

**ADMINISTRATIVE ORDER NO. 5-1992
EFFECTIVE FEBRUARY 20, 1992**

**OREGON DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 30**

CLAIMS EVALUATION AND DETERMINATION

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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 30**

436-30-001 Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726(3) and ORS 656.268.

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Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
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Renumbered from OAR 436-65-000, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88

436-30-002 Purpose of Rules

These rules provide uniform standards for the claim closure process performed by Evaluation and insurers. These rules also prescribe the claim closure request and appeal process.

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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

436-30-003 Applicability of Rules

(1) Except as provided in section (4) of this rule, these rules are effective February 20, 1992 and apply to all accepted claims for workers' compensation benefits and all requests for reconsideration received by the Department on or after that date.

(2) All orders or requests issued by Evaluation or the Appellate Unit are considered an "order or request of the Director."

(3) These rules take the place of the rules adopted on December 10, 1990, by Workers' Compensation Department Administrative Order 33-1990 and temporary rules adopted on August 20, 1991, by Administrative Order 6-1991, and carry out the provisions of ORS 656.726(3), 656.206, 656.214, 656.268, 656.277, 656.325, and 656.262.

(4) The provisions of OAR 436-30-009, 30-020, 30-030, and 30-050 apply to all determinations or claims for workers who become medically stationary after July 1, 1990; for claims in which the claimant becomes medically stationary prior to July 2, 1990 the provisions of OAR 436-30-020, 30-030, 30-050 as contained in WCD Administrative Order 13-1987 shall apply.

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
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436-30-005 Definitions

Except where the context requires otherwise, the construction of these rules is governed

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by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrator" means the Administrator of the Workers' Compensation Division, Department of Insurance and Finance.

(2) "Appellate Unit" means the Appellate Unit of the Workers' Compensation Division of the Department of Insurance and Finance.

(3) "Department" means the Department of Insurance and Finance.

(4) "Determination" means the review by Evaluation or an insurer which establishes the extent of temporary and/or permanent disability to which a worker is entitled as a result of an accepted disabling injury.

(5) "Director" means the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

(6) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance.

(7) "Evaluation" means the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(8) "Insurer" means the State Accident Insurance Fund, or an insurer authorized under ORS chapter 731 to transact worker's compensation insurance in Oregon, a self-insured employer or a self-insured employer group.

(9) "Medical Arbitrator" means a physician who is an attending physician pursuant to 656.005 12(b)(A) selected by the Director pursuant to OAR 436 Division 10; after consultation with the Board of Medical Examiners for the State of Oregon and consultation with the labor/management advisory committee by the Department.

(10) "Medically stationary" means that no further material improvement in a worker's condition would reasonably be expected from treatment, or the passage of time.

(11) "Notice of Closure" means a notice to the worker issued by the insurer to close an accepted disabling claim provided by ORS 656.268(4).

(12) "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer.

(13) "Reconsideration" means a review proceeding by the Appellate Unit when a party is dissatisfied with a Notice of Closure or Determination Order.

(14) "Regular work" means an employment of the kind the worker held at the time of injury or aggravation, or the worker's customary employment.

(15) "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure or Determination Order.

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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

436-30-008 Administrative Review

(1) Evaluation and the Appellate Unit may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order. Evaluation will act within 180 days after the Determination Order being changed or cancelled is mailed only if a request for reconsideration pursuant to 436-30-050 has not been made. The Appellate Unit will act within the remainder of the appeal period after the reconsideration order being changed or cancelled is mailed only if a hearing has not been requested.

(2) Any party to a claim who does not agree with an order of Evaluation may, within 180 days of the mailing date of the Determination Order:

(a) Request an administrative review of any inadvertent error or omission in a Determination Order, by writing to the Evaluation Section, Workers' Compensation Division, Department of Insurance and Finance, Room 230, Labor and Industries Building, Salem, OR 97310; or

(b) Ask the Appellate Unit for a reconsideration of the order, pursuant to OAR 436-30-009 and as provided in OAR 436-30-050.

(3) For the purpose of this rule, an inadvertent error or omission in the routine administrative processing of orders would include but not be limited to:

(a) Typographical errors, which include discrepancies between the worksheet and the Determination Order or Notice of Closure.

(b) An error in the aggravation date.

(4) For any other matter in which a worker's right to compensation or the amount thereof is directly in issue, any party as defined in ORS 656.005(20), including SAIF Corporation as a designated processing agent pursuant to ORS 656.054, aggrieved by an action taken pursuant to these rules, may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law except as otherwise provided in ORS Chapter 656.

(5) Any party as described in section (4) aggrieved by a proposed order or proposed assessment of civil penalty of the Director or Division issued pursuant to ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds upon which the person requesting said hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the Administrator of the Workers' Compensation Division within twenty (20) days of receipt by the aggrieved person of notice of the proposed order or assessment. No hearing shall be granted unless the request is received by the administrator within said twenty (20) days of receipt of notice.

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(6) Any party as described in section (4) aggrieved by an action or order of the Director or Division pursuant to these rules, other than as described in section (5), where such action or order qualifies for review by hearing before the Director as a contested case, may request review pursuant to ORS 183.310 through 183.550 as modified by these rules pursuant to ORS 183.315(1). When the matter qualifies for review as a contested case, the process for review shall be as follows:

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing shall be granted unless the request specifies the grounds upon which the action or order is contested and is received by the Administrator within thirty (30) days of the action or from the date of mailing or other service of an order.

(b) The hearing shall be conducted by the Director or the Director's designee.

(c) Any order in a contested case issued by another person on behalf of the Director is a proposed order subject to revision by the Director. The Director may allow objections to the proposed order to be filed for the Director's consideration within thirty (30) days of issuance of the proposed order.

(7) Any party described in section (4) aggrieved by an action taken pursuant to these rules by another person except as described in sections (1) through (6) above may request administrative review by the Division on behalf of the Director. The process for administrative review of such matters shall be as follows:

(a) The request for administrative review shall be made in writing to the Administrator of the Workers' Compensation Division within ninety (90) days of the action. No administrative review shall be granted unless the request specifies the grounds upon which the action is contested and is received by the Administrator within ninety (90) days of the contested action unless the Director or his designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) The review, including whether the request is timely and appropriate, may be conducted by the Administrator, or the Administrator's designee, on behalf of the Director.

(c) In the course of said review, the person conducting the review may request or allow such input or information from the parties as he or she deems to be helpful.

(d) The determination by the person conducting the review will specify whether the determination constitutes a final order or whether an aggrieved party may request a contested case hearing before the Director pursuant to ORS 183.310.

(e) Any request for a contested case hearing before the Director regarding a review determination made pursuant to this section must comply with the procedures provided in section (4) above.

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436-30-009 Appeals of Notices of Closure, Determination Orders or Notices of Refusal to Close

(1) If the worker disagrees with a Notice of Closure or a Determination Order and the worker was determined medically stationary after July 1, 1990, the worker must first request a reconsideration by the Appellate Unit pursuant to 436-30-050. If the worker was determined medically stationary on or before July 1, 1990, WCD Admin. Order 13-1987 rules apply.

(2) If the worker disagrees with the notice of refusal to close, the worker may request redetermination by Evaluation.

(a) The request shall be in writing.

(b) The request must be received by the Department within 60 days from the date of a notice of refusal to close.

(3) If the insurer disagrees with a Determination Order and the worker was determined medically stationary after July 1, 1990, the insurer must first request a reconsideration by the Appellate Unit pursuant to 436-30-050. If the worker was determined medically stationary on or before July 1, 1990, WCD Admin Order 13-1987 rules apply.

Stat. Auth. ORS Chapter 656
Hist: Renumbered from OAR 436-30-020
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
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436-30-010 Evaluation Responsibility

(1) Evaluation, when requested by a party to a claim, is responsible for, but not limited to:

- (a) Determining the extent of permanent partial disability;
- (b) Determining the extent of temporary disability benefits;
- (c) Determining permanent total disability;
- (d) Determining medically stationary and nonstationary dates;
- (e) Determining the disabling/nondisabling status of a claim;
- (f) Reviewing permanent total disability awards;
- (g) Reviewing permanent disability awards pursuant to ORS 656.325(3);
- (h) Granting/approving offsets of overpayments pursuant to ORS 656.268(13).

(2) The Appellate Unit, when requested by a party responsible for, but not limited to:

- (a) Reconsideration of Notices of Closure;
- (b) Reconsideration of Determination Orders.

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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

436-30-020 Insurer Claim Closure

(1) The insurer may issue a Notice of Closure on an accepted disabling claim when medical information indicates the worker is medically stationary, and the worker has:

(a) returned to regular or modified work; OR

(b) the attending physician has released the worker to return to regular or modified work;
OR

(c) completed a Department authorized training program and has returned to work.

(2) When the insurer closes the claim, it shall issue a Notice of Closure to the worker within 14 days after evidence is received which shows the worker's condition is medically stationary, and information is sufficient to determine the extent of disability. When making a determination of disability, the insurer shall:

(a) Apply OAR 436-30-035 and OAR 436-30-036 regarding temporary disability determination and medically stationary status as prescribed by the Department.

(b) Prepare a summary worksheet.

(3) For the purposes of section (2) of this rule, medical information is sufficient if it includes the information required in OAR 436-30-030(5)(6).

(4) If the worker's condition became stationary on or after January 1, 1988, the insurer may determine the extent of permanent disability. The insurer shall apply the standards developed for the rating of permanent disability pursuant to ORS 656.726(3).

(5) The insurer shall not issue a Notice of Closure if an insurer's Determination Request (Form 1503) has been sent to the Department within the past 70 days and the matter is still pending resolution.

(a) A 1503 may be rescinded by written or telephone notification to the Department and the insurer's receipt of written confirmation from the Department that it has accepted the request to rescind.

(b) If Evaluation has not acted on the 1503 request within the time limits prescribed by ORS 656.268(5), the insurer or self-insured employer may proceed to issue a Notice of Closure after rescinding the 1503 request in accordance with section (5)(a) of this rule.

(c) Notices of Closure issued by the insurer in violation of this rule are void and without legal effect.

(6) The Notice of Closure shall be effective the date mailed. The notice shall be in the form and format that the Director shall describe by bulletin. The notice shall include but not be limited to:

(a) The dollar value of any permanent disability based on the value for the degree at the time the injury occurred;

(b) The body part(s) awarded disability, coded to the table of body part codes, the percentage of loss, and the number of degrees that loss represents;

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- (c) The type and duration of temporary disability compensation;
- (d) The medically stationary date;
- (e) The worker's aggravation rights;
- (f) The worker's appeal rights;
- (g) The right of the worker to consult with the Ombudsman for injured workers; and
- (h) The worker's return to work status.

(7) The original and three color coded copies of the Notice of Closure shall be mailed to:

- (a) The worker (white copy);
- (b) The employer (goldenrod copy);
- (c) The Department (yellow copy);
- (d) The worker's attorney, if represented.

(8) The insurer shall provide to the Department a copy of the worksheet upon which the Notice of Closure is based.

(9) When a claim is closed by the insurer pursuant to ORS 656.268, the relevant records used to issue the Notice of Closure shall be supplied to the Department, the worker or the worker's representative, if requested. Failure to supply this information in accordance with this rule may result in civil penalties pursuant to 436-30-580.

(10) A worker who has returned or has been released to work may request closure from the insurer. The insurer may:

- (a) Request a Determination Order;
- (b) Issue a Notice of Closure;
- (c) Issue a Notice of Refusal to Close.

(11) These rules do not prohibit an insurer from rescinding or correcting its Notice of Closure or Notice of Refusal to Close prior to the time a request for reconsideration is received by the Department.

(12) Insurers may allow adjustments of benefits awarded to the worker pursuant to the documentation requirements of OAR 436-60-170 for the following purposes:

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

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

Hist: Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80

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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92

436-30-030 Claim Closure By Evaluation Procedure

(1) Requests by the insurer for determination by Evaluation shall be as prescribed by the Director.

(2) The worker or worker's representative may write to Evaluation and request determination. If the worker has returned to work or has been released to work, Evaluation will notify the insurer of the worker's request so the insurer may choose whether to close the claim pursuant to OAR 436-30-020. If the insurer does not state that it will proceed to close the claim, Evaluation will act on the request for determination. The insurer shall submit all records to Evaluation within 14 days after being notified of the worker's request if it elects not to close the claim.

(3) Unless the worker is actively engaged in training, the insurer shall request determination for those claims it elects not to close within 14 days after the worker becomes medically stationary and sufficient information is available to determine the extent of disability pursuant to sections (5) and (6) of this rule.

(4) The insurer shall notify the worker and the worker's representative pursuant to ORS 656.331(1)(b), when a request for determination is made. Failure to notify the worker or their representative pursuant to this section may result in civil penalties pursuant to 436-30-580.

(5) When requesting a claim determination the insurer shall submit completed "Insurers Determination Request," Department form 1503 and provide to Evaluation:

- (a) Copies of all medical reports;
- (b) A closing examination report which shall describe in detail all permanent residuals attributable to the accepted claim pursuant to 436-10-080;
- (c) The dates of medically verified time loss including dates of modified work. Any reasons for broken periods of time loss shall also be explained or documented;
- (d) The name and address of the worker's attorney, if represented.
- (6) In claims involving unscheduled permanent impairment the insurer shall provide the worker's work history and education to include:
 - (a) The highest school grade level completed.
 - (b) A description of professional certificates or licenses the worker holds.
 - (c) The work history by Dictionary of Occupational Titles or a job description for each job held for the 10 years preceding the determination request, including dates or period of time spent at each position.
 - (d) The injured worker's current employment status. If working, also include the appropriate Dictionary of Occupational Title code for the job.

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- (e) All other records pertinent to claim determination.
- (f) Documentation of any periods of time the worker was incarcerated.
- (7) Failure to submit the information in accordance with sections (5) and (6) may result in civil penalties pursuant to 436-30-580.
- (8) When requesting claim determination pursuant to ORS 656.268(2) the same records shall be supplied to the worker or the worker's attorney and the employer, if requested.
- (9) Evaluation may require the insurer to provide additional information within appropriate time frames.
- (10) Failure to submit the information requested pursuant to Section (9) of this rule may result in the issuance of penalties pursuant to 436-30-580.
- (11) Evaluation shall issue a Determination Order within 10 working days if claim closure is premature because:
 - (a) The worker is not medically stationary.
 - (b) The worker is enrolled in a Department approved training program.
- (12) When requested by the insurer, the Division shall declare the date on which the worker became medically stationary if the worker was in training pursuant to OAR 436-120, and the worker's date of injury was after December 31, 1973 and before January 1, 1986. This date will control administrative fund reimbursements to insurers by the Department for injuries prior to January 1, 1986.
- (13) Upon receipt of a request for determination Evaluation shall:
 - (a) Apply standards developed pursuant to ORS 656.726(3) when evaluating the permanent disability of an injured worker; and
 - (b) Issue a Determination Order within 10 working days following receipt of the request for determination; or
 - (c) Postpone the determination for not more than a total of 70 days, from receipt of the request, to obtain additional information necessary to that determination and notify the worker and any representative of the worker within 10 working days following receipt of the request;
 - (d) If the worker is medically stationary, close the claim based on whatever information is available on the 70th day after the receipt of the request for claim closure, or;
 - (e) Issue a Determination Order that claim closure is premature if the worker's condition has not become medically stationary.
- (14) The effective date of the Determination Order shall be the date it is mailed. The mailing date appears on the order under "Date of Determination".
- (15) A Determination Order will be mailed to the insurer. Copies of the Determination Order will be mailed to the worker at the worker's last known address, the worker's representative, and the employer at injury.
- (16) Evaluation may allow adjustments of benefits awarded to the worker for the

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following purposes:

- (a) To recover payments for permanent disability which were made prematurely;
- (b) To recover overpayments for temporary disability; or
- (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.

(17) Evaluation may only allow overpayments made on a claim to be deducted from compensation to which the worker is entitled on that claim but has not yet been paid.

(18) If, after claim closure, a worker is in a Department approved training program pursuant to OAR 436-120, permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's accepted compensable condition is medically stationary. The insurer shall submit the claim to Evaluation for determination if the worker has not returned or been released to work or chooses not to close the claim pursuant to 436-030-020(1). If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination.

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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92

436-30-035 Determining Medically Stationary Status

(1) A worker's condition shall be determined to be medically stationary when the attending physician 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 is medically stationary, more weight shall be 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 is or is not medically stationary, deference shall generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference shall be 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 became medically stationary, the following conditions shall govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established pursuant to Section (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

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(5) A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the concurring physician expressly states to the contrary.

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

(7) The worker will be presumed to be medically stationary when the worker no longer requires medical treatment, when:

(a) the worker has not sought medical care for a period in excess of 28 days, unless so instructed by the attending physician, and;

(b) the insurer has notified the worker that claim closure may be requested for failure to seek medical treatment.

(8) Unless the attending physician has declared, or a preponderance of medical opinion is that, the worker is medically stationary on an earlier day, the worker is presumed to be medically stationary 10 days from the expected date of response to an insurer's notification letter pursuant to section (7) of this rule, unless subsequent medical evidence based on actual examination of the worker affirmatively and persuasively establishes that the worker was not and could not have been medically stationary on that date.

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

Stat. Auth. ORS Chapter 656
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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92

436-30-036 Temporary Disability Determination Procedure

(1) Except as provided in section (2) and (4) of this rule, a worker is entitled to an award of temporary disability for all periods of time during an open claim in which the attending physician or authorized medical service providers as provided in OAR 436-10-030, has authorized temporary disability.

(2) A worker is not entitled to any award for temporary disability for the first three days of temporary disability unless the worker was temporarily totally disabled for at least 14 consecutive days or was hospitalized as an inpatient during the initial time loss period.

(3) For the purpose of this rule, "inpatient" means admission to a hospital prior to and extending past midnight for treatment and lodging. The need for medical services such as Emergency Room, Observation Room or short stay surgical treatments are not considered "inpatient."

(4) A worker is not entitled to any award for temporary disability for any period of time in which:

(a) The worker is medically stationary;

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- (b) The worker has been released by the attending physician to return to regular work;
- (c) The worker has returned to regular work;
- (d) The worker's compensation is suspended pursuant to OAR 436-60-020 and 436-60-085 through OAR 436-60-105;
- (e) The worker is incarcerated pursuant to OAR 436-60-045;
- (f) The worker has withdrawn from the workforce;
- (g) The worker's attending physician has not authorized temporary disability.
- (h) The worker is deceased;
- (i) The temporary disability is authorized by someone without the authority to do so;
- (j) The worker has disposed of the right to temporary disability compensation pursuant to ORS 656.236.

(5) For the purpose of determining the applicability of section (4)(f) of this rule, a worker has withdrawn from the workforce when:

(a) If, prior to reopening pursuant to ORS 656.273 or 656.278, the worker was not working and had not made reasonable efforts to obtain employment unless, but for the compensable injury, such efforts would be futile.

(b) A worker who was a full time student for at least six months in the 52 weeks prior to injury elects to return to school full time, unless the worker can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.

(6) A worker is entitled to an award for temporary total disability if total disability is authorized unless the worker is entitled to an award for temporary partial disability as provided in section (7) of this rule.

(7) A worker is entitled to an award for temporary partial disability to be calculated pursuant to 436-60-030 if the worker is released to some form of work, whether or not the worker has returned to any form of work. A worker is entitled to an award of temporary partial disability for any periods of time in which the worker accrues any form of earnings as described in OAR 436-60-030(2) and (3).

(8) A worker, with a date of injury after December 31, 1973, who is in a department approved training program (ATP) is entitled to an award of temporary disability for the duration of the program pursuant to OAR 436-120. If the claim is in its initial open period, or if the claim has been reopened pursuant to ORS 656.273 before the end of training, the worker is entitled to an award for temporary disability after the end of the training program as authorized until the worker's accepted condition is medically stationary.

(9) Awards of temporary disability shall include the day the worker is first determined to be medically stationary unless, pursuant to this rule, temporary disability is not authorized for another reason at that time.

(10) Where a worker is not entitled to an award for temporary disability due to any of the

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reasons specified in subsection (4)(e) or (f), the order shall so specify the reason.

Stat. Auth. ORS Chapter 656
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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

436-30-045 Disabling/Nondisabling Status Determination

(1) Evaluation shall not determine the disabling or nondisabling classification of a claim in which the aggravation rights had properly run before the claim was reopened.

(a) No claim shall be reclassified unless the request or notice to an insurer that a nondisabling injury is disabling is made within one year of the date of injury.

(b) Where an insurer or self-insured employer is ordered to accept a claim by the Hearings Division and the worker has made a request to review the nondisabling status within one year of the date of injury, Evaluation shall proceed with the review upon receiving notice from the worker or worker's representative.

(2) Upon receipt of a request to review the status of a nondisabling claim, Evaluation shall request all medical and vocational reports from the insurer's claim file.

(3) Information requested by Evaluation shall be submitted by the insurer within 14 days of the request. Failure to submit the information timely may result in penalties pursuant to OAR 436-30-580.

(4) Upon receipt of the information in the claim file, Evaluation shall within 10 working days issue an order.

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

(a) Temporary disability is due and payable;

(b) If the worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726;

(c) The worker is not medically stationary, but there is a substantial likelihood that the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726 when the worker does become medically stationary.

(d) The worker is released to and doing a modified job at reduced wages from the job at injury.

(e) If the modified job the worker is released to and doing at the wage of job at injury no longer exists or a job offer is withdrawn. This includes but is not limited to termination of temporary employment, layoff, or plant closure.

(6) For claims that are reclassified, the aggravation rights begin with the first valid closure pursuant to ORS 656.268. For claims that are not reclassified, the aggravation rights continue to run from the date of injury.

(7) Pursuant to ORS 656.277, claims for nondisabling injuries will be processed by the Department in the same manner as claims for disabling injuries and if either party objects to the determination of Evaluation as to the worker's disabling/nondisabling status, that party must

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request a reconsideration by the Appellate Unit in accordance with ORS 656.268 before requesting a hearing under ORS 656.283.

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436-30-050 Reconsideration of Determination Orders or Notices of Closure

(1) A Determination Order shall be reconsidered by the Appellate Unit upon receipt by the Department of a written request for reconsideration by the worker, the worker's representative, the insurer or the self-insured employer. A Notice of Closure shall be reconsidered by the Appellate Unit upon receipt by the Department of a written request for reconsideration by the worker or the worker's representative. The request must be received within 180 days from the mailing date of the Determination Order or Notice of Closure .

(2) For the purpose of this rule, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure or Determination Order and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the Department. All information to correct the record and any medical evidence regarding the claimant's condition as of the time of claim closure that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding.

(3) The time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the Notice of Closure or Determination Order to request a hearing.

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

(b) The 180-day time limit will be tolled for all parties upon the request for reconsideration of either party.

(4) The Director shall by Bulletin prescribe the form and format of a completed request for reconsideration. Pursuant to this section, a "completed reconsideration request" shall include, but not be limited to:

(a) the Worker's Name, Social Security Number, Date of Injury and WCD File Number;

(b) a statement in bold face print and capital letters, "REQUEST FOR RECONSIDERATION";

(c) the date of closure, type of closure and the specific reason(s) for objection to the Determination Order or Notice of Closure;

(d) whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure and if so, an explanation is required of the specific areas of disagreement;

(e) any information and documentation deemed necessary to correct any part of the claim

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record the party believes to be erroneous; and/or

(f) any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at or before claim closure;

(g) in accordance with section (5) of this rule, a signed certification, submitted with the reconsideration request, that states the party requesting a reconsideration has provided copies of the request plus supporting evidence to all other interested parties; and,

(h) a statement in bold face print and capital letters:

NOTICE TO PARTIES: AT THE RECONSIDERATION PROCEEDING, THE WORKER OR THE INSURER OR SELF-INSURED EMPLOYER MAY CORRECT INFORMATION IN THE RECORD THAT IS ERRONEOUS AND MAY SUBMIT ANY MEDICAL EVIDENCE THAT SHOULD HAVE BEEN BUT HAS NOT SUBMITTED BY THE PHYSICIAN SERVING AS THE ATTENDING PHYSICIAN AT THE TIME OF CLAIM CLOSURE. (ORS 656.268)

IF YOU WISH ANY INFORMATION TO BE CONSIDERED AS PART OF THE RECONSIDERATION PROCEEDING, YOU MUST SUBMIT THE INFORMATION TO THE APPELLATE UNIT, WORKERS' COMPENSATION DIVISION, 210 LABOR & INDUSTRIES BLDG., SALEM, OREGON 97310, WITHIN SIX (6) WORKING DAYS FROM THE DATE THE REQUEST FOR RECONSIDERATION IS RECEIVED BY THE DEPARTMENT.

(5) When requesting reconsideration of a Notice of Closure or Determination Order, an insurer and a worker represented by an attorney must submit a "completed reconsideration request," pursuant to section (4) of this rule and, at the same time, provide copies of the completed request to the other interested parties:

(a) The notice to the other parties must advise them of their right to correct information in the record and the time frames for submitting such information in accordance with section (7) of this rule.

(b) The requesting party must certify, by means of a signed statement, submitted with the reconsideration request, that copies of the "completed reconsideration request" were provided to all other interested parties. This is the sole means of notifying other interested parties that a reconsideration request has been filed. When the requesting party fails to comply with this section, the Appellate Unit will not consider any correcting or clarifying evidence submitted with the reconsideration request, and such evidence will not be part of the record on reconsideration.

(c) If, within six working days from the request for reconsideration, the noncomplying party subsequently certifies to the Department that other interested parties have received copies of the appropriate information, the additional information will be considered in the reconsideration proceeding.

(d) All information submitted to the Department by any interested party during the reconsideration process must be copied to all interested parties and be accompanied by certification that it has been provided to all interested parties. Failure to comply with this

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requirement will result in the information not being included as part of the record on reconsideration.

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

(6) Upon receipt of a request for reconsideration, the Appellate Unit will advise all parties of the date the request was received, and the date the record will close. The Appellate Unit will also notify the parties of the last date an Order on Reconsideration can be issued and the status of their request if the Department fails to mail a reconsideration order pursuant to the time limits specified in ORS 656.268(6)(a).

(7) Six working days after the date the request for reconsideration is received, the request and all other appropriate information submitted by the parties shall become part of the record used in the reconsideration proceeding.

(a) Evidence received subsequent to the sixth (6) working day deadline may not be considered in the reconsideration proceeding.

(b) Upon review of the record the Appellate Unit may request, in accordance with ORS 656.268(5), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(c) When a basis for the Request for Reconsideration is a disagreement with the impairment findings used in rating the worker's disability at the time of claim closure, the Director shall refer the claim to a medical arbiter or panel of arbiters. The department will notify the parties within 18 working days from the date the reconsideration request was received that a medical arbiter review will be scheduled.

(d) The parties may not request an arbiter examination or change their request for a single arbiter to a panel of arbiters after the sixth working day from receipt of the reconsideration request.

(8) Upon written notice by the worker, or the worker's representative, of the intent to request reconsideration of a Notice of Closure or Determination Order, the insurer or self-insured employer shall, within six (6) working days of the mailing date of said request, furnish the Department, and the worker or the worker's representative, without cost, a copy of all documents pertaining to the claim or the specific documents so requested.

(9) An insurer failing to provide information or documentation as set forth in sections 5, 6, 7, and 8 of this rule may be assessed civil penalties pursuant to OAR 436-30-580. Failure to comply with the requirements set forth in Sections 5, 6, 7, and 8 may also be grounds for extending the reconsideration proceeding pursuant to ORS 656.268(5).

(10) Upon receipt of a request from an unrepresented worker the Appellate Unit shall acknowledge receipt of the request and notify all parties of their right to correct information in the record and the time frames for submitting such information in accordance with section (7) of this rule. The Appellate Unit shall also assist the worker in developing a completed request;

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inform the worker of the right to consult with the ombudsman or an attorney; and mail a copy to the insurer. Notwithstanding any other provision of this rule, the Division may extend any nonstatutory time frames or request any information deemed necessary to assure the unrepresented worker's reconsideration request is complete.

(11) When the Director refers the claim to a medical arbiter or panel of arbiters, the following applies:

(a) If the worker or the worker's representative requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the closure will be used to issue the reconsideration order.

(b) If the insurer requests reconsideration and the worker fails without good cause to appear for the medical arbiter examination, the worker's benefits may be suspended pursuant to OAR 436-60-085 and 436-60-095.

(c) A party's failure to provide an explanation of the specific disagreement with the findings used to rate impairment may preclude a medical arbiter review if a preponderance of medical evidence at the time of claim closure does not raise an issue regarding the validity of the closing examination.

(d) When a medical arbiter examination is requested by a party and the worker has subsequently become non-medically stationary and the claim has been reopened, or where a subsequent unrelated worsening has occurred, a medical arbiter examination is not appropriate. In such cases, the Appellate Unit may order a record review by an arbiter and base its impairment rating on the medical arbiter's opinion regarding impairment at the time of claim closure.

(e) The Department shall instruct the medical arbiter to provide copies of the arbiter report to the Department, the worker or the worker's representative, and the insurer or self-insured employer within five (5) working days after completion of the arbiter review. The cost of providing copies of such additional reports shall be reimbursed according to OAR 436-10-090.

(12) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. If an increase in compensation results from new information obtained through a medical arbiter examination or from the promulgation of a temporary emergency rule, penalties will not be assessed.

(13) For the purpose of section (12) of this rule, a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled.

(14) Attorney fees may only be authorized when a request for reconsideration is submitted by an attorney representing a worker and a valid signed retainer agreement has been filed with the Appellate Unit. The reconsideration order shall order the insurer or self-insured employer to pay the attorney out of any additional compensation awarded but not more than the maximum attorney fee allowed in OAR 438-15-040(1) and (2) and OAR 438-15-045.

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(15) When a worker has received a lump sum payment, pursuant to OAR 436-60-060, of an award granted by a Notice of Closure or Determination Order, the Appellate Unit shall not consider the adequacy of that award in a reconsideration proceeding.

(16) When the Appellate Unit finds, upon reconsideration, that the claim was closed prematurely, the Appellate Unit shall issue an order rescinding the Notice of Closure or Determination Order.

(17) Compensation reduced in a Reconsideration Order shall be "in lieu of" any compensation awarded by the Notice of Closure or Determination Order.

(18) Additional compensation awarded in a Reconsideration Order shall be "in addition to" any compensation awarded by the Notice of Closure or Determination Order.

(19) Any compensation affirmed in a Reconsideration Order shall be so stated.

(20) A copy of the Reconsideration Order will be sent to the worker, employer, insurer, and attorney if the worker is represented.

(21) The documents relied upon in issuing the Order on Reconsideration as well as any additional material submitted but not considered will be identified in the Workers' Compensation Division's claim file.

(22) The Department will either mail an Order on Reconsideration within 18 working days after the date the reconsideration request was received or it will 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(5) and/or 656.268(6)(a).

(23) If the Department fails to mail an Order on Reconsideration or a Notice of Postponement pursuant to the time frames specified in ORS 656.268(5) and/or 656.268(6)(a), the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the Department had issued an Order on Reconsideration affirming the Notice of Closure or the Determination Order. In accordance with section (3) of this rule, the counting of the 180-day time limit for requesting a hearing under ORS 656.268(6)(b) shall resume on the date after the Department should have issued an Order on Reconsideration.

(24) Pursuant to ORS 656.726(3)(f)(C), the reconsideration proceeding may be stayed to determine whether temporary rules amending "the standards" are required to properly rate the worker's impairment. The Department will notify the parties that the proceeding has been stayed for this purpose.

(25) Pursuant to ORS 656.236, the reconsideration proceeding is stayed until a Claims Disposition Agreement is either approved by a final order of the Workers' Compensation Board or the Board sets aside the disposition. The Department will notify the parties that the proceeding has been stayed for this purpose.

(26) After a Notice of Closure or Determination Order has been issued and a request for reconsideration has been filed, if the parties resolve issues by stipulation, including all matters being reconsidered, they may advise the Appellate Unit of their resolution and request that the Department enter an Order on Reconsideration affirming the Notice of Closure or Determination Order. The request for an affirming order must be made prior to the date an Order on

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Reconsideration is issued and in accordance with the following procedure:

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

(b) After the affirming Order on Reconsideration has issued, the parties will submit their stipulation to a referee of the Hearings Division, Workers' Compensation Board, for approval in accordance with the provisions of ORS 656.289(1) and the Board's rules of practice and procedure.

(c) An Order on Reconsideration issued pursuant to section (26) of this rule is final and is subject to a review under OAR 436-30-008(1) and a hearing pursuant to ORS 656.283.

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

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Renumbered from OAR 436-65-100, May 1985
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92

436-30-055 Permanent Total Disability

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

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

(b) "Suitable occupation" means those types of general occupations that exist in a theoretically normal labor market which is located within a reasonable geographic distance, being either full time or part time in duration.

(c) "Gainful occupation" is defined as: those types of general occupations that are either full time or part time in duration and pay wages equivalent to, or greater than, the state and federal mandated minimum hourly wage. Those types of general occupations that pay on a commission or piece-work basis, as opposed to a wage or salary basis, may not be "gainful employment" depending upon the facts of the individual situation.

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

(e) A "reasonable geographic distance" as used in this rule means either of the following

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unless the worker is medically precluded from commuting:

(A) The area within a 60-mile radius of claimant's place of residence at the time of:

- (i) the original injury; or
- (ii) claimant's last gainful employment; or
- (iii) the time of reconsideration by the Appellate Unit.

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

(f) "Types of general occupations" as used in this rule means: groups of jobs which exist in a theoretically normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening currently exists.

(g) "Theoretically normal labor market" as used in OAR 436-30-055 and 065 means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity or technology trends in the long-term labor market.

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

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

- (a) Prove permanent and total disability,
- (b) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, but for the compensable injury, make such efforts futile.
- (c) Be willing to seek regular and gainful employment.

(4) When a worker retains some residual functional capacity and is not medically permanently and totally disabled, the worker must prove inability to regularly perform work at a gainful and suitable occupation, and the futility of seeking work if claimant has not made reasonable work search efforts, by competent vocational testimony. Competent vocational testimony is that which comes from the opinions of persons fully certified by the State of Oregon to render vocational services. It does not include opinions by claimants or physicians not certified.

(5) Every Determination Order which grants permanent total disability shall notify the worker that:

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

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

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

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

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

Hist: Filed 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

436-30-065 Review of Permanent Total Disability Awards

(1) The insurer shall review each permanent total disability claim every two years or when requested to do so by the Director to see if the worker's medical or vocational status has changed. The insurer shall send the results of the review to the Department.

(2) Any request from the insurer to Evaluation to reduce permanent total disability shall be accompanied by documentation to support the request. That documentation may include medical, vocational, or investigation reports (including visual records, if available) which demonstrate a change in the physical condition or in employability. The insurer shall notify the worker, and the worker's attorney, if represented, when requesting a reduction in permanent total disability benefits.

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

(4) An award of permanent total disability for scheduled injuries on or after July 1, 1975, shall be considered for reduction by Evaluation only when the insurer has evidence that the worker is working at a suitable and gainful occupation or is capable of doing so.

(5) An award of permanent total disability for unscheduled injuries shall be considered for reduction by Evaluation when the insurer has evidence that the worker's medical condition has improved or the worker is working at a suitable and gainful occupation or is capable of doing so.

(6) Upon receipt of a request for reduction of permanent total disability pursuant to section (2) of this rule, Evaluation shall issue either a Determination Order reducing the permanent total disability and stating the permanent partial disability or issue a Determination Order affirming the permanent total disability status.

(7) Any party to the claim who does not agree with the order of Evaluation may, within 180 days of the mailing date of the determination order:

(a) Request reconsideration by the Evaluation Section if the worker became medically stationary on or before July 1, 1990, or request a hearing by writing to the Hearings Division of the Workers Compensation Board; or

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(b) If the worker became medically stationary after July 1, 1990, must first request reconsideration by the Appellate Unit pursuant to OAR 436-30-050.

(8) Any party who disagrees with the reconsideration order may request a hearing.

(a) Requests for hearing must be made in writing to the Workers' Compensation Board.

(b) Requests for hearing must be made within 180 days after the mailing date of the order reducing the award.

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436-30-066 Review of Prior Unscheduled Permanent Partial Disability Awards.

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

(a) Requests for review and adjustment shall be made in writing to the Evaluation Section of the Workers' Compensation Division, 230 Labor & Industries Building, Salem, OR 97310.

(b) The party requesting review of permanent disability shall inform the affected parties at the same time of the request. The worker may submit any information in rebuttal.

(c) All pertinent medical/vocational records shall be submitted with the request.

(d) The basis for the request for adjustment in the disability award shall be stated in the request for adjustment.

(2) Evaluation shall make any necessary adjustments pursuant to OAR 436-35-270 through 436-35-315.

(3) Evaluation shall issue a Determination Order within 20 days of receipt of a complete request, allowing 10 days for the worker to respond to the notice of a request for adjustment in permanent disability.

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Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

436-30-580 Penalties

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

(2) An insurer failing to meet the time frame and reporting requirements set forth in OAR 436-30-020, 436-30-030, 436-30-045, and 436-30-050 may be assessed a civil penalty.

(3) In arriving at the amount of penalty, the Director or designee may assess a penalty of \$2,000 for each violation or \$10,000 in the aggregate for all violations in any three-month period. Each day the employer or insurer fails to provide the requested reports or information shall be considered a separate violation.

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436-30-581 Issuance/Service of Penalty Orders

(1) When a penalty is assessed as provided in OAR 436-30-580, the Director or designee shall serve an order on the party with a notice of the party's appeal rights provided under ORS 656.704.

(2) The Order shall be served by:

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

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

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

"IF YOU DISAGREE WITH THIS ORDER, YOU ARE ENTITLED TO A HEARING AS PROVIDED BY ORS 656.704(2), OAR 436-30-008, AND THE CONTESTED CASE PROVISIONS OF THE ADMINISTRATIVE PROCEDURES ACT (ORS CHAPTER 183). IF YOU DESIRE A HEARING, YOU MUST NOTIFY THE ADMINISTRATOR IN WRITING WITHIN TWENTY (20) DAYS OF THE DATE OF RECEIPT OF THIS NOTICE TO YOU. YOUR REQUEST MUST BE SENT TO THE DEPARTMENT OF INSURANCE AND FINANCE, WORKERS' COMPENSATION DIVISION, LABOR AND INDUSTRIES BUILDING, SALEM, OREGON 97310. YOU WILL BE NOTIFIED OF THE TIME AND PLACE OF HEARING BY THE ADMINISTRATOR. IF YOU REQUEST A HEARING, YOU WILL BE GIVEN INFORMATION ON PROCEDURES, RIGHT OF REPRESENTATION, AND THE RIGHTS OF PARTIES RELATING TO THE CONDUCT OF THE HEARING. IF YOU FAIL TO REQUEST A HEARING WITHIN TWENTY (20) DAYS, THIS ORDER WILL BECOME FINAL BY OPERATION OF LAW AND THEREAFTER SHALL NOT BE SUBJECT TO REVIEW BY ANY AGENCY OR COURT."

Hist: Filed 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92