-mail [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us). Proposed rules are available on the Workers' Compensation Division's website: <http://wcd.oregon.gov/policy/rules/rules.html#proprules>

**Oct. 27, 2011**

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

*/s/ John L. Shilts*

John L. Shilts

Sept. 15, 2011

Signature

Printed name

Date

\*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Distribution: WCD-S0, S1, S3, S4, S, U, AT, CE, EG, LU, NM, CI, MR, TT, DC, DO, GR, MD, ND, OT, PY, M1, M2, E-mail lists; and legislators under ORS 183.335(15)

**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

436

Administrative Rules Chapter Number

Medical fee schedule; managing care; attending physicians; delay of reconsideration of claim closure pending settlement

**Rule Caption** (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

**In the Matter of: 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

**Statutory Authority:** ORS 656.726(4), 656.248, 656.260, 656.268

**Other Authority:**

**Stats. Implemented:** ORS chapter 656, primarily 656.005(12) [OL 2011, ch. 117, HB 2743], 656.245, 656.248, 656.260 [OL 2011, ch. 98, HB 2093], 656.268 [OL 2011, ch. 99, HB 2094]

**Need for the Rule(s):** Rule amendments are needed: to implement legislation passed by the 2011 Legislature; to provide a fee schedule with commonly used billing codes for durable medical equipment, prosthetics, orthotics, and supplies; to remove obsolete information; and to align rules with standard practices and Oregon statutes.

**Documents Relied Upon, and where they are available:** The agency relied on advisory committee meeting records and written advice from stakeholders and customers, as well as Enrolled House Bills 2093, 2094, and 2743. These records are available for public inspection in the Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301, 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:** The agency projects the following impacts:

Proposed changes to OAR 436-009 will establish a fee schedule for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The agency projects that adoption of the DMEPOS schedule should not have a large impact on any of the affected service providers, and overall payments for these services should remain approximately the same as under the current rule. However, with adoption of a standard code set and a payment rate at 110% of the rate currently paid by the Centers for Medicare and Medicaid Services, payments to individual providers and provider types may increase or decrease slightly as follows:

- "A" codes are mainly supplies that are billed by medical service providers and DME providers. The agency projects a small increase in payments to these providers.
- "E" codes mainly affect DME providers. The agency projects a very small increase in payments to these providers, though the impact is less significant than for the "A" codes.
- "K" codes are temporary codes and difficult to assign to a specific provider group. Providers who bill "K" codes might see a slight decrease in payments. However, these codes represent a very small percentage of payments and the effect on any provider group should be minimal.
- "L" codes are mainly used for prosthetics and orthotics, and these providers might see a very slight decrease in payments.
- "V" codes are mainly vision services and represent a very small portion of the DMEPOS services. Providers billing V codes might experience a very slight decrease in payments.

Services under the proposed rule that are not listed in the DMEPOS schedule will be paid at 80% of the provider's usual fee unless otherwise provided by contract. This could result in up to a 20% reduction in payment for unlisted services, but the impact on providers will depend on the number of unlisted services they provide. (Medical supplies are subject to the 80% ceiling under the current rule.)

Proposed changes to OAR 436-010 will implement House Bill 2743. The agency projects a small positive effect on podiatric physicians and surgeons, because these providers will be authorized to serve as attending physicians without limitation in the workers' compensation system. Increased use of podiatric care will likely be offset by decreased use of other forms of care, and therefore may have a small negative impact on other providers.

## Statement of Need and Fiscal Impact

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Proposed changes to OAR 436-015 will implement House Bill 2093. The agency does not project a significant economic impact due to these rule amendments.

Proposed changes to OAR 436-030 will implement House Bill 2094. The agency does not project a significant economic impact due to delays in reconsideration during settlement negotiations.

Except as described above, the agency projects no significant negative or positive economic impact of the proposed rule changes on any party. However, the agency invites public testimony on potential impacts.

### Statement of Cost of Compliance:

#### 1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

- The agency projects no significant cost of compliance for state agencies, including SAIF Corporation, or units of local government.
- The agency projects no significant cost of compliance to the public, except as described under “Fiscal and Economic Impact” above.

#### 2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

- The types of small businesses potentially affected by proposed rule changes are primarily health care providers, specifically providers of durable medical equipment, orthotic and prosthetic services, and medical supplies. The agency does not have an exact count of these providers, though available data suggests fewer than 250 unique business entities are operating in Oregon. The agency also does not have data showing how many workers are employed by each provider, but based on discussions with the advisory committee members, probably a substantial percentage of the providers would be defined as small businesses under OAR 183.310.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

- The agency projects no significant economic impact.

c. Equipment, supplies, labor and increased administration required for compliance:

- The agency projects no significant economic impact.

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

- Several health care providers, representing the interests of providers of durable medical equipment, orthotic and prosthetic services, and medical supplies, participated in a rulemaking advisory committee – see more below.

#### Administrative Rule Advisory Committee consulted?:

Yes – regarding OAR 436-009-0080, on Aug. 4, 2011. No\* – regarding OAR 436-010, 436-015, and 436-030.

If not, why? \*Because proposed changes to OAR 436-010, 436-015, and 436-030 are mostly limited to what is required to implement 2011 legislation, the agency was uncertain about the value of an advisory committee meeting or public interest. The agency issued a “request for advice; possible formation of advisory committee” to approximately 2,700 people. One person asked to meet with the agency, and this was done via teleconference.

*/s/ John L. Shilts*

Signature

John L. Shilts

Printed name

Sept. 15, 2011

Date



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

*Proposed*

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**NOTE:** Revisions are marked as follows:

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

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

#### **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 receives on or after the effective date of these rules.

(2) All orders ~~issued by the division~~ issues 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 2, 2008, by Workers' Compensation Division Administrative Order 07-059, and~~ carry out ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.278, and 656.325.

(a) For claims in which the worker became medically stationary ~~prior to~~ before 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 436-030-0055(3)(b), (3)(d), and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.

**Stat. Auth.:** ORS 656.268, 656.726

**Stats. Implemented:** ORS 656.206, 656.210, 656.212, 656.262, 656.268, 656.273, 656.325, 656.726

Hist: Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

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

#### **436-030-0036 Determining Temporary Disability**

(1) Temporary disability must be determined under ORS ~~C~~chapter 656, OAR 436-060, and this rule, less time worked. Beginning and ending dates of each authorized period of

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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 in section (3) of this rule and ORS 656.268(9)(10), a worker is not entitled to any award ~~for~~of 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:** Amended 10/26/04 as WCD Admin. Order 04-062, eff. 1/1/05

**Amended xx/xx/xx as WCD Admn. Order xx-xxx, eff. xx/xx/xx**

### 436-030-0145 Reconsideration Time Frames and Postponements

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

~~(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 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 that are medically stationary date, or date the claim that statutorily qualified ds for closure; on or after June 7, 1995, a request for reconsideration must be mailed within:~~

~~(a) 60Sixty (60) days of the mailing date of the Notice of Closure for a worker's request. A request for hearing must be made within 30 days of the mailing date of the Order on Reconsideration.~~

~~(e)(b) 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 sSeven (7) days of the mailing date of the Notice of Closure for an insurer's request. An insurer's request for reconsideration is limited to the findings used to rate impairment.~~

(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)(e)(b) of this rule; or

(b) The 61<sup>st</sup> day after the closure of the claim, if the insurer has requested reconsideration consistent with subsection (1)(e)(b) of this rule; unless the director receives, within the appeal

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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 from the date of the director's notice of the start of the reconsideration proceeding, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding. **Requests for a medical arbiter panel must be submitted within this time frame.**

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

(4) **The director may delay the reconsideration proceeding and toll the reconsideration timeline for up to 45 days when both parties provide written notice to the director requesting the delay for settlement negotiations. The notice is only effective if the director receives it before the 18<sup>th</sup> working day after the reconsideration proceeding begins.** ~~Medical arbiter panel requests must be received by the department within 14 days from the date of the director's notice of the start of the reconsideration proceeding.~~

**(a) This delay of the reconsideration proceeding expires:**

**(A) When the director receives a written request from either party to resume the reconsideration proceeding;**

**(B) When the director receives a copy of the approved settlement resolving some or all of the issues raised at the reconsideration proceeding; or**

**(C) On the next calendar day following the authorized delay period.**

**(b) The director may authorize only one delay period for each reconsideration proceeding.**

(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)~~**(8)**, the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(6) The reconsideration proceeding may be stayed for one of the following reasons:

(a) The parties consent to deferring the reconsideration proceeding, under ORS 656.268~~(7)~~**(8)**(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

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(b) When a Claim Disposition Agreement (CDA) is filed, the reconsideration proceeding is stayed until the CDA is either approved or set aside.

(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  
**Stats. Implemented:** ORS 656.268  
**Hist:** Amended 12-1-2009 as WCD Admn. Order 09-056 eff. 1-1-2010  
**Amended xx/xx/xx as WCD Admn. Order xx-xxx, eff. xx/xx/xx**

#### **436-030-0165 Medical Arbitrator Examination Process**

(1) The director will select a medical arbitrator physician or a panel of physicians in accordance with ORS 656.268~~(7)~~**(8)**(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~~ **of the specific objection before** 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)~~**(8)**.

(c) Arbitrators or panel members will not include any health care provider whose examination or treatment is the subject of the review.

**(d) The insurer must pay all costs related to the completion of the medical arbitrator process in this rule.**

(2) ~~If~~ **When the director has determined there are enough appropriate physicians available to create a list of possible arbitrators and it is practicable, each party will be given the opportunity to agree on a physician and to remove one physician from the list through the process described below:** ~~a claim qualifies for medical arbitrator deselection, a list of appropriate physicians will be faxed or sent by overnight mail to the parties.~~

(a) **The director will send the list to the parties electronically or by overnight mail.** ~~Each party may eliminate one physician from the list by crossing out the physician's name.~~

(b) **If the parties agree on a physician, every party must send a signed, written notice of that choice to the director.** ~~The parties may agree to one physician from the list by~~

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responding in writing. The parties must also deselect one physician from the list in case the agreed upon physician is unavailable.

(c) **A party can remove a physician from the list, even when the parties have agreed on a physician to conduct the exam, by submitting a signed, written notice of that choice to the director.** All responses must be signed and received by the director within three working days. No further opportunity will be given for the parties to provide input regarding the arbiter deselection process once the three working day period has expired. No further attempts at deselection will be made when continuing the arbiter deselection process is not practical.

**(d) To be effective, the written notice of agreement on or rejection of a physician must be received by the director within three working days of the date the director sent the list.**

(3) **The worker's disability benefits will be suspended when the director determines the worker failed to attend or cooperate with the medical arbiter examination.** 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 worker must call the director within 24 hours ~~of after failing to attend the missed~~ 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.

(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."

(4) 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.

(5) 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 worker's disability benefits will be suspended and the reconsideration proceeding postponed for up to an additional 60 days.

(6) The suspension will be lifted if any of the following occur during the additional 60-day postponement period:

- (a) The worker establishes a "good cause" reason for missing or failing to cooperate with the examination;
- (b) The worker withdraws the request for reconsideration; or
- (c) The worker attends and cooperates with a rescheduled arbiter examination.

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(7) If none of the events which end the suspension under section (6) of this rule occur ~~prior to~~**before** the expiration of the 60-day additional postponement, the suspension of benefits will remain in effect.

(8) 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.

(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 of the date of the director's notice of the start of the reconsideration proceeding. The parties must not submit issues directly to the medical arbiter or panel of medical arbiters. 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 medical arbiter will provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer 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.

(9) 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 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 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)~~**(8)**.

(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).

(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) 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

**Stats. Implemented:** ORS 656.268

**Hist:** Amended 12-1-2009 as WCD Admin. Order 09-056 eff. 1-1-2010

**Amended xx/xx/xx as WCD Admn. Order xx-xxx, eff. xx/xx/xx**