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

CLAIMS EVALUATION, DETERMINATION, AND RECONSIDERATION

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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
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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.

Hist: Filed 2/6/75 as WCB Admin. Order 5-1975, eff. 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-000, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88

436-30-002 Purpose of Rules

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

- (a) determining medically stationary status;
- (b) determining periods of temporary disability benefits;
- (c) awards of permanent partial disability;
- (d) determining permanent total disability awards;
- (e) review and determination of prior unscheduled permanent partial disability awards;
- (f) review and determination of the disabling or nondisabling status of a claim;
- (g) review for reduction of permanent total disability awards;
- (h) requests for closure by the worker; and
- (i) mandatory reconsideration of determination orders and notices of closure.

Hist: Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-002, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-003 Applicability of Rules

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

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

(3) These rules take the place of the rules adopted on January 17, 1992, by Workers' Compensation Division Administrative Order 5-1992, 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, 30-115, 30-125, 30-135, 30-145,

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30-155, 30-165, 30-175 and 30-185 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
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-030, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-005 Definitions

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

- (1) "Administrator" means the Administrator of the Workers' Compensation Division, Department of Consumer and Business Services.
- (2) "Department" means the Department of Consumer and Business Services.
- (3) "Determination" means the review by the Department 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.
- (4) "Director" means the Director of the Department of Consumer and Business Services or the Director's delegate for the matter.
- (5) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.
- (6) "Insurer" means the State Accident Insurance Fund, or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer or a self-insured employer group.
- (7) "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).
- (8) "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
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[ED NOTE: OAR 436-30-008(1), (2), and (3) are amended and renumbered to OAR 436-30-020 and 30-030.]

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436-30-008 Administrative Review

(1) Dispute Resolution Before the Director:

(a) Determination Orders issued by the Department and Notices of Closure issued by insurers are appealed to the Director in accordance with the reconsideration procedures described in sections 436-30-115 through 436-30-185 of these rules.

(b) Abating, withdrawing or amending an Order on Reconsideration: If a hearing has not been requested, at the Director's discretion, the Department may abate, withdraw and/or amend an Order on Reconsideration within the time limit permitted to appeal a Notice of Closure or Determination Order.

(2) Contested cases before the Hearings Division of the Workers' Compensation Board:

(a) Except as noted in subsection (3) of these rules, Orders on Reconsideration are appealable to the Hearings Division of the Workers' Compensation Board as follows:

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

(B) The request must be filed within 180 days of the mailing date of the Notice of Closure or Determination Order. Pursuant to ORS 436-30-145 (1), for the purpose of filing such appeal, the time required to complete the reconsideration proceeding shall not be included in the 180 day time limit.

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

(3) Contested cases before the Workers' Compensation Division's hearings officer: Pursuant to 183.310 through 183.550 as modified by ORS 183.315 (1) and ORS 656.704(2), any party that disagrees with an action or order of the Director pursuant to these rules may request a contested case review, if the matter qualifies for review before the Director as a contested case. This may include orders denying reconsideration, jurisdictional dismissals, and other actions or orders of the Director pursuant to ORS Chapter 656 which do not involve the payment of compensation, when the matter qualifies for review as a contested case. Orders and actions which qualify for review as contested cases before the Director are those specified by statute, by rule or by specific notice of right to such appeal. A party may appeal to the Director as follows:

(a) The party must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the denial of reconsideration, or other order or action of the Director, is contested.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of action being appealed, unless the Director determines that there was good cause for delay and the hearings officer determines that substantial injustice may otherwise result.

(c) The Workers' Compensation Division will conduct the hearing in accordance with the rules governing contested case hearings in OAR 436-01.

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(d) Any order that results from a contested case is a preliminary order subject to revision by the Director pursuant to OAR 436-01-270.

(4) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.704, any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the Director pursuant to ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

(a) A written request for hearing must be sent to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be received by the Workers' Compensation Division within 20 calendar days after service of the order or notice of assessment.

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

(d) A referee from the Hearings Division, acting on behalf of the Director, shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

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

(a) A written request must be sent to the administrator within ninety (90) days of the disputed action and must specify the grounds upon which the action is taken, unless the Director determines that there was good cause for delay or that substantial injustice may result otherwise.

(b) The Workers' Compensation Division may require and allow such evidence as it deems appropriate to complete the review.

(c) A Director's order will be issued and will specify if the order is final or if it may be appealed in accordance with section (3) above.

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Amended 03/20/80 as WCD Admin. Order 4-1980, eff. 04/01/80
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Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-009 Appeals of Notices of Closure and Determination Orders

(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 Department pursuant to these rules. If the worker was determined medically stationary on or before July 1, 1990, WCD Admin. Order 13-1987 rules apply.

(2) An insurer may not request reconsideration of its own Notice of Closure; however, if the insurer disagrees with a Determination Order issued by the Department and the worker was

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determined medically stationary after July 1, 1990, the insurer must first request a reconsideration by the Department pursuant to these rules. If the worker was determined medically stationary on or before July 1, 1990, WCD Admin Order 13-1987 rules apply.

Hist: Stat. Auth. ORS Chapter 656; renumbered from OAR 436-30-020
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-010 Department Responsibility

(1) The Department, 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) Reviewing and 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);
- (i) Conducting the mandatory reconsideration proceeding when a party is dissatisfied with a Notice of Closure or Determination Order.

Hist: Filed 2/6/75 as WCB Admin. Order 5-1975, eff. 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
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Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

[ED NOTE: PARTS OF THIS RULE HAVE BEEN RENUMBERED FROM OAR 436-30-020 AND 030]

436-30-015 Insurer Responsibility

- (1) When an insurer elects to issue a Notice of Closure, the insurer is responsible for:
- (a) Providing a copy of the Notice of Closure, a copy of the worksheet upon which the Notice is based, and a completed "Insurer Notice of Closure Summary or Request for Determination", Department form 1503, to the Department and parties pursuant to 436-30-020;
 - (b) Providing the Department, the worker or the worker's representative, if requested, the records used to issue the Notice of Closure; and
 - (c) Maintaining a copy of the worksheet upon which the Notice of Closure is based in its claim file for audit purposes.

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(2) When an insurer elects to request closure by the Department, the insurer is responsible for providing:

(a) A completed "Insurer Notice of Closure Summary or Request for Determination, Department form 1503;

(b) Copies of all medical reports;

(c) A closing medical examination report which describes in detail all permanent residuals attributable to the accepted claim pursuant to 436-10-080;

(d) 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;

(e) The name and address of the worker's attorney, if represented;

(f) The name and address of the worker's attending physician; and

(g) The accepted conditions of the claim.

(3) In claims involving unscheduled injuries to, or disease of, body parts or conditions pursuant to OAR 436-35-330 through 436-35-450, the insurer shall provide the worker's work history and education to include:

(a) The worker's level of education;

(b) The worker's work history pursuant to OAR 436-35-310 including the job at injury and work history for five years preceding the determination request. The work history shall include the Dictionary of Occupational Titles (DOT) code with the Specific Vocational Preparation (SVP) for the five years preceding determination, including dates or period of time spent at each position; and

(c) Documentation of any periods of time the worker was incarcerated.

(4) The insurer shall provide any other records or information pertinent to claim determination that the department may require within appropriate time frames.

(5) 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 and provide the worker's attorney and the employer, if requested, the same documents required for claim closure.

(6) 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 the 1503.

(b) If the Department has not acted on the 1503 request for determination 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 (6)(a) of this rule.

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

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legal effect.

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

(8) Failure to meet the requirements and timeframes of this rule shall result in civil penalties pursuant to OAR 436-30-580.

Hist: Amended and Renumbered 11/18/94 from 436-30-020 and 030 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-017 Requests for Claim Closure by the Worker

(1) A worker who has returned or has been released to work may request closure from the insurer. The insurer shall within 14 days of said request:

(a) Request a Determination Order by the Department; OR

(b) Issue a Notice of Closure; OR

(c) Issue a Notice of Refusal to Close advising the worker of the appeal rights in accordance with ORS 656.268(4)(d).

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

(a) Name of the worker;

(b) Date of injury;

(c) Worker's social security number;

(d) Insurer's claim number;

(e) Mailing date of the notice;

(f) The notice shall advise the worker of the decision not to close the claim and provide an explanation of the insurer's rationale. The notice shall also advise the worker of the right to be represented by an attorney and the right to request a hearing within 60 days after the notice is mailed.

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

(4) Failure by the insurer to meet the requirements of Section (1) shall result in civil penalties against the insurer pursuant to OAR 436-30-580.

Hist: Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-020 Requirements for Claim Closure by Insurers

(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

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- (b) been released to return to regular or modified work by the attending physician; OR
- (c) ceased to be enrolled and actively engaged in a Department authorized training program and has returned to work.

(2) In accordance with OAR 436-30-035, when the insurer closes the claim, it shall issue a Notice of Closure to the worker within 14 days after evidence is received from the attending physician 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; and

(b) Prepare a summary worksheet which contains the information, and is in the form and format, prescribed by bulletin of the Director.

(3) For the purposes of section (2) of this rule, medical information is sufficient if it includes the information required in OAR 436-30-015(2)(3) and the Disability Rating Standards in OAR 436-35.

(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 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;

(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.

(6) 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.

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(7) Where prior approval has been given by the Department, an insurer may use electronically produced Notice of Closure forms where the computerized format is consistent with the Department determination order format. The original and three copies of the electronically produced form shall be mailed to all affected parties pursuant to Section (6) of this rule.

(8) An insurer who intentionally or repeatedly fails to provide the worker's attorney a copy of the Notice of Closure may be assessed a civil penalty pursuant to OAR 436-30-580. For the purposes of this rule, "repeatedly fails" refers to any instance where the attorney has requested a copy of the Notice of Closure on a particular claim and must subsequently make a second request due to the insurer's failure to provide the requested copy.

(9) 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 of the Notice of Closure is received by the Department. A Notice of Closure may be corrected or rescinded when:

(a) it is found to contain an inadvertent error, omission, or a typographical or clerical error which includes discrepancies between the worksheet and Notice of Closure;

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

(c) additional information has been received pertaining to wages or unemployment benefits previously paid the worker, actual time worked, periods of time loss, or which indicates that the worker was not actually medically stationary at the time the Notice was issued; or

(d) the Department has instructed the insurer to correct a Notice of Closure because it did not contain information pursuant to Section (5) of this rule.

(10) Requests for reconsideration of a Notice of Closure corrected pursuant to Section (9) of this rule must be received within 180 days of the mailing date of the corrected Notice of Closure. Requests for reconsideration of a corrected Notice of Closure may only address those areas changed by the corrected Notice.

(11) 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.

(12) 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
Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82
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Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)

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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
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-030 Requirements for Claim Closure By the Department

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

(2) 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 30-015(2) and (3) of these rules. For purposes of this rule, a determination order shall be deemed to have been requested on the date the Form 1503 is received by the Department.

(3) 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. As defined in OAR 436-60-200(2), intentional or repeated failure to notify the worker or the worker's representative pursuant to this section may result in civil penalties pursuant to 436-30-580.

(4) The Department shall issue a Determination Order within 10 working days if claim closure is premature because:

(a) The worker is not medically stationary; and/or

(b) The worker is enrolled in a Department approved training program.

(5) When requested by the insurer, the Department 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.

(6) Upon receipt of a request by the insurer for determination the Department 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 for that determination and notify the worker and any representative of the worker within 10 working days following receipt of the request; or

(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.

(7) Where determination has been postponed to obtain additional information and the insurer fails to respond to the Department request for that information by the date requested, penalties may be assessed pursuant to OAR 436-30-580. In cases where the insurer provides sufficient documentation to substantiate lack of cooperation by the medical provider, the

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provider will be sent a warning letter about possible penalties and a date for submitting the requested information. Failure by the medical provider to submit the requested information within the specified time frame may result in the subsequent issuance of civil penalties, pursuant to OAR 436-30-580.

(8) Pursuant to Section (7) of this rule, adequate documentation to substantiate lack of cooperation by the medical provider would include:

- (a) copies of letters to the medical provider;
- (b) memos to the claim file of follow-up phone calls and/or the lack of response;
- (c) letters from the medical provider indicating a lack of cooperation; or
- (d) medical reports received by the insurer which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-35.

(9) 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".

(10) 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.

(11) The Department 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.

(12) The Department may allow adjustments of benefits awarded to the worker for the 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.

(13) The Department may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order within 21 days of issuance of the Determination Order, and only if request for reconsideration pursuant to these rules has not been made. Determination Orders may be corrected or rescinded when:

- (a) the Determination Order contains a typographical or clerical error which includes discrepancies between the worksheet and the order;
- (b) additional information has been received pertaining to wages or unemployment benefits previously paid the worker, actual time worked, periods of time loss, or which indicates that the worker was not actually medically stationary at the time the Order was issued;
- (c) additional information has been received pertaining to the permanent disability that was generated before the closure.

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(14) Requests for reconsideration of a Determination Order corrected pursuant to Section (13) of this rule must be received within 180 days of the mailing date of the corrected Determination Order. Requests for reconsideration of a corrected Determination Order may only address those areas changed by the corrected Order.

(15) If, after claim closure, a worker becomes enrolled and actively engaged 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 the Department 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 unless the worker's attending physician provides a written statement that there has been no change in the worker's condition since the previous closing examination.

Hist: Filed 2/6/75 as WCB Admin. Order 5-1975, eff. 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, eff. 1/1/82
Renumbered from OAR 436-65-010, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

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.

(5) Notwithstanding Sections (1) through (4) of this rule, OAR 436-35-007(8) requires the attending physician's concurrence when the attending physician arranges, or refers the worker for, a closing examination with another physician to determine the extent of impairment, or when

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the insurer refers a worker for an insurer medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the concurring physician expressly states to the contrary and explains the reasons for their disagreement.

(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 by letter that claim closure may be requested for failure to seek medical treatment. The notification letter shall inform the worker of the responsibility to seek treatment if needed, and of the consequences, including but not limited to claim closure, for failure to seek medical treatment or a closing examination.

(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 14 days from the certified mailing date of the insurer's notification letter pursuant to section (7) of this rule, unless prior to claim closure the insurer receives:

(a) subsequent medical evidence based on actual examination of the worker that affirmatively and persuasively establishes that the worker was not and could not have been medically stationary on that date or;

(b) subsequent medical information that is based on actual examination of the worker and which states that the worker was medically stationary on a later date.

(9) Notwithstanding Section (8) of this rule, if the insurer receives a written response from the worker prior to the 14th day after the notification letter indicating the worker does not wish to obtain further medical treatment or schedule a closing exam, then the medically stationary date will be presumed to be the date the worker's response was received by the insurer.

(10) 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.

Hist: Stat. Auth. ORS Chapter 656
Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-036 Determining Temporary Disability

(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, have authorized temporary disability.

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(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 and totally disabled for at least 14 consecutive days or was hospitalized as an inpatient during the initial time loss period pursuant to OAR 436-60-020.

(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;
- (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 436-60-095 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

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disability for any periods of time in which the worker accrues any form of earnings as described in OAR 436-60-030.

(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 period of time the worker is enrolled and actively engaged in training 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 reasons specified in subsection (4)(e) or (f), the order shall so specify the reason.

Hist: Stat. Auth. ORS Chapter 656
Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-038 Permanent Partial Disability

The standards developed pursuant to ORS 656.726(3) and contained in OAR 436-35 shall be applied when evaluating a worker's permanent partial disability. The Notice of Closure or Department Determination Order shall report the body part, percentage of loss, number of degrees that loss represents and the dollar value for that loss based on the value of the degree at the time of injury. Body part codes shall be reported as prescribed by the Director.

Hist: Stat Auth. ORS Chapter 656
Filed 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-045 Disabling/Nondisabling Reporting Requirements and Change in Status Determinations

(1) When an insurer receives notice or knowledge that a nondisabling injury has become disabling, the insurer shall do one of the following:

(a) If the insurer agrees that the claim is disabling, an "Insurer's Report", Form 440-1502, indicating a change in status shall be submitted to the Department within 21 days. A notice of change of status to disabling shall be sent to the worker, and to the worker's representative, explaining the change in status. If the worker is medically stationary, the insurer may close the claim in accordance with ORS 656.268(4) and these rules or submit an "Insurer Notice of Closure Summary or Request for Determination", Form 440-1503, requesting department closure; OR

(b) If the insurer disagrees that the claim is disabling, or is unable to decide whether the claim is disabling, the insurer shall submit an "Insurer's Report", Form 440-1502, and "Insurer Notice of Closure Summary or Request for Determination", Form 1503, to the Department with copies of the Form 801 and Notice of Acceptance and all medical, vocational, and time loss

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records within 21 days. The 1502 form shall indicate that the claim is nondisabling, and will state in the "explanation" section that the claim is being reported pursuant to ORS 656.277 for Department review of the nondisabling classification. A copy of the Form 1503 shall be sent to the worker and the worker's representative, explaining that the worker's assertion that the claim is disabling has been reported to the Director for determination.

(2) The source of the insurer's notice or knowledge of a claim becoming disabling may come in the form of a physician's report indicating medical conditions that will result in disability.

(3) The Department 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 reviewed for reclassification 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, the Department shall proceed with the review upon receiving notice from the worker or worker's representative.

(4) Upon receipt of a request by a party other than the insurer to review the status of a nondisabling claim, the Department shall request all medical and vocational reports from the insurer's claim file.

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

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

(7) 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.

(8) 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

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continue to run from the date of injury.

(9) 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 the worker's disabling/nondisabling status by the Department, that party must request a reconsideration by the Department in accordance with ORS 656.268 before requesting a hearing pursuant to ORS 656.283.

Hist: Stat. Auth. ORS Chapter 656
Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92
Amended as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

[**ED. NOTE:** OAR 436-30-050 has been renumbered to 436-30-115, 125, 135, 145, 155, 165, 175, and 185 in its entirety.]

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

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Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
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Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, f. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Renumbered to OAR 436-30-115 through 185 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-055 Determining Permanent Total Disability

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

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

(c) "Gainful occupation" 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.

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(e) A "reasonable geographic distance" as used in this rule means either of the following 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) determination by the Department; or
- (iv) 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, including the residuals of the compensable injury, make such efforts futile; and
- (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 reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

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(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.

(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
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-065 Review of Permanent Total Disability Awards

(1) The insurer shall reexamine 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. Reexamination of a PTD claim may be performed by the insurer whenever the insurer considers it necessary. Once an insurer has obtained the statutory three medical examinations for an open period and wants an additional medical examination on a PTD claim more frequently than every two years, the insurer is required to notify and request authorization from the Director for the additional medical examination. The insurer shall send the results of the reexamination to the Department.

(2) Any request from the insurer to the Department 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 the Department 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 the Department 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 the Department 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

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section (2) of this rule, the Department 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 Department may, within 180 days of the mailing date of the determination order:

(a) Request reconsideration by the Department 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 within 180 days after the mailing date of the order; or

(b) If the worker became medically stationary after July 1, 1990, must first request reconsideration by the Department pursuant to these rules.

(8) Any party who disagrees with the reconsideration order may request a hearing from the Worker's Compensation Board, Hearings Division.

(a) Requests for hearing must be made in writing to the Workers' Compensation Board within 180 days after the mailing date of the order.

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
Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

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 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) The Department shall make any necessary adjustments pursuant to OAR 436-35-270 through 436-35-315.

(3) The Department 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.

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90 (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

[**ED. NOTE:** OAR 436-30-050 has been amended and renumbered in Sections 115 through 185.]

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436-30-115 Reconsideration of Determination Orders or Notices of Closure

(1) A Determination Order shall be reconsidered by the Department upon receipt by the Department of a written request for reconsideration by the worker, the worker's representative, or the insurer. A Notice of Closure shall be reconsidered by the Department 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 these rules, "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 or clarify 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) Only one reconsideration proceeding may be completed on each Determination Order or Notice of Closure and the Department will do a complete review of that closure; however, pursuant to OAR 436-30-008(1), at the Director's discretion, an Order on Reconsideration can be abated, withdrawn and/or amended.

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
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Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-125 Reconsideration Form and Format

(1) 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, "**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) the name of the worker's attorney (if any);
- (e) the name of the insurer's attorney (if any);
- (f) 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;
- (g) any information and documentation deemed necessary to correct or clarify any part of the claim record the party believes to be erroneous; and/or

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(h) 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;

(i) in accordance with OAR 436-30-135, 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,

(j) a statement in bold face print:

Note to the Worker: A reconsideration may result in a decrease or an increase of your benefits.

Notice to Parties: The worker or the insurer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure (ORS 656.268)

This is the only reconsideration proceeding by the Appellate Review Unit for this claim closure. If you wish any information to be considered as part of the reconsideration proceeding, you must submit the information to the Appellate Review 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.

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)

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

Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)

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

Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-135 Reconsideration Procedure

(1) 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 OAR 436-30-125 and, at the same time, provide copies of the completed request to the other interested parties:

(a) The notice to the parties must advise them that the reconsideration proceeding for the claim closure has begun, of their right to correct information in the record, and of the time frames for submitting such information in accordance with OAR 436-30-145.

(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 Department 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.

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(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 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

(2) Upon receipt of a request from an unrepresented worker, the Department shall assist the worker in developing a completed request; 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 Department may extend any nonstatutory time frames or request any information deemed necessary to assure the unrepresented worker's reconsideration request is complete.

(3) Upon receipt of a request for reconsideration, the Department will advise all parties of the date the request was received and the time lines for submitting additional information. The acknowledgement letter shall include a certification of service verifying that the letters have been mailed to the parties listed. The Department 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).

(4) The insurer shall furnish within six (6) working days of the mailing date of the reconsideration request made by the worker or the worker's representative, the following copies without cost:

(a) for a Notice of Closure, all documents pertaining to the claim shall be furnished to the Department and the worker or the worker's representative;

(b) for a Determination Order, any documents supplemental to the Determination Order shall be furnished to the Department and the worker or the worker's representative as well as other documents as requested by the Department or the worker or the worker's representative.

(5) 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 Department shall not consider the adequacy of that award in a reconsideration proceeding.

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

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

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

(b) additional compensation awarded in a reconsideration order shall be "in addition to" any compensation awarded by the Notice of Closure or Determination Order. The

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reconsideration order may award total compensation due less any compensation previously ordered.

(c) any compensation affirmed in a reconsideration order shall be so stated.

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

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-100, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-145 Reconsideration Time Frames and Postponements

(1) 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 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.

(c) The 180-day time limit will not be tolled when a request for reconsideration is withdrawn by the parties pursuant to OAR 436-30-185.

(2) Six working days after the date the request for reconsideration is received by the Director, 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 Department may request, in accordance with ORS 656.268(5), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(3) 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).

(4) 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.

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(5) Pursuant to ORS 656.236 when a Claims Disposition Agreement (CDA) is filed with the Board, the reconsideration proceeding is stayed until a CDA 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.

(6) 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 (1) 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.

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

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-100, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-155 Reconsideration Record

The record used in the reconsideration proceeding shall include the documents relied upon in issuing the Order on Reconsideration as well as any additional material submitted but not considered. The record shall be maintained in the Workers' Compensation Division's claim file and shall include all documents date stamped prior to the issuance of the reconsideration order.

Hist: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-100, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, Of. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-165 Medical Arbitr Examination Process

(1) 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.

(a) When additional medical information is required pursuant to ORS 656.268 (5), the Director may refer the claim to a medical arbiter or panel of arbiters.

(b) 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.

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(c) The parties may not be granted their request for an arbiter examination or a change from a single arbiter to a panel of arbiters if the request is received after the sixth working day from receipt of the reconsideration request by the Director.

(d) When the Director requests clarification, a party's failure to provide an explanation 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.

(e) The costs related to record review, examinations and reports of the medical arbiter shall be paid pursuant to OAR 436-10-047.

(2) The Director shall select a medical arbiter physician or a panel of physicians from a list of physicians qualified to be attending physicians who are licensed pursuant to ORS 656.005(12)(b)(A). Arbiters or panel members shall not include any providers whose examination or treatment is the subject of the review.

(a) Any party that objects to a physician on the basis that the physician does not qualify in one of the areas described in subsection (2)(a) of this rule, must notify the Director prior to the examination of the specific objection. If the Director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician. All costs related to the completion of the medical arbiter process in this subsection shall be paid by the insurer.

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

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

(a) Any issues the parties wish the medical arbiter or panel of medical arbiters to address must be submitted to the Department within six (6) working days after the date the reconsideration request is received by the Director. No issues should be submitted to the medical arbiter or panel of medical arbiters directly by the parties. Only issues appropriate to the reconsideration proceeding will be submitted by the Department to the medical arbiter or panel of medical arbiters.

(b) The medical arbiter or panel of medical arbiters shall address all questions raised by the Department in the report. Issues raised directly to the medical arbiter by the parties shall not be addressed in the medical arbiter report.

(c) 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 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 and shall be paid by the insurer.

(4) When the Director refers the claim to a medical arbiter or panel of arbiters and the

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worker fails to appear for the medical arbiter exam:

(a) if the worker presents evidence to the Director that the exam should be rescheduled, the Director shall determine whether it is appropriate to reschedule the exam. The exam shall be rescheduled only when the worker, or the worker's representative, provides evidence at the reconsideration proceeding that the worker was unable to attend the exam for reasons beyond the worker's control.

(b) when the Director determines that the exam should not be rescheduled, or when no evidence is presented by the worker, the record developed at the time of the closure will be used to issue the reconsideration order.

(c) if the insurer requests reconsideration raising a dispute with the impairment findings used in rating the disability, and the worker fails without good cause to appear for the medical arbiter examination, the worker's benefits may be suspended pursuant to OAR 436-60-095. If the insurer pursues suspension of benefits on any claim, the insurer shall provide notice to the worker in accordance with OAR 436-60-095 and shall notify the Department of its intention to seek suspension of benefits if the worker fails to keep the medical arbiter exam.

(5) When a medical arbiter examination is requested by a party and the worker has subsequently become non-medically stationary and/or the claim has been reopened, or where a subsequent unrelated worsening has occurred, a medical arbiter examination is not appropriate. In such cases, the Department 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.

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)

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

Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)

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

Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-175 Fees and Penalties within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-30-135, 145 and 165 may be assessed civil penalties pursuant to OAR 436-30-580. Failure to comply with the requirements set forth in OAR 436-30-135, 145 and 165 may also be grounds for extending the reconsideration proceeding pursuant to ORS 656.268(5).

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

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, shall be found to be at least 20% disabled. As an illustration, a worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether

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scheduled, unscheduled or a combination thereof, shall be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the Department. The reconsideration order shall order the insurer to pay the attorney 10 percent out of any additional compensation awarded but not more than the maximum attorney fee allowed in OAR 438-15-040(1) and (2) and OAR 438-15-045.

Hist: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-185 Reconsideration: Settlements and Withdrawals

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

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

(b) list the body part(s) for which any award is made and shall recite all disability awarded in both degrees and percent of loss when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement, the stated percent of loss shall be controlling

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

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

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

(a) address the disapproval, and/or

(b) to request that the Department issue an Order on Reconsideration addressing the substantive issues.

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

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assistance of the Director to mediate an agreement.

(6) When the parties desire to enter a stipulated agreement that addresses issues including all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the Department 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 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 this subsection is final and is subject to review pursuant to ORS 656.283.

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

(7) A party requesting a reconsideration may withdraw the request for reconsideration if no response or additional information has been submitted by the other party and no medical arbiter exam has occurred. If information has been submitted by the other party, or a medical arbiter exam has occurred, both parties must agree to withdraw the reconsideration. When appropriate, an order withdrawing the reconsideration will be issued.

list: Filed 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp.)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp.)
Amended 1/17/92 as WCD Admin. Order 5-1992, eff. 2/20/92
Amended and renumbered from OAR 436-30-050, 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-575 Audits

(1) Notices of Closure issued by insurers and supporting documentation including, but not limited to, the worksheet upon which the Notice of Closure is based, shall be subject to periodic audit by the Department. Supporting documentation and records shall be maintained in accordance with OAR 436-50.

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

Hist: Filed 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

436-30-580 Penalties and Sanctions

(1) Pursuant to ORS 656.745, the Director or designee may assess a civil penalty against

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an employer or insurer who fails to comply with the rules and orders of the Director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(2) An insurer or medical provider failing to meet the time frame and reporting requirements set forth in OAR 436-30-017, 436-30-020, 436-30-030, 436-30-038, 436-30-045, and 436-30-050 may be assessed a civil penalty.

(3) Pursuant to OAR 436-10-130, the Director may impose sanctions for any medical provider failing to meet the time frame and reporting requirements set forth in OAR 436-30-030(7).

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

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
Amended 1/17/92 as WCD Admin Order 5-1992, eff. 2/20/92
Amended 11/18/94 as WCD Admin. Order 94-059, eff. 1/1/95

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 CONSUMER AND BUSINESS SERVICES, 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

Appendix "A"
Rule Renumbering Cross Reference

NEW SECTION

OLD REFERENCE

Insurer Responsibility

015(1), (1)(a)	New text
015(1)(b)	020(9)
015(1)(c)	New text, deletes 020(7)
015(2)	New text
015(2)(a) thru (e)	030(5)
015(2)(f) and (g)	New text
015(3)(a) thru (e)	030(6)(a) thru (d)
015(4)	030(6)(e)
015(5)	030(3)
015(6)(a) thru (c)	020(5)
015(7)	New text
015(8)	020(9)

Requests for Claim Closure by the Worker

017(1)(a) thru (c)	020(10)
017(2)	New text
017(3)	009(2)
017(4)	New text

Permanent Partial Disability

038	New text
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Reconsideration of Determination Orders of Notices of Closure
(New Sections 115 thru 185 with now deleted Section 050)

115 (1)	050 (1)
115 (2)	050 (2)
115 (3)	New Text

Reconsideration Form and Format

125 (1)(a) thru (c)	050 (4)(a) thru (c)
125 (1)(d) and (e)	New Text
125 (f) thru (j)	050 (4)(d) thru (h)

Reconsideration Procedure

135 (1)(a) thru (e)	050 (5)(a) thru (e)
135 (2)	050 (10)
135 (3)	050 (6)
135 (4)	050 (8)

135 (5)	050 (15)
135 (6)	050 (16)
135 (7)	New Text
135 (7)(a)	050 (17)
135 (7)(b)	050 (18)
135 (7)(c)	050 (19)
135 (8)	050 (20)

Reconsideration Time Frames and Postponements

145 (1)(a) thru (b)	050 (3)(a) thru (b)
145 (c)	New Text
145 (2)(a) thru (b)	050 (7)(a) thru (b)
145 (3)	050 (22)
145 (4)	050 (24)
145(5)	050 (25)
145 (6)	050 (23)
145 (7)	New Text

Reconsideration Record

155	050 (21)
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Medical Arbitrator Examination Process

165 (1)	050 (7)(c)
165 (1)(a)	New Text
165 (1)(b)	050 (7)(c)
165 (1)(c)	050 (7)(d)
165 (1)(d)	050 (11)(c)
165 (1)(e) thru (3)(b)	New Text (some from Division 10-047)
165 (3)(c)	050 (11)(e)
165 (4)	050 (11) thru (a)
165 (4)(a)	New Text
165 (4)(b)	050 (11)(a)
165 4)(c)	050 (11)(b)
165 (5)	050 (11)(d)

Fees and Penalties within the Reconsideration Proceeding

175 (1)	050 (9)
175 (2)	050 (12)
175 (3)	050 (13)
175 (4)	050 (14)

Reconsideration: Settlements and Withdrawals

185 (1) thru (5)	New Text
185 (6)	050 (26)(a) thru (d)
185 (7)	New Text