



Oregon

Theodore R. Kulongoski, Governor

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

Proposed Changes to Workers' Compensation Rules

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

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

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

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

The closing date for written comments is September 27, 2007.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>

Or call (503) 947-7627 to get free paper copies

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

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

OAR CHAPTER 436

Agency and Division	Address	Administrative Rules Chapter Number
Fred Bruyns	PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879	(503) 947- 7717 Fax (503) 947-7581

RULE CAPTION

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

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

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

The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

ADOPT: OAR 436-105-0511; 436-105-0512; 436-160-0400; 436-160-0410; 436-160-0420; 436-160-0430

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

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

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

ORS 656.726(4)

Stat. Auth.

Other Authority

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

Stats. Implemented

RULE SUMMARY

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

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

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

General amendments to OAR chapter 436, including:

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

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

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

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

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

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

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

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

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

- Provide standards for rating impairment for vaginal prolapse;

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

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

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

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

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

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

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

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

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

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

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

Request for public comment: The Workers’ Compensation Division requests public comment on whether other options should be considered for achieving the rules’ substantive goals while reducing the negative economic impact of the rules on business.

Address questions to:

Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us

Proposed rules are available on the Workers’ Compensation Division’s Web site:

<http://wcd.oregon.gov/policy/rules/rules.html#proprules>

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

September 27, 2007
Last Day for Public Comment

John L. Shilts
Authorized Signer and Date

8-14-07

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

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

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

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

OAD CHAPTER 436
Administrative Rules Chapter Number

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

Rule Caption:

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

Statutory Authority: ORS 656.726(4)

Other Authority:

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

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

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

These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

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

Amendments to implement changes in the Workers' Compensation Law

- Senate Bill 504 restricts emergency room physicians' rights to be attending physicians and authorize temporary disability benefits. Overall emergency-room treatment charges can be substantially higher than charges for visits to primary care physicians. In addition, early referral to primary care physicians should improve insurers' ability to keep track of authorization of temporary disability benefits and to promote return-to-work. The agency estimates that these changes should result in a small reduction in insurers' claims costs.
- Senate Bill 563 eliminates the requirement that managed care organizations (MCOs) send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval. In

the “Statement of Need and Fiscal Impact” filed with the Secretary of State on 8/14/06, DCBS estimated reporting costs for such reporting based on advice from MCOs. The low-high range of estimated reporting costs was then \$100 per year to \$50,000 per year per MCO, potentially \$400/year to \$200,000/year for the four active MCOs. The agency projects elimination of these reporting costs for MCOs.

- House Bill 2756 provides authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians. Because we cannot project how many injured workers will choose these providers as their attending physicians, we cannot now project the fiscal impacts. However, DCBS will monitor the effects of HB 2756 to identify impacts over time.
- House Bill 2783 requires insurers to notify the employer of termination of a guaranty contract 45 days in advance instead of the 30 days currently required. In addition, HB 2783 allows for a shorter notice requirement of only 10 days if the termination is based on nonpayment of premium. The agency projects some reductions in costs for insurers, because they can shorten their liability under the 10-day notice provision. The agency projects that these savings will be greater than any increased costs due to the 45-day notice provision, because insurers can adjust notice procedures in order to end liability, in most cases, by a date certain. The agency projects a small positive impact for employers subject to the 45-day notice, as it will give them more time to shop for cost-effective workers’ compensation insurance coverage.

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

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

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

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

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

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

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

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

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

- The agency projects that expanded benefits for the PWP will cost the Workers' Benefit Fund (maximum/annual):
 - Providing Employment Purchases needed to create a new worksite..... \$100,000.00
 - Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment \$100,000.00
 - Total \$200,000.00

- The agency projects that issuing PWP identification cards with no expiration date will increase use of premium exemption and thus increase costs to the Workers' Benefit Fund. However, the impact would be very minor in the near term and increase gradually over time. The agency does not have a basis to project how many workers will use their cards for future employment, but will monitor this closely.

- Additional proposed changes that expand access to reemployment incentives will have lesser impacts on the Workers' Benefit Fund; however, the agency does not have a basis to project how extensively these incentives will be used.

- All moneys paid out of the Workers' Benefit Fund would have a positive economic impact on Oregon employers and insurers. In addition to the direct dollar transfer, by promoting early return to work, the proposed rules may reduce claims costs. In addition, the proposed changes should positively affect injured workers by promoting early return to work, which produces better long-term employment outcomes.

- The Workers' Benefit Fund has adequate reserves to cover any increased costs resulting from proposed rule changes.

Regarding: Additional proposed changes:

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

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

Representatives from small businesses participated in the stakeholder advisory committees.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

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

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

The proposed rule amendments will affect managed care organizations.

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

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

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

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

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

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

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

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

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

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

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

Administrative Rule Advisory Committee consulted:

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

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

John L. Shilts

8-14-07

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Claims Administration
Proposed Oregon Administrative Rules
Chapter 436, Division 060

Summer/Fall 2007

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Revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~
Added text is bold and underlined, as in **Added**

HISTORY LINES: These rules include only the most recent "History" lines. A rule's history line shows when the rule was last revised and its effective date. To obtain a "Chapter 436 revision history index," please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site:

<http://www.wcd.oregon.gov/policy/rules/history.html>

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed Rules CLAIMS ADMINISTRATION

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060

436-060-0008 Administrative Review and Contested Cases

(1) Any party as defined by ORS 656.005, including an assigned claims agent as a designated processing agent under ORS 656.054, aggrieved by an action taken under these rules in which a worker's right to compensation or the amount thereof is directly in issue, 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 where otherwise provided in ORS chapter 656.

(2) Contested case hearings of Sanctions and Civil Penalties: Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director issued under 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 will be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The aggrieved person must file a hearing request with the Administrator of the Workers' Compensation Division within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request for hearing is mailed or delivered to the administrator within 60 days of the mailing date of the proposed order or assessment.

(3) Hearings before an administrative law judge: Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (2), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(4) Administrative review by the director or designee: Any party aggrieved by an action taken under these rules by another person except as described in sections (1) through (3) above may request administrative review by the division on behalf of the director. The process for administrative review of such matters will be as follows:

(a) The request for administrative review must be made in writing to the Administrator of the Workers' Compensation Division within 90 days of the action. No administrative review will be granted unless the request specifies the grounds upon which the action is contested and is mailed or delivered to the administrator within 90 days of the contested action unless the director or the director's designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) In the course of the review, the division may request or allow such input or information from the parties deemed to be helpful.

~~(c) The division's determination will specify whether it is a final order or whether an aggrieved party may request a hearing under section (3).~~

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Stat. Auth: ORS 656.704, 656.726(4), and 656.745

Stat. Impltd: ORS 656.245, 656.260, 656.704, 656.726(4), and 656.740(1) (section 9, chapter 170, Oregon Laws 2003)

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0010 Reporting Requirements

(1) A subject employer must accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative. The employer must provide a copy of the "Report of Job Injury or Illness," Form 440-801 (Form 801) to the worker immediately upon request; the form must be readily available for workers to report their injuries. Proper use of this form satisfies ORS 656.265.

(2) A "First Medical Report," Form 440-827 (Form 827), signed by the worker, is written notice of an accident which may involve a compensable injury under ORS 656.265. The signed Form 827 shall start the claim process, but shall not relieve the worker or employer of the responsibility of filing a Form 801. If a worker reports a claim electronically, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records, under OAR 436-010-0240, necessary to process the claim.

(3) Employers, except self-insured employers, must report the claim to their insurers no later than five days after notice or knowledge of any claim or accident which may result in a compensable injury. The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a claim, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility. The report must provide the information requested on the Form 801, and include, but not be limited to, the worker's name, address, and social security number, the employer's legal name and address, and the data specified by ORS 656.262 and 656.265.

(4) For the purpose of this section, "first aid" means any treatment provided by a person who does not require a license in order to provide the service. If an injured worker requires only first aid, no notice need be given the insurer, unless the worker chooses to file a claim. If a worker signs a Form 801, the claim must be reported to the insurer. If the person must be licensed to legally provide the treatment or if a bill for the service will result, notice must be given to the insurer. When the worker requires only first aid and chooses not to file a claim, the employer must maintain records showing the name of the worker, the date, nature of the injury and first aid provided for ~~one~~ **five** years. These records shall be open to inspection by the director, or any party or its representative. If an employer subsequently learns that such an injury has resulted in medical services, disability or death, the date of that knowledge will be considered as the date on which the employer received notice or knowledge of the claim for the purposes of processing under ORS 656.262.

(5) The director may assess a civil penalty against an employer delinquent in reporting claims to its insurer in excess of ten percent of the employer's total claims during any quarter.

(6) An employer intentionally or repeatedly paying compensation in lieu of reporting to its insurer claims or accidents which may result in a compensable injury claim may be assessed a civil penalty by the director.

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(7) The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, WCD administrative rules, and WCD bulletins. Such filings shall not be made by computer-printed forms, facsimile transmission (FAX), electronic data interchange (EDI), or other electronic means, unless specifically authorized by the director.

(8) When a claim is received and the insurer does not provide insurance coverage for the worker's employer on the date of injury, the insurer may check for other coverage or forward it to the director. The insurer must do one or the other within three days of determining they did not provide coverage on the date of injury. If the insurer checks for coverage and coverage exists, the insurer must send the claim to the correct insurer within the same three day period. If the insurer checks for coverage and coverage cannot be found, the insurer must forward the claim to the director within the same three day period.

(9) The insurer or self-insured employer and third party administrator, if any, must be identified on all insurer generated workers' compensation forms, including insurer name, third party administrator name (if applicable), address, and phone number of the location responsible for processing the claim.

(10) The insurer must file all disabling claims with the director within 14 days of the insurer's initial decision either to accept or deny the claim. To meet this filing requirement, the Insurer's Report, Form 440-1502 (Form 1502) accompanied by the Form 801, or its electronic equivalent, is to be submitted to the director. However, when the Form 801 is not available within a time frame that would allow a timely filing, a Form 1502, accompanied by a signed Form 827 when available, will satisfy the initial reporting requirement. If the Form 801 is not submitted at the time of the initial filing of the claim, the Form 801 must be submitted within 30 days from the filing of the Form 1502. A Form 801 prepared by the insurer in place of obtaining the form from the employer/worker does not satisfy the filing requirement of the Form 801, unless the employer/worker cannot be located, or the form cannot be obtained from the employer/worker due to lack of cooperation, or the form is computer-printed based upon information obtained from the employer and worker. The insurer must submit copies of all acceptance or denial notices not previously submitted to the director with the Form 1502. Form 1502 is used to report claim status and activity to the director.

(11) When submitting an initial compensability decision Form 1502, the insurer must report:

- (a) The status of the claim;
- (b) Reason for filing;
- (c) Whether first payment of compensation was timely, if applicable;
- (d) Whether the claim was accepted or denied timely; and
- (e) Any Managed Care Organization (MCO) enrollment, and the date of enrollment, if applicable.

(12) The insurer must file an additional Form 1502 with the director within 14 days of:

- (a) The date of any reopening of the claim;
- (b) Changes in the acceptance or disability status;

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(c) Any litigation order or insurer's decision that causes reopening of the claim or changes the acceptance or disability status;

(d) MCO enrollment that occurs after the initial Form 1502 has been filed;

(e) The insurer's knowledge that a previous Form 1502 contained erroneous information;
or

(f) The date of any denial.

(13) A nondisabling claim must only be reported to the director if it is denied, in part or whole. It must be reported to the director within 14 days of the date of denial. A nondisabling claim which becomes disabling must be reported to the director within 14 days of the date of the status change.

(14) If the insurer voluntarily reopens a qualified claim under ORS 656.278, it must file a Form 3501 with the director within 14 days of the date the insurer reopens the claim.

(15) The insurer must report a new medical condition reopening on the Form 1502 if the claim cannot be closed within 14 days of the first to occur: acceptance of the new condition, or the insurer's knowledge that interim temporary disability compensation is due and payable.

(16) New condition claims that are ready to be closed within 14 days must be reported on the "Insurer Notice of Closure Summary," Form 440-1503 (Form 1503) at the time the insurer closes the claim. The Form 1503 must be accompanied by the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" letter.

(17) If, after receiving a claim from a worker or from someone other than the worker on the worker's behalf, the insurer receives written communication from the worker stating the worker never intended to file a claim and wants the claim "withdrawn," the insurer must submit a Form 1502 with a copy of the worker's communication to the director, if the claim had previously been reported.

(18) The director may issue a civil penalty against any insurer delinquent in reporting or in submitting Forms 801, 1502, 1503 or 1644 with a late or error ratio in excess of twenty percent during any quarter. For the purposes of this section, a claim or form shall be deemed to have been reported or submitted timely according to the provisions of ORS 656.726(4).

(19) Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms furnished by the director for that purpose. Reports for each calendar year must be filed not later than March 1 of the following year.

(20) If an insurer elects to process and pay supplemental disability benefits, under ORS 656.210(5)(a), the insurer does not need to inform the director of their election. The insurer must request reimbursement, under OAR 436-060-0500, by filing Form 3504 "Supplemental Disability Benefits Quarterly Reimbursement Request" with the director for any quarter during which they processed and paid supplemental disability benefits. If an insurer elects not to process and pay supplemental disability benefits, the insurer must submit Form 3530, "Supplemental Disability Election Notification," to the director. The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election. The

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election is made by the insurer and applies to all third party administrators an insurer may use for processing claims.

(21) An insurer may change its election made under section (20):

(a) Annually and

(b) Once after the division completes its first audit of supplemental disability payments made by the insurer.

Stat. Auth: ORS 656.262, 656.264, 656.265(6), 656.704, 656.726(4) and 656.745

Stat. Impltd: ORS 656.210, 656.262, 656.264, 656.265, 656.704, 656.726(4), and section 3 (5)(a), chapter 865, Oregon Laws 2001

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0015 Required Notice And Information

(1) When an injured worker's attorney has given written notice of representation, prior or simultaneous written notice must be given to the worker's attorney under ORS 656.331:

(a) When the director or insurer requests the worker to submit to a medical examination;

(b) When the insurer contacts the worker regarding any matter which may result in denial, reduction or termination of the worker's benefits; or

(c) When the insurer contacts the worker regarding any matter relating to disposition of a claim under ORS 656.236.

(2) The director shall assess a civil penalty against an insurer who intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) The insurer or the third party administrator must provide the pamphlet, "What Happens if I'm Hurt on the Job?," Form 440-1138 (Form 1138), to every injured worker who has a disabling claim with the first time-loss check or earliest written correspondence. For nondisabling claims, the information page, "~~Understanding workers' compensation claims,~~" "**A Guide for Workers Hurt on the Job,**" Form 440-3283 (Form 3283) may be provided in lieu of Form 1138, unless the worker specifically requests Form 1138.

(4) The insurer must provide Form 3283 to their insured employers for distribution to workers at the time a worker completes a Form 801, for all claims filed.

(5) The insurer must provide the "Notice to Worker," Form 440-3058 (Form 3058) or its equivalent to the worker with the initial notice of acceptance on the claim under OAR 436-060-0140(6). For the purpose of this rule, an equivalent to the Form 3058 must include all of the statutory and rule requirements.

(6) Additional notices the insurer must send to a worker are contained in OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180.

(7) When an insurer changes claims processing locations, third party administrators, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor.

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(8) The insurer must provide the worker an explanation of any change in the wage used that differs from what was initially reported in writing to the insurer. Prior to claim closure on a disabling claim, the insurer must send the worker a notice documenting the wage upon which benefits were based and work disability, if applicable, will be determined when the claim is closed. The notice must also explain how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage. The insurer shall resolve disputes regarding wage calculations under OAR 436-060-0025(4).

Stat. Auth: ORS 656.331, 656.704, 656.726(4), and 656.745
Stat. Impltd: ORS 656.331, 656.704, and 656.726(4)
Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0018 Nondisabling/Disabling Reclassification

(1) When the insurer changes the classification of an accepted claim, the insurer must submit an "Insurer's Report," Form 440-1502 to the director, indicating a change in status within 14 days from the date of the new classification. A notice of change of classification must be communicated by issuing a Modified Notice of Acceptance. This notice must include an explanation of the change in status and must be sent to the director, the worker, and the worker's attorney if the worker is represented. If the claim qualifies for closure, the insurer must close the claim under ORS 656.268(5).

(2) The insurer must reclassify a nondisabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in this rule. A claim is disabling if any of the following criteria apply:

(a) Temporary disability is due and payable; or

(b) 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; or

(c) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary.

(3) Under ORS 656.262 (6)(b)(F) and (7)(a) the insurer must issue a Modified Notice of Acceptance and change the classification from nondisabling to disabling upon acceptance of a new or omitted condition that meets the disabling criteria in this rule.

(4) If a claim has been classified as nondisabling for less than one year after the date of acceptance and the worker believes the claim was or has become disabling, the worker may request reclassification by submitting a written request for review of the classification status to the insurer under ORS 656.277.

(5) Within 14 days of the worker's request, the insurer must review the claim and,

(a) If the classification is changed to disabling, provide notice under this rule; or

(b) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must send a Notice of Refusal to Reclassify to the worker and the worker's attorney, if the worker is represented. The notice must include the following statement, in bold print:

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“If you disagree with this Notice of Refusal to Reclassify, you must appeal by contacting the Workers’ Compensation Division within sixty (60) days of the mailing of this notice or you will lose your right to appeal. The address and telephone number of the Workers’ Compensation Division are: [INSURER: Insert current address and telephone number of the Workers’ Compensation Division, Appellate Review Unit, here.]”

(6) A worker dissatisfied with the decision in the Notice of Refusal to Reclassify may appeal to the director. Such appeal must be made no later than the 60th day after the Notice is mailed. The appeal must **include** ~~be accompanied by~~ **a copy of the insurer’s Notice of Refusal to Reclassify.**

- ~~(a) A copy of all Notices of Acceptance in the claim,~~
- ~~(b) A copy of the request for reclassification the worker sent to the insurer, and~~
- ~~(c) A copy of the insurer’s Notice of Refusal to Reclassify that the worker received in response.~~

(7) For claims that are reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights begin with the first valid closure of the claim.

(8) For claims that are not reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights continue to run from the date of injury.

(9) When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation according to the provisions of ORS 656.273.

(10) Failure of the insurer or self-insured employer to respond timely to a request for reclassification may result in penalties under OAR 436-060-0200.

(11) Notwithstanding (12), once a claim has been accepted and classified as disabling for more than one year from date of acceptance, all aspects of the claim are classified as disabling and remain disabling. Any additional conditions or aggravations subsequently accepted must be processed according to provisions governing disabling claims, including closure under ORS 656.268.

(12) If a claim has been classified as disabling and the insurer determines the criteria for a disabling claim were never satisfied, the insurer may reclassify the claim to nondisabling. The insurer must notify the worker and the worker’s representative, if applicable, by issuing a Modified Notice of Acceptance.

(a) The Modified Notice of Acceptance must advise the worker that he or she has 60 days from the date of the notice to appeal the decision.

(b) Appeals of such reclassification decisions are made to the Appellate Review Unit for issuance of a Director’s Review order.

(13) The worker’s appeal must be in writing. The worker may use the form specified by the director for requesting review of the insurer’s claim classification decision.

(14) The worker’s appeal under section (6) or (12) must be copied to the insurer.

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(15) A worker need not be represented by an attorney to appeal the insurer's classification decision.

(16) The director will acknowledge receipt of the request in writing to the injured worker, the worker's attorney, if any, and the insurer, and initiate the review.

(17) Within 14 days of the director's acknowledgement, the insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The insurer may be subject to penalties under OAR 436-060-0200 for failure to provide claim documents in a timely manner.

(18) Within the same 14 days, the worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time.

(19) After receiving and reviewing the required documents, the director will issue a Director's Review order.

(20) The worker and the insurer have 30 days from the mailing date of the Director's Review order to appeal the director's decision to the Hearings Division of the Workers' Compensation Board.

(21) The director may reconsider, abate, or withdraw any Director's Review order before the order becomes final by operation of law.

Stat. Auth.: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313

Stats. Implemented: ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.262, ORS 656.268, ORS 656.273, ORS 656.277, ORS 656.745, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 350, Oregon Laws 2001

Hist: Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05

436-060-0055 Payment of Medical Services on Nondisabling Claims; Employer/Insurer Responsibility

Under ORS 656.262(5) **the Director will establish the maximum reimbursable amount for medical services. The maximum reimbursable amount will be published annually by Bulletin No. 345.** ~~†~~The costs of medical services for nondisabling claims, ~~in~~ amounts not to exceed \$500 per claim, for dates of injury prior to January 1, 2006, or \$1,500 per claim, for dates of injury on or after January 1, 2006, must first be paid by the insurer. Then the insurer may be reimbursed by the employer if the employer so chooses. Such choice does not relieve the employers of their claim reporting requirements or the insurers of their responsibility to determine entitlement to benefits and process the claims accurately and timely. Also, when paid by the employer, such costs cannot in any way be used to affect the employer's experience rating modification or otherwise be charged against the employer. To enable the director to ensure these conditions are met, insurers and employers must comply with the following process and procedures:

(1) Notwithstanding the choice made by the employer under section (2) of this rule, the employer and insurer must process the nondisabling claims in accordance with all statutes and rules governing claims processing. The employer, however, may reimburse the medical service costs paid by the insurer if the employer has chosen to make such payments. The method and manner of reimbursement by the employer shall be as prescribed in section (3) of this rule. In no case, however, shall the employer have less than 30 days to reimburse the insurer.

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(2) Prior to the commencement of each policy year, the insurer must send a notice to the insured or prospective insured, advising of the employer's right to reimburse medical service costs up to the maximum amount established by the director \$500 per claim, for dates of injury prior to January 1, 2006, or \$1,500 per claim, for dates of injury on or after January 1, 2006, on accepted, nondisabling claims. The notice must advise the employer:

- (a) Of the procedure for making such payments as outlined in section (3) of this rule;
- (b) Of the general impact on the employer if the employer chooses to make such payments;
- (c) That the employer is choosing not to participate if the employer does not respond in writing within 30 days of receipt of the insurer's notice;
- (d) That the employer's written election to participate in the reimbursement program remains in effect, without further notice from the insurer, until the employer advises otherwise in writing or is no longer insured by the insurer; and
- (e) That the employer may participate later in the policy period upon written request to the insurer, however, the earliest reimbursement period shall be the first completed period, established under subsection (3)(a) of this rule, following receipt of the employer's request.

(3) If the employer wishes to make such reimbursement, and so advises the insurer in writing, the procedure for reimbursement shall be:

- (a) Within 30 days following each three month period after policy inception or a period mutually agreed upon by the employer and insurer, the insurer must provide the employer with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim.
- (b) The employer, no later than 30 days after receipt of the list, must identify those claims and the dollar amount the employer wishes to pay for that period and reimburse the insurer accordingly.
- (c) Failure by the employer to reimburse the insurer within the 30 days allowed by subsection (3)(b) of this rule shall be deemed notice to the insurer that the employer does not wish to make a reimbursement for that period.
- (d) Notwithstanding subsection (3)(b) of this rule, the employer and insurer may, by written agreement, establish a period in excess of thirty (30) days for the employer to reimburse the insurer.
- (e) The insurer shall continue to bill the employer for any payments made on the claims within 27 months of the inception of the policy period. Any further billing and reimbursement will be made only by mutual agreement between the employer and the insurer.

(4) Insurers must maintain records of amounts reimbursed by employers for medical services on nondisabling claims. Insurers, however, shall not modify an employer's experience rating or otherwise make charges against the employer for any medical services reimbursed by the employer. For employers on retrospective rated plans, medical costs paid by the employer on nondisabling claims must be included in the retrospective premium calculation, but the amount paid by the employer shall be applied as credits against the resulting retrospective premium.

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(5) If a claim changes from a nondisabling to a disabling claim and the insurer has recovered reimbursement from the employer for medical costs billed by the insurer prior to the change, the insurer shall exclude those amounts reimbursed from any experience rating, or other individual or group rating plans of the employer. If the employer is on a retrospective rated plan, premium calculation shall be as provided in section (4) of this rule.

(6) Insurers who do not comply with the requirements of this rule or in any way prohibit an employer from reimbursing the insurer under section (3) of this rule, shall be subject to a penalty as provided by OAR 436-060-0200(7).

(7) Self-insured employers must maintain records of all amounts paid for medical services on nondisabling claims in accordance with OAR 436-050-0220. When reporting loss data for experience rating, the self-insured may exclude costs for medical services paid on nondisabling claims in amounts not to exceed **the maximum amount established by the director**, \$500 per claim, for dates of injury prior to January 1, 2006, or \$1,500 per claim, for dates of injury on or after January 1, 2006.

Stat. Auth: ORS 656.262(5), 656.704, 656.726(4), and 656.745

Stat. Impltd: ORS 656.262(5), 656.704, and 656.726(4)

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0060 Lump Sum Payment of Permanent Partial Disability Awards

(1) Under ORS 656.230, in all cases where an award for permanent partial disability does not exceed \$6,000, the insurer must pay all of the award to the worker in a lump sum. When the award for permanent partial disability exceeds \$6,000, the insurer ~~or director~~ may approve an application of ~~of~~ **from** the worker **or worker's representative** for lump sum payment **of all or part of the award. The insurer may deny the request for lump sum payment if any of the following apply:** ~~when the order has become final by operation of law or the worker has waived their right to appeal the adequacy of the award. The lump sum application shall be in the form and format provided by the director.~~

(a) The worker has not waived the right to appeal the adequacy of the award;

(b) The award has not become final by operation of law;

(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) The worker is enrolled and actively engaged in training according to the rules adopted pursuant to ORS 656.340 and 656.726. For dates of injury prior to January 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after January 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(A) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;

(B) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or

(C) Has temporarily withdrawn from such a program.

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(2) When an insurer receives a request for a lump sum application from the worker or the worker's representative, the insurer must send the lump sum application form to the requestor within ten business days.

(3) For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.

(4) If the insurer agrees with the worker's request for lump sum payment of a permanent partial disability award in excess of \$6,000, they must make the lump sum payment within 14 days of receipt of the signed application.

(5) If the insurer disagrees with the worker's request for lump sum payment of a permanent partial disability award in excess of \$6,000, the insurer must **respond to the requestor within 14 days of receiving the request explaining the reason for denying the lump sum request.** ~~submit the lump sum application with the reason for disagreement to the director within 14 days of receipt of the signed application. The insurer must simultaneously copy the worker and the worker's attorney, if represented, of the disagreement and submission to the division.~~

~~(6) For dates of injury prior to January 1, 2005, the insurer or the division may not approve an application for lump sum payment of unscheduled permanent disability when the worker:~~

~~—— (a) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;~~

~~—— (b) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or~~

~~(c) Has temporarily withdrawn from such a program.~~

~~—— (7) For dates of injury on or after January 1, 2005, the insurer or the division may not approve an application for lump sum payment of work disability when the worker:~~

~~—— (a) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;~~

~~—— (b) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or~~

~~(c) Has temporarily withdrawn from such a program.~~

~~(8) The insurer or the division shall not approve an application for lump sum payment of permanent disability when the worker is involved in litigation affecting the permanent partial disability award.~~

~~—— (9) When the division approves a disputed application, the insurer must pay the lump sum amount to the worker within 14 days after the mailing of the order.~~

~~—— (10) If any party disagrees with the decision of the division, the party may petition the director to reconsider the decision within 14 days after the mailing of the decision. Appeal of an~~

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~~order approving a lump sum payment stays payment of the lump sum until the director's review is complete and an order on the appeal is issued. The director's decision shall be final and not subject to review.~~

~~(11) (6)~~ A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement under ORS 656.236 does not require further approval by the insurer or the division.

~~(12) (7)~~ When a partial payment is approved by the insurer or the division, it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid under ORS 656.216. Denial or partial approval of an application **a request** does not prevent another application **request** by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.

Stat. Auth: ORS 656.704 and 656.726(4)

Stat. Impltd: ORS 656.230, 656.704, and 656.726(4)

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0140 Acceptance or Denial of a Claim

(1) The insurer is required to conduct a "reasonable" investigation based on all available information in ascertaining whether to deny a claim. A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(2) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(3) The insurer must give the claimant written notice of acceptance or denial of a claim within:

(a) 90 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical condition claim for claims with a date of injury prior to January 1, 2002; or

(b) 60 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical or omitted condition claim for claims with a date of injury on or after January 1, 2002; or

(c) 90 days after the employer's notice or knowledge of the claim if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, regardless of the date of injury.

(4) The director may assess a penalty against any insurer delinquent in accepting or denying a claim beyond the days required in (3) in excess of 10 percent of their total volume of reported disabling claims during any quarter.

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(5) A notice of acceptance must comply with ORS 656.262(6)(b) and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's representative, if any, and the worker's attending physician, and specify to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) Of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) Of the employment reinstatement rights and responsibilities under ORS chapter 659A;

(e) Of assistance available to employers from the Reemployment Assistance Program under ORS 656.622;

(f) That expenses personally paid for claim related expenses up to a maximum established rate must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses;

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(6) On fatal claims, the notice must be addressed "to the estate of" the worker and the requirements in (5)(a) through (h) shall not be included.

(7) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice. When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015. Additionally, when reopening a claim, the notice of acceptance must specify the condition(s) for which the claim is being reopened. Under ORS 656.262(6)(b)(F) the insurer must modify acceptance from time to time as medical or other information changes. An insurer must issue a "Modified Notice of Acceptance" (MNOA) when they:

(a) Accept a new or omitted condition: on a nondisabling claim, while a disabling claim is open or after claim closure;

(b) Accept an aggravation claim;

(c) Change the disabling status of the claim; or

(d) Amend a notice of acceptance, including correcting a clerical error.

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(8) Notwithstanding OAR 436-060-0140(7)(d), to correct an omission or error in an "Updated Notice of Acceptance at Closure"(UNOA), under OAR 436-030-0015(1)(e), the insurer must add the word "Corrected" to the UNOA.

(9) When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267.

(10) A notice of denial must comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438, and must:

(a) Specify the factual and legal reasons for the denial, including the worker's right to request a Worker Requested Medical Examination and a specific statement indicating if the denial was based in whole or part on an independent medical examination, under ORS 656.325, and one of the following statements, as appropriate:

(A) "Your attending physician agreed with the independent medical examination report";
or

(B) "Your attending physician did not agree with the independent medical examination report"; or

(C) "Your attending physician has not commented on the independent medical examination report"; and

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283.

(c) If the denial is under ORS 656.262(14), it must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291.

(d) If paragraph (10)(a)(B) above applies, the denial notice must also include the division's Web site address and toll free Infoline number for the worker's use in obtaining a brochure about the Worker Requested Medical Examination.

(11) The insurer must send notice of the denial to each provider of medical services and health insurance when compensability of any portion of a claim for medical services is denied **when any of the following applies:**

(a) ~~at the same time as~~ The denial is sent to the worker;

(b) **Within 14 days of receipt of** ~~If the insurer receives any billings from medical providers~~ **not previously notified of the denial.** ~~after claim denial, they must send a copy of the denial to the medical provider and~~ **The notice must** advise the medical provider of the status of the denial; or

(c) **Within 60 days of the compensability date when** ~~When~~ compensability of the claim has been finally determined or when disposition of the claim has been made, ~~the insurer must notify each affected service provider of the results of the compensability determination or disposition.~~ The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(12) The insurer must pay compensation due under ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident

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as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer must report to the division payments of compensation made by the employer as if the insurer had made the payment.

(13) Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include the costs of medical benefits or burial.

Stat. Auth: ORS 656.704 and 656.726(4)

Stat. Impltd: ORS 656.262(6), 656.704, 656.726(4), and sections 7 (6)(a) and 13 (1)(b), chapter 865, Oregon Laws 2001

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0147 Worker Requested Medical Examination

(1) The director shall determine the worker's eligibility for a Worker Requested Medical Examination (Exam) under ORS 656.325(1). The worker is eligible for an exam if the worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability as required by ORS 656.319(1)(a); and the denial was based on one or more Independent Medical Examination reports with which the attending physician or authorized nurse practitioner disagreed.

(2) The worker must submit a request for the exam to the director. A copy of the request must be sent simultaneously to the insurer or self-insured employer. The request must include:

(a) The name, address, and claim identifying information of the injured worker;

(b) A list of physicians, including name(s) and address(es), who have previously provided medical services to the worker on this claim or who have previously provided medical services to the worker related to the claimed condition(s);

(c) The date the worker requested a hearing and a copy of the hearing request;

(d) A copy of the insurer's denial letter; and

(e) Document(s) that demonstrate that the attending physician or authorized nurse practitioner did not concur with the independent medical examination report(s).

(3) The insurer must, upon written notice from the worker, mail to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:

(a) Acted as attending physician or authorized nurse practitioner;

(b) Provided medical consultations and/or treatment to the worker;

(c) Examined the worker at an independent medical examination; or

(d) Reviewed the worker's medical records on this claim. For the purpose of this rule, "Attending Physician" and "Independent Medical Examination" have the meanings defined in OAR 436-010-0005 and 436-010-0265(1), respectively.

(4) Failure to provide the required documentation described in section ~~(4)~~ **(3)** in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(5) The director will notify all parties in writing of the physician selected, or will provide the worker or the worker's representative a list of appropriate physicians.

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(6) If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's representative's response must be in writing, signed, and received by the director within ten business days of providing the list.

(b) The worker or the worker's representative may eliminate the name of one physician from the list.

(c) If the worker or the worker's representative does not respond as provided in this section, the director will select a physician.

(d) The director will notify the parties in writing of the physician selected.

(7) The worker and/or the worker's legal representative shall schedule the exam with the selected physician and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the notification date in (6) of this rule. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(8) The insurer must send the physician the worker's complete medical record on this claim and the original questions asked of the independent medical examination(s) physician(s) no later than 14 days prior to the date of the scheduled exam.

(9) The worker or the worker's representative shall communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days prior to the scheduled date of the exam. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(10) Upon completion of the exam the physician must address the original independent medical examination(s) questions and the questions from the worker or the worker's representative under section (9) of this rule and send the report to the worker's legal representative, if any, or the worker, and the insurer within 5 working days.

(11) The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Delivery of medical services to injured workers shall be in accordance with OAR 436-010.

(12) If the worker fails to attend the scheduled Worker Requested Medical Exam, the insurer must pay the physician for the missed examination. The insurer is not required to pay for another examination unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

(13) The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Stat. Auth: ORS 656.704, 656.726(4), and section 13 (1)(b), chapter 865, Oregon Laws 2001

Stat. Impltd: ORS 656.325(1), 656.704, and 656.726(4)

Hist: Amended 12/5/05 as WCD Admin. Order 05-077, eff. 1/1/06

436-060-0150 Timely Payment of Compensation

(1) Benefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail or deposited in the worker's or beneficiary's account by approved electronic equivalent. Payments falling due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day prior to or the first working day

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following the weekend or legal holiday. Subsequent payments may revert back to the payment schedule prior to the weekend or legal holiday.

(2) For the purpose of this rule, legal holidays in the State of Oregon are:

- (a) Each Sunday;
- (b) New Year's Day on January 1;
- (c) Martin Luther King, Jr.'s Birthday on the third Monday in January;
- (d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;
- (e) Memorial Day on the last Monday in May;
- (f) Independence Day on July 4;
- (g) Labor Day on the first Monday in September;
- (h) Veterans Day on November 11;
- (i) Thanksgiving Day on the fourth Thursday in November; and
- (j) Christmas Day on December 25.

(k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday shall be a legal holiday. Each time a holiday falls on Saturday, the preceding Friday shall be a legal holiday.

(l) Additional legal holidays shall include every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) First payment of time loss must be timely. An insurer's performance is in compliance when 90 percent of payments are timely. The director may assess a penalty against an insurer falling below these norms during any quarter.

(4) Compensation withheld under ORS 656.268(12) and (13), and ORS 656.596(2), shall not be deemed untimely provided the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(5) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:

(a) The date of the employer's notice or knowledge of the claim, provided the attending physician or authorized nurse practitioner has authorized temporary disability. Temporary disability accrued prior to the date of the employer's notice or knowledge of the claim shall be due within 14 days of claim acceptance;

(b) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim;

(c) The start of authorized vocational training under ORS 656.268(9), if the claim has previously been closed;

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(d) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;

(e) The date of any division order, including, but not limited to, a reconsideration order, which orders payment of temporary disability. If a reconsideration order has been appealed by the insurer, the appeal stays payment of temporary disability benefits except those which accrue from the date of the order, under ORS 656.313;

(f) The date of a notice of claim closure issued by the insurer which finds the worker entitled to temporary disability;

(g) The date a notice of closure is set aside by a reconsideration order;

(h) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the signature date and from the courts, it is the date of the appellate judgment;

(i) The date the division refers a claim to the insurer for processing under ORS 656.029;

(j) The date the division refers a noncomplying employer claim to an assigned claims agent under ORS 656.054; or

(k) The date a claim disposition is disapproved by the Board **or Administrative Law Judge**, if temporary disability benefits are otherwise due;

(l) The date the division designates a paying agent under ORS 656.307;

(m) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; and

(n) The date an insurer voluntarily rescinds a denial of a disabling claim.

(6) Temporary disability must be paid to within seven days of the date of payment at least once each 14 days. When making payments as provided in OAR 436-060-0020(1), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals.

(7) Permanent disability and fatal benefits must be paid no later than the 30th day after:

(a) The date of a notice of claim closure issued by the insurer;

(b) The date of any litigation order which orders payment of permanent total disability or fatal benefits. Permanent total or fatal benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the signature date and from the courts it is the date of the appellate judgment;

(c) The date of any division order, including, but not limited to, a reconsideration order, which orders payment of compensation for permanent disability;

(d) The date any litigation authorizing permanent partial disability becomes final; or

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(e) The date a claim disposition is disapproved by the Board **or Administrative Law Judge**, if permanent disability benefits are otherwise due.

(f) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(9) and OAR 436-060-0040(2).

(8) Subsequent payments of permanent disability and fatal benefits are made in monthly sequence. The insurer may adjust monthly payment dates, but must inform the beneficiary prior to making the adjustment. No payment period shall exceed one month without the division approval.

(9) The insurer must notify the worker or beneficiary in writing when compensation is paid of the specific purpose of the payment, the time period for which the payment is made, and the reimbursable expenses. The insurer must maintain records of compensation paid for each claim where benefits are due and payable. If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for non-payment or reduction of each item.

(10) Payment of a Claim Disposition Agreement must be made no later than the 14th day after the Board **or Administrative Law Judge** mails notice of its approval of the agreement to the parties, unless otherwise stated in the agreement.

(11) Under ORS 656.126(6), when Oregon compensation is more than the compensation under another law for the same injury or occupational disease, or compensation paid the worker under another law is recovered from the worker for the same injury or occupational disease, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Stat. Auth: ORS 656.704 and 656.726(4)

Stat. Impltd: ORS 656.262(4), 656.268(9), 656.273, 656.278, 656.289, 656.307, 656.313, 656.704, and 656.726(4)

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