Oregon
Kate Brown, Governor

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April 21, 2022

Proposed Changes to
Workers' Compensation Rules

Caption: Replacement of gender-specific pronouns

The Workers' Compensation Division proposes to amend OAR chapter 436.

How can I make a comment? Send written comments to the rules coordinator, by:

Email – WCD.Policy@dcbs.oregon.gov
or
US Mail –
Workers' Compensation Division
PO Box 14480
Salem, OR 97309-0405
or
Fax – 503-947-7514

The closing date for written comments is May 24, 2022.

Questions? Contact Fred Bruyns, 971-286-0316.

Proposed rules and public testimony are available on the Workers' Compensation Division's website: **http://wcd.oregon.gov/laws/Pages/proposed-rules.aspx**. Or, call 971-286-0316 to get paper copies.

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

Summary of proposed changes: Each of the rules below is amended to remove gender-specific pronouns "he," "she," "his," and "her."

436-009-0010	436-010-0270	436-035-0385	436-120-0145
436-009-0025	436-015-0070	436-035-0390	436-120-0157
436-010-0210	436-030-0015	436-060-0075	436-120-0165
436-010-0220	436-030-0055	436-105-0520	436-120-0175
436-010-0240	436-035-0230	436-110-0350	436-120-0443
436-010-0265	436-035-0380	436-120-0115	436-120-0820

The agency 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.

Need for the Rule(s): The proposed amendments are needed to ensure the workers' compensation rules are gender-neutral. The Oregon Court of Appeals decided in *Hollister, 305 Or App 368 (2020)* that a person may legally change their sex to nonbinary. Gov. Kate Brown, in Executive Order 19-08, "Ensuring Equal Treatment under Law to Oregon's LGBT+ Community," stated, in part, that an agency of the executive branch of state government may not discriminate against any person on the basis of sexual orientation or gender identity when discharging government functions.

Documents Relied Upon, and where they are available: Court of Appeals decision in *Hollister, 305 Or App 368 (2020)*. Gov. Kate Brown's Executive Order 19-08. These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Fred Bruyns, rules coordinator, 971-286-0316, WCD.Policy@dcbs.oregon.gov.

Fiscal and Economic Impact: The agency projects the proposed amendments to these rules, if adopted, will not affect the agency's cost to carry out its responsibilities under ORS chapter 656 and OAR chapter 436.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
a. The agency estimates that proposed rule changes will not increase or decrease costs to state agencies for compliance with the rule.

b. The agency estimates that proposed rule changes will not increase or decrease costs to units of local government for compliance with the rule.

c. The agency estimates that proposed rule changes will not increase or decrease costs to the public for compliance with the rule.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

The proposed rule amendments, if adopted, will not require any actions or increase costs for businesses of any size.

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

The agency projects that proposed rule amendments, if adopted, will not increase costs for reporting, recordkeeping, other administrative activities required for compliance, including the costs of professional services.

c. Equipment, supplies, labor and increased administration required for compliance:
The agency projects that proposed rule amendments, if adopted, will not increase costs for equipment, supplies, labor, or increased administration required for compliance.

How were small businesses involved in the development of this rule? The agency did not consult business representatives regarding the proposed wording changes, because the changes should not affect the interests of businesses large or small, but the agency welcomes input about any impacts.

Statement identifying how adoption of the rule will affect racial equity in this state: The proposed rule amendments, if adopted, will not affect the rights, benefits, or responsibilities of any person, but they make the language in the rules more inclusive. There should be no impact on racial equity in Oregon, but the agency welcomes input about any impacts.

Administrative Rule Advisory Committee consulted?: No **If not, why?** The proposed rule amendments, if adopted, will not affect the rights, benefits, or responsibilities of any persons or communities subject to the Oregon workers' compensation rules. Therefore, forming and consulting an advisory committee would not be an appropriate use of stakeholders' time.

Sally Coen	April 21, 2022
Authorized Signer	Printed name	Date

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Oregon Administrative Rules
Chapter 436

Proposed

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NOTE: Revisions are marked: new text | ~~deleted text~~.

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436-009-0010 Medical Billing and Payment

(1) General.

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim.

Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner.

Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

(f) When rebilling, medical providers must indicate that the charges have been previously billed.

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)

(a) Medical providers must bill within:

(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause.

(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

(3) Billing Forms.

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:

(A) Dental billings, which must be submitted on American Dental Association dental claim forms;

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or

(C) Electronic billing transmissions of medical bills (see OAR 436-008).

(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.

(d) Medical providers may use computer-generated reproductions of the appropriate forms.

(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2022 or in OAR 436-009-0004(3); • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2022 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the nonshaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2022, OAR 436-009-0004(3), or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service.

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2022 or the appropriate unlisted HCPCS code, and provide a description of the service provided.

A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2022, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

(A) Unusually lengthy procedure;

(B) Excessive blood loss during the procedure;

(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);

(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or

(F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."

(7) Chart Notes.

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider's Bill.

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.

(9) Billing the Patient and Patient Liability.

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that ~~he or she is~~they are medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(c) A provider may bill a patient for a missed appointment under section (13) of this rule.

(10) Disputed Claim Settlement (DCS).

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) Payment Limitations.

(a) Insurers do not have to pay providers for the following:

(A) Completing forms 827 and 4909;

(B) Providing chart notes with the original bill;

(C) Preparing a written treatment plan;

(D) Supplying progress notes that document the services billed;

(E) Completing a work release form or completion of a PCE form, when no tests are performed;

(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or

(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.

(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) Excluded Treatment.

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface electromyography (EMG) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography;

(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:

(A) The single level artificial disc replacement is between L3 and S1;

(B) The patient is 16 to 60 years old;

(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and

(D) The procedure is not found inappropriate under OAR 436-010-0230;

(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and

(i) Platelet rich plasma (PRP) injections.

(13) Missed Appointment (No Show).

(a) In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:

(A) The provider has a written missed-appointment policy that applies not only to workers' compensation patients, but to all patients;

(B) The provider routinely notifies all patients of the missed-appointment policy;

(C) The provider's written missed-appointment policy shows the cost to the patient; and

(D) The patient has signed the missed-appointment policy.

(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.

Stat. Auth.: ORS 656.245, 656.248, 656.252, 656.254, 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254
Hist: Amended 12/14/21 as Admin. Order 21-059, eff. 1/1/22 (temp)
Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22

436-009-0025 Worker Reimbursement

(1) General.

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

(A) The insurer will reimburse claim-related services paid by the worker; and

(B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use Form 3921 – Request for Reimbursement of Expenses.

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

(A) The amount of reimbursement for each type of out-of-pocket expense requested.

(B) The specific reason for nonpayment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within two days, excluding Saturdays, Sundays, and legal holidays;

(D) The following notice, Web link, and phone number:

"To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit wcd.oregon.gov or call 503-947-7606.";

(E) Space for the worker's signature and date; and

(F) A notice of right to administrative review as follows:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(4), when a worker attends an independent medical

examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) Timeframes.

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

(A) Two years from the date the costs were incurred or

(B) Two years from the date the claim or medical condition is finally determined compensable.

(b) The insurer may disapprove the reimbursement request if the worker requests reimbursement after two years as listed in subsection (a).

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement or disapprove the request.

(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, the insurer must, within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day or 14-day time frame for the insurer to issue reimbursement or disapprove the request.

(e) When any action, other than those listed in subsections (c) and (d) of this section, causes the reimbursement request to be payable, the insurer must reimburse the worker within 14 days of the action.

(f) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(g) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) Meal and Lodging Reimbursement.

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(4) Travel Reimbursement.

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer must inform the worker that ~~he or she~~the worker may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112.

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

(5) Other Reimbursements.

(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515.

When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug

out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.

(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) Advancement Request.

If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth: ORS 656.245, 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22

436-010-0210 Attending Physician, Authorized Nurse Practitioner, and Temporary Disability Authorization

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes temporary disability, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

(b) Type A and B attending physicians and authorized nurse practitioners may authorize temporary disability and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

(2) Chiropractic Physicians, Naturopathic Physicians, Physician Assistants (Type B providers).

(a) Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director.

(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days or 18 visits, whichever occurs first, from the first visit on the initial claim with any type B provider.

(c) Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim to any type B provider.

(d) Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(3) Emergency Room Physicians.

Emergency room physicians may authorize temporary disability for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in ~~his or her~~the physician's private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

(4) Authorized Nurse Practitioners.

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

(5) Unlicensed to Provide Medical Services.

Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(6) Out-of-State Attending Physicians.

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days. If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician.

(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

(A) The Oregon medical fee and payment rules, OAR 436-009;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and

(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

(b) If the insurer disapproves the worker's out-of-state attending physician or withdraws a prior approval, the insurer must send the worker written notice that:

(A) Clearly states the reasons for the disapproval or withdrawal of the prior approval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010;

(B) Identifies at least two other physicians of the same healing art and specialty in the same area that the insurer would approve;

(C) Informs the worker that if the worker disagrees with the disapproval or withdrawal, the worker may request approval from the director under OAR 436-010-0220; and

(D) Informs the worker that the worker may be liable for payment of services provided after the date of notification if the worker receives further medical services from the disapproved or no longer approved out-of-state physician.

(c) If the insurer withdraws approval of the out-of-state attending physician, the insurer must notify the physician of the following in writing:

(A) The reasons for withdrawing the approval;

(B) That any future services provided by that physician will not be paid by the insurer; and

(C) That the worker may be liable for payment of services provided after the date of notification.

(d) The worker or worker's representative may request approval from the director under OAR 436-010-0220 if the worker disagrees with the insurer's decision to:

(A) Disapprove an out-of-state attending physician; or

(B) Withdraw the approval of the out-of-state attending physician.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.005(12), 656.245, 656.260
Hist: Amended 3/11/19 as Admin. Order 19-052, eff. 4/1/19

Appendix A - Matrix for health care provider types * See OAR 436-010-0210

	Attending physician status (primarily responsible for treatment of a patient)	Provide compensable medical services for initial injury or illness	Authorize payment of temporary disability and release the patient to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathic medicine Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician Physician assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan. (Note: physician assistants are not required to have a written treatment plan)	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	An ER physician who is not authorized to serve as attending physician under ORS 656.005(12)(c) may authorize temporary disability for up to 14 days, including retroactive authorization.	No, if patient referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit with any authorized nurse practitioner on the initial claim.	No	No, unless authorized by the attending physician
"Other Health Care Providers" e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any "Other Health Care Providers." Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

436-010-0220 Choosing and Changing Medical Providers

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment ~~he or she~~the physician considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:

(a) Emergency services;

(b) Insurer or director requested examinations;

(c) A Worker Requested Medical Examination;

(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and

(e) Diagnostic studies provided by radiologists and pathologists upon referral.

(2) Changing Attending Physician or Authorized Nurse Practitioner.

The worker may choose to change ~~his or her~~ attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;

(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or

(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:

(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;

(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;

(D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");

(E) When the authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;

(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or

(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(3) Insurer Notice to the Worker.

When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change ~~his or her~~ attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.

(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:

(A) Send the worker a written explanation of the reasons;

(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and

(C) Inform the worker that ~~he or she~~the worker may request director approval by sending Form 2332 to the director.

(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse

practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.

(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:

(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(d) Any party that disagrees with the director's order 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.

(5) Managed Care Organization (MCO) Enrolled Workers.

(a) An MCO enrolled worker must choose:

(A) A panel provider unless the MCO approves a non-panel provider, or

(B) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.

(b) Notwithstanding subsection (a) of this section, if a worker is unable to find three providers that are willing to treat the worker in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's geographic service area (GSA), the worker may contact the MCO for a list of three providers who are willing to treat the worker. If the MCO, within a reasonable period of time, is unable to provide a list of three providers who are willing to treat the worker, the worker may choose a non-panel provider in that category.

(c) Notwithstanding subsection (a) of this section, if the MCO has fewer than three providers in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's GSA, the worker may choose a non-panel provider in that category.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.252, 656.260
Hist: Amended 3/11/19 as Admin. Order 19-052, eff. 4/1/19

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

(1) Medical Records and Reports.

(a) Medical providers must maintain records necessary to document the extent of medical services provided.

(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).

(2) Diagnostic Studies.

When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs.

When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and

(B) HIV-related information protected by ORS 433.045.

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

(A) Psychotherapy notes;

(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or ~~his or her~~the patient's representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of ~~his or her~~the patient's medical records because of inability to pay.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

(6) Temporary Disability and Medically Stationary.

(a) When temporary disability is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request. If the medical provider fails to provide information under this rule within 14 days of receiving a request sent by fax or certified mail, penalties under OAR 436-010-0340 may be imposed.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

(A) The anticipated date of release to work;

(B) The anticipated date the patient will become medically stationary;

(C) The next appointment date; and

(D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

(7) Consultations.

When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 3/11/19 as Admin. Order 19-052, eff. 4/1/19

436-010-0265 Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs)

(1) General.

(a) An independent medical exam (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325, except as provided in section (13) of this rule. A worker requested medical exam (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker's attending physician or authorized nurse practitioner.

(b) The insurer may obtain three IMEs for each opening of the claim without authorization by the director. These IMEs may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as one of the three IMEs. A claim for aggravation, Board's Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training under OAR 436-120 (Vocational Assistance to Injured Workers) allows a new series of three IMEs. Refer to section (12) of this rule to request additional IMEs.

(c) The IME may be conducted by one or more providers of different specialties, generally performed at one location. If the providers are not at one location, the IME must be at locations reasonably convenient to the worker. IMEs completed within a 72-hour period count as one IME.

(d) The insurer must choose the medical service provider from the director's list of authorized IME providers online at www.oregonwcdoc.info. If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

(e) The provider will determine the conditions under which the IME will be conducted. The IME should be performed in a professional setting that is primarily used for conducting exams. If an IME is not performed in a professional setting that is primarily used for conducting exams, the IME location should be a safe and secure environment, including a place for the worker to disrobe in private, and allow for confidentiality.

(f) IMEs must be scheduled at times and intervals reasonably convenient to the worker and must not delay or interrupt medical treatment that the worker has scheduled.

(g) The insurer must comply with the notification and reimbursement requirements under OAR 436-009-0025 and 436-060-0095.

(h) A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a medical service provider of the insurer's choice.

(i) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.

(j) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the division's website. If the worker does not have access to the Internet, the worker may call the division at 800-452-0288.

(2) IME and WRME Provider Authorization and Removal.

(a) Medical service providers can perform IMEs, WRMEs, or both once they are on the director's list of authorized IME providers.

(b) To be on the director's list of authorized IME providers, a medical service provider must:

(A) Complete the online application available at www.oregonwcdoc.info;

(B) Hold a current license with ~~his or her~~the provider's professional regulatory licensing board;

(C) Be in good standing as determined by the division. For the purpose of this paragraph, the division determines good standing to mean the provider is not currently, or within the past two years has not been subject to, a disciplinary action or stipulated agreement with the provider's regulatory licensing board that the division determines to be detrimental to performing IMEs; and

(D) Complete the director's Training Guide to Performing Independent Medical Exams including the corresponding quiz both of which are available at www.oregonwcdoc.info; or

(E) Complete a director-approved training course regarding IMEs provided by an outside vendor.

(c) By submitting the application to the division, the medical service provider agrees to abide by:

(A) The standards of professional conduct for performing IMEs adopted by the provider's regulatory licensing board or the IME standards of professional conduct published in Appendix B if the provider's regulatory licensing board does not have standards of professional conduct for performing IMEs; and

(B) All relevant workers' compensation laws and rules.

(d) A provider may be removed from the director's list of authorized IME providers after the director finds that the provider:

(A) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory licensing board or the IME standards published in Appendix B if the provider's regulatory licensing board does not have IME standards;

(B) Has a current restriction on ~~his or her~~their license or is under a current disciplinary action from their professional regulatory licensing board; or

(C) Has entered into a voluntary agreement with ~~his or her~~their regulatory licensing board that the director determines is detrimental to performing IMEs.

(e) A provider may appeal the director's decision to remove the provider from the director's list within 60 days of the mailing date of the order under ORS 656.704(2) and OAR 436-001-0019.

(3) IME Complaint Process.

(a) A complaint about an IME may be submitted to the division for investigation.

(b) The division reviews IME complaints to determine the appropriate action under the director's jurisdiction.

(c) The division investigates IME complaints to determine if there is a violation of one or more of the standards of professional conduct or workers' compensation laws or rules.

(d) If the division determines additional information is needed the division will contact the IME provider regarding the allegations in the complaint and request:

(A) A written response regarding the allegations;

(B) A copy of the IME report;

(C) Contact information for scribes, chaperones, or other people attending the IME at the IME provider's request; or

(D) A copy of a video or audio recording of the IME, if the IME was recorded.

(e) If the division does not receive a response to information requested under subsection (d) within 14 days from the date of the request, the division may make a decision based on available information.

(f) The division may contact any person who may have information or view any documentation or items regarding the IME or complaint.

(g) The division will notify the IME provider and complainant in writing of the outcome of the IME investigation.

(h) When investigating a new complaint regarding an IME provider, the division will review all complaints about that

provider received in the past two years, excluding complaints where the director found no violation, to determine if there is a pattern of behavior involving the IME provider. If there is a pattern of behavior, the director may take additional action, up to and including removal of the provider from the director's list of authorized IME providers.

(i) An order issued by the director to remove an IME provider from the director's list of authorized IME providers will include a notice of appeal rights under ORS 656.704(2) and OAR 436-001-0019.

(4) IME Training.

An outside vendor may provide initial IME training to providers wanting to become an IME provider, as long as the training is approved by the director before it is provided.

(5) IME Related Forms.

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

(A) Form 3923, "Important Information about Independent Medical Exams," available to the worker before the exam; and

(B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.

(6) IME Observer.

(a) A worker may choose to have an observer present during the IME. An observer is not allowed to be present during a psychological examination unless the IME provider approves.

(b) The worker's observer must not be paid to attend the IME. The worker's attorney or any representative of the worker's attorney may not be an observer.

(c) If the observer interferes with or obstructs the IME, the IME provider may ask the observer to leave and continue the IME with the worker's consent or end the IME.

(d) If the worker chooses to have an observer present, the provider must verify that the worker has signed Form 3923A, "IME Observer Form," acknowledging that the worker understands:

(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;

(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and

(C) The observer must not be paid to attend the exam.

(7) Invasive Procedure.

(a) For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form. The IME provider must make a copy of the signed Form 3227 for the worker and send the original to the insurer.

(b) An IME provider may be sanctioned under OAR 436-010-0340(1) for failing to follow this section.

(8) Recording the IME.

With the IME provider's approval, the worker may use a video camera or other device to record the IME.

(9) Objection to the IME Location.

When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, fax, email, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if travel is medically contraindicated or unreasonable because:

(A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;

(B) Alternative methods of travel will not overcome the limitations; or

(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

(10) Failure to Attend an IME.

If the worker fails to attend an IME and does not notify the insurer before the date of the IME or does not have sufficient reason for not attending the IME, the director may impose a monetary penalty against the worker for failure to attend.

(11) IME Report.

(a) After the IME is complete, the IME provider must send the insurer a report that includes, but is not limited to the following:

(A) Clear and accurate documentation of all tests performed;

(B) Who performed the IME;

(C) Who dictated the report;

(D) A signed quality assurance statement acknowledging that to the best of the IME provider's ability all statements contained in the report are true and accurate; and

(E) A copy of the observer Form 3923A, the invasive procedure Form 3227, or both, if applicable.

(b) The IME provider must communicate with the insurer if the IME provider is unable to provide the report within the insurer's requested time period and provide a date when the report will be sent.

(c) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within three business days of the insurer's receipt of the report.

(12) Request for Additional IME.

(a) When the insurer has obtained the three IMEs allowed under section (1) of this rule, the insurer must request authorization from the director before scheduling the worker for an additional IME. An insurer that fails to request authorization from the director may be assessed a civil penalty.

(b) The insurer must submit a request for authorization to the director for an additional IME by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if represented.

(c) The director will review the request and determine if additional information from the insurer or the worker is needed.

(A) Upon receiving a written request for additional information from the director, the parties have 14 days to respond.

(B) If the parties do not provide the requested information within the timeframes in paragraph (A), the director will issue an order approving or disapproving the request based on available information.

(d) The director, when making a determination to approve or deny the request for an additional IME, will consider, but is not limited to, whether:

(A) An IME involving the same disciplines or review of the same condition has been completed within the past six months;

(B) There has been a significant change in the worker's condition;

(C) There is a new condition or compensable aspect in the claim;

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits;

(E) The IME is requested to establish a preponderance for medically stationary status;

(F) The IME is medically harmful to the worker, and

(G) The IME is requested for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(e) Any party that disagrees with the director's order to approve or disapprove a request for an additional IME may request a hearing by the board under ORS 656.283 and OAR chapter 438.

(13) Other Exams – Not Considered IMEs.

The following exams are not considered IMEs and do not require approval as outlined in section (12) of this rule:

(a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;

(b) An exam requested by the director;

(c) An elective surgery consultation requested under OAR 436-010-0250(2)(b);

(d) An exam of a permanently totally disabled worker required under ORS 656.206(5);

(e) A closing exam that has been arranged by the insurer at the attending physician's or authorized nurse practitioner's request; and

(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/11/19 as Admin. Order 19-052, eff. 4/1/19

Independent Medical Examination (IME)

Requirements and Standards of Professional Conduct

Appendix B

1. IME providers must maintain effective communication, which includes but is not limited to:

a. Taking steps to avoid personal conflicts during the IME and to the extent they arise, an IME provider must be prepared to address the conflict in a professional and constructive manner and adapt to situations by changing strategy or communication style when appropriate.
b. Maintaining the confidentiality of the parties involved in the exam subject to applicable laws.
c. Allowing the worker to express themselves fully without unnecessary interruption. If the IME provider needs more information after a worker has answered a question, the IME provider must rephrase the question and explain why they are asking again.

2. IME providers must conduct an objective and impartial examination, which includes but is not limited to:

a. Conducting the IME without any preconceived notions or premature conclusions.
b. Not sharing personal feelings or personal opinions.
c. Remaining objective and impartial, both in reporting and during the examination.
d. Basing findings and opinions only on established medical fact, practice, and theory, and not on an accepted fee for services.
e. Recusing themselves prior to the IME if there is any sort of pre-existing conflict, whether apparent or actual.
f. Being fair, truthful, and forthright in interactions with the worker and insurers whether through written documentation or oral communication.

3. IME providers must maintain dignity and respect for the parties involved, which includes but is not limited to:

a. Treating the worker with dignity and respect and listening attentively.
b. Giving the worker appropriate empathy for pain, discomfort, and anxiety.
c. Using an appropriate tone and being aware of the worker's demeanor and body language when conducting the IME.
d. Being courteous and polite to the worker.

e. Being respectful of the worker's scheduled time for the IME and minimizing the necessary preparation for the IME while the worker waits.
f. Refraining from making disparaging or insulting comments to the worker about any party to the claim.
g. Refraining from criticizing or degrading the worker about their behavior or the history they provide.
h. Respecting a worker's answer of no, if the IME provider asks for permission to allow someone other than a scribe or chaperone to sit in on the IME without further questioning or encouraging a worker to provide permission.

4. Before the IME starts, the IME provider must:
a. Identify themselves to the worker as an IME provider;
b. Verify the worker's identity;
c. Tell the worker who requested the IME;
d. Tell the worker that an ongoing physician-patient relationship will not be sought or established;
e. Tell the worker that any information provided during the IME will be documented in a report;
f. Let the worker know that the IME provider cannot share opinions with them but will document findings in the report;
g. Explain the procedures that will be used during the IME;
h. Tell the worker that they may terminate a procedure if the worker feels the activity is beyond ~~his or her~~the worker's physical capacity or when pain occurs; and
i. Ask the worker if they have any questions about the IME process.

5. During the IME, the IME provider must:
a. Ensure the worker has privacy to disrobe;
b. Sufficiently examine the conditions being evaluated to answer the requesting party's questions; and
c. Let the worker know when the exam has concluded, and ask if the worker wants to provide more information or has questions.

436-010-0270 Insurer's Rights and Duties

(1) Notifications.

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) Pre-authorization. Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

(4) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);

(B) How workers can receive compensable medical services within the MCO;

(C) How workers can receive compensable medical services by non-panel providers; and

(D) The geographical service area governed by the MCO.

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the worker's attorney's name, mailing address, phone number, and, if known, fax number and email address to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

(i) Provide a telephone number the worker may call to ask for a written list; and

(ii) Tell the worker that ~~he or she has~~ they have seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or

(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the workers with health care benefits even if a workers' compensation claim is denied; and

(F) Notify the worker of ~~his or her~~the worker's right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

(g) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0037(3).

(h) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(i) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) When the worker obtains representation by an attorney, the attorney's name, mailing address, phone number, and, if known, fax number and email address;

(B) Any changes to the worker's or worker's attorney's name, address, or telephone number;

(C) Any requests for medical services from the worker or the worker's medical provider; or

(D) Any request by the worker to continue treating with a "come-along" provider.

(j) Insurers under contract with MCOs must maintain records including, but not limited to:

(A) A listing of all employers covered by MCO contracts;

(B) The employers' WCD employer numbers;

(C) The estimated number of employees governed by each MCO contract;

(D) A list of all workers enrolled in the MCO; and

(E) The effective dates of such enrollments.

(k) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(l) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/13/18 as Admin. Order 18-054, eff. 4/1/18
Statutory minor correction – ORS 183.335(7), filed and effective 7/6/20

436-015-0070 Come-along Providers

(1) The MCO must authorize a physician or nurse practitioner who is not an MCO panel provider to provide medical services to an enrolled worker if:

(a) The nurse practitioner is an authorized nurse practitioner under ORS 656.245, the chiropractic physician has certified to the director that ~~he or she~~the chiropractic physician has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);

(b) The physician or authorized nurse practitioner agrees to comply with MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services under OAR 436-015-0090; and

(c) The physician or authorized nurse practitioner agrees to refer the worker to the MCO for specialized care that the worker may require, including physical therapy.

(2) The physician or authorized nurse practitioner who is not an MCO panel provider will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if a worker has selected a physician or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.

(3) The MCO may not limit the length of treatment authority of a come-along provider unless such limits are stated in ORS chapter 656.

(4) Notwithstanding section (1), for those workers receiving their medical services from a facility that maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians or authorized nurse practitioners who are not MCO panel providers, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician or authorized nurse practitioner to treat the compensable injury.

(5) Any questions or disputes relating to the worker's selection of a physician or authorized nurse practitioner who is not an MCO panel provider must be resolved under OAR 436-015-0110.

(6) Any disputes relating to a come-along provider's or other non-MCO provider's compliance with MCO standards and protocols must be resolved under OAR 436-015-0110.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-030-0015 Insurer Responsibility

(1) When an insurer issues a Notice of Closure (Form 1644), the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the Notice of Closure Worksheet (Form 2807) upon which the Notice is based, a completed Insurer Notice of Closure Summary (Form 1503), and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and

(c) Issuing the Updated Notice of Acceptance at Closure on the same date as the Notice of Closure.

(A) The Updated Notice of Acceptance at Closure must contain the following title, information, and language:

(i) Title: "Updated Notice of Acceptance at Closure";

(ii) Information: A list of all compensable conditions, even if a condition was denied, ordered accepted by litigation, and is under appeal. Any conditions under appeal and those which were the basis for this claim opening must be specifically identified; and

(iii) Language, in bold print:

"Notice to Worker: This notice restates and includes all prior acceptances. The conditions that were the basis of this claim opening were the only conditions considered at the time of claim closure. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal, unless and until the condition is found to be compensable after all litigation is complete. Appeal of any denied conditions or objections to this notice will not delay claim closure. Any condition found compensable after the Notice of Closure is issued will require the insurer to reopen the claim for processing of that condition. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(B) In the case of an instant fatality, the Updated Notice of Acceptance may be combined with the Notice of Closure if the following is included:

(i) Title: "Updated Notice of Acceptance and Closure";

(ii) Information: A statement that beneficiaries may be entitled to death benefits under ORS 656.204 and 656.208, and the medically stationary date; and

(iii) Language, in bold print:

"Notice to Worker's Beneficiary or Estate: This notice restates any prior acceptances. The insurer is required to determine the appropriate benefits to be paid to any beneficiaries and begin those payments within 30 days of the mailing date of this notice.

If you disagree with the notice of acceptance, you may appeal the decision to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, OR 97302-1280 within 30 days of the mailing date.

A beneficiary who was mailed this notice may request reconsideration of the notice by the Workers' Compensation Division, Appellate Review Unit, 350 Winter Street NE, PO Box 14480 Salem, OR 97309-0405 within 60 days of the mailing date of this notice.

Beneficiaries who were not mailed a copy of this notice may request reconsideration of this notice within one year of the date this notice was mailed to the estate of the worker.

If you have questions about this notice, you may contact the Ombudsman for Injured Workers, the Workers' Compensation Division, or consult with an attorney."

(C) If the "Initial Notice of Acceptance" is issued at the same time as the "Updated Notice of Acceptance at Closure," both titles must appear near the top of the document.

(D) When an omission or error requires correcting an Updated Notice of Acceptance at Closure, the document must be clearly titled "Corrected Updated Notice of Acceptance at Closure."

(2) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(3) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(4) In claims with a date of injury on or after January 1, 2005, where the worker has not returned to regular work and ORS 656.726(4)(f) does not apply, or in claims with a date of injury on or after January 1, 2006, when the worker has not been released to regular work and ORS 656.726(4)(f) does not apply, the insurer must consider:

(a) The worker's age at the time the notice is issued;

(b) Adaptability to return to employment;

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements. If the insurer cannot obtain five years of work history despite all reasonable efforts, the insurer must document its efforts and provide as much work history as it can obtain.

(5) In claims where the date of injury is before January 1, 2005, the worker has not returned or been released to regular work, ORS 656.726(4)(f) does not apply, and the claim involves injury to, or disease of, unscheduled body parts, areas, or systems, the insurer must consider:

(a) The worker's age at time the notice is issued;

(b) Adaptability to return to employment:

(c) The worker's level of education; and

(d) The worker's work history, including an accurate description of the physical requirements of the worker's job held at the time of injury, for the period from five years before the date of injury to the mailing date of the Notice of Closure with dates or period of time spent at each position, tasks performed or level of specific vocational preparation (SVP), and physical requirements.

(6) The insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.

(7) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of ~~his or her~~ impending claim closure and that any temporary disability payments will end soon.

(8) The insurer must, within 14 days of closing the claim, provide the worker's attorney the same documents relied upon for claim closure.

(9) The insurer may not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure 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.

(10) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.

(11) Denials issued under ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

(12) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

(13) Forms 1503, 1644, and 2807 are published with Bulletin 139.

Statutory authority: ORS 656.268, 656.726
Statutes implemented: ORS 656.262, 656.268, 656.331, 656.726
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-030-0055 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 and OAR 436-030-0065:

(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 the essential functions of the job. Employment in a sheltered workshop is not considered regular employment unless this was the worker's job at the time of injury.

(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" means those types of general occupations that provide wages that:

(A) Meet the requirements in ORS 656.206(11)(a) for workers with a date of injury prior to January 1, 2006; or

(B) Meet the requirements in ORS 656.206(11)(b) for workers with a date of injury on or after January 1, 2006.

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

(e) A **"reasonable geographic distance"** means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 50-mile radius of the worker's place of residence at the time of:

(i) The original injury;

(ii) The worker's last gainful employment;

(iii) Insurer's determination; or

(iv) Reconsideration by the director.

(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 the worker does at the time of ~~his~~ the rating of disability, would go to seek work.

(f) "Types of general occupations" means groups of jobs which actually exist in a 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 may exist in the future.

(g) "Normal labor market" 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.

(h) "Withdrawn from the workforce" means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. The receipt of retirement benefits does not establish a worker has withdrawn from the workforce.

(2) All disability that existed before the injury must 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) Be willing to seek regular and gainful employment;

(c) 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

(d) Not have withdrawn from the workforce during the period for which benefits are being sought.

(4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:

(a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) Inability to regularly perform work at a gainful and suitable occupation; and

(c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.

(5) Notices of Closure and Orders on Reconsideration that grant permanent total disability must notify the worker that:

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

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker must 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) of this rule, 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 may suspend the worker's permanent total disability benefits. Benefits must be resumed when the statement is provided. Benefits not paid for the period the statement was withheld must be recoverable for no more than one year from the date of suspension.

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

Statutory authority: ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, and 1999 OR Laws Chapter 313
Statutes implemented: ORS 656.005, ORS 656.206, ORS 656.268, ORS 656.726, 1995 OR Laws Chapter 332, 1999 OR Laws Chapter 313, and chapter 865, Oregon Laws 2001
Hist: Amended 2/7/20 WCD Admin. Order 20-050, eff. 3/1/20

436-035-0230 Other Lower Extremity Findings

(1) Loss of sensation or hypersensitivity in the leg is not considered disabling except for the plantar surface of the foot and toes, including the great toe, where it is rated as follows:

(a)	Toe (in any toe)	Foot
partial loss of sensation or hypersensitivity	5%	5%
total loss of sensation or hypersensitivity	10%	10%

(b) Partial is part of the toe or foot. Total means the entire toe or foot.

(c) Loss of sensation or hypersensitivity in the toes in addition to loss of sensation or hypersensitivity in the foot is rated for the foot only. No additional value is allowed for loss of sensation or hypersensitivity in the toes.

(d) When there are hypersensitivity and sensation loss, both conditions are rated.

(2) The following ratings are for length discrepancies of the injured leg. However, loss of length due to flexion/extension deformities is excluded. The rating is the same whether the length change is a result of an injury to the foot or to the upper leg:

Discrepancy in inches	**Leg**
1/4 to 1/2 inch	5%
More than 1/2 inch up to and including 1 inch	10%
More than 1 inch up to and including 1-1/2 inches	15%
More than 1-1/2 inches	20%

(3) Valid instability in the ankle or knee substantiated by clinical findings is valued based on the ligament demonstrating the laxity, as described in the table below. The instability value is given even if the ligament itself has not been injured.

	Mild		Moderate		Severe	
Ligament	Ankle	Leg	Ankle	Leg	Ankle	Leg
Collateral (medial)	6%	10%	11%	15%	17%	20%
Collateral (lateral)	9%	10%	18%	15%	28%	20%
Anterior cruciate		5%		10%		15%
Posterior cruciate		5%		10%		15%

(a) For ankle joint instability to be rated as severe there must be a complete disruption of two or more ligaments. Following are examples of ankle ligaments that may contribute to joint instability:

(A) The lateral collateral ligaments including the anterior talofibular, calcaneofibular, talocalcaneal, posterior talocalcaneal, and the posterior talofibular.

(B) The medial collateral ligaments, or deltoid ligament, including the tibionavicular, calcaneotibial, anterior talotibial, and the posterior talotibial.

(b) For knee joint instability the severity of joint opening is mild at a grade 1 or 1+ (1-5mm), moderate at a grade 2 or 2+ (6-10mm), and severe at a grade 3 or 3+ (>10mm).

(c) Ankle joint instability with additional anterior or posterior instability receives an additional 10%.

(d) When there is a prosthetic knee replacement, instability of the knee is not rated unless the severity of the instability is equivalent to Grade 2 or greater.

(e) Rotary instability in the knee is included in the impairment value(s) of this section.

(f) Multiple instability values in a single joint are combined.

(4) When injury in the ankle or knee/leg results in angulation or malalignment, impairment values are determined under the following:

(a) Varus deformity greater than 15° of the knee/leg is rated at 10% of the leg and of the ankle is rated at 10% of the foot.

(b) Valgus deformity greater than 20° of the knee/leg is rated at 10% of the leg and of the ankle is rated at 10% of the foot.

(c) Tibial shaft fracture resulting in angulation or malalignment (rotational deformity) affects the function of the entire leg and is rated as follows:

Severity	**Leg impairment**
Mild: 10°– 14°	17%
Moderate: 15°– 19°	26%
Severe: 20°+	26% plus 1% for each additional degree, to 43% maximum

(d) Injury resulting in a rocker bottom deformity of the foot is valued at 14%.

(5) The following values are for surgery of the toes, foot, or leg:

(a)	**In the great toe:**	**Toe impairment**
	interphalangeal joint arthroplasty or resection	20%
	metatarsophalangeal joint arthroplasty or resection	30%
(b)	**In the second through fifth toes:**	**Toe impairment**
	distal interphalangeal joint arthroplasty or resection	15%
	proximal interphalangeal joint arthroplasty or resection	25%
	metatarsophalangeal joint arthroplasty or resection	25%
(c)	**Foot surgery**	**Foot/ankle impairment**
	Resection of any part of a metatarsal	10%
	Ankylosed tarsometatarsal joint	10%
	Prosthetic ankle replacement	25%
(d)	**Leg surgery**	**Leg impairment**
	Less than complete loss of one meniscus (no additional value is allowed for multiple partial resections of a single meniscus)	5%
	Complete loss of one meniscus	10%
	Complete loss of one meniscus with less than complete loss of the other	15%
	Complete loss of both menisci	25%
	Each 1/4 of patella removed	5%
	Prosthetic femoral head replacement	15%
	Total or partial prosthetic knee replacement (no additional value is allowed for multiple, partial or total, replacements).	20%

(e) When rating a prosthetic knee replacement, a separate value for meniscectomy(s) or patellectomy for the same knee is not granted.

(f) A meniscectomy is rated as a complete loss unless the record indicates that more than the rim of the meniscus remains.

(6) Dermatological conditions including burns which are limited to the leg, foot, or toes are rated based on the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g., a Class 1 dermatological condition of the foot is 3% of the foot, or a Class 1 dermatological condition of the leg is 3% of the leg. Contact dermatitis is determined under this section unless it is caused by an allergic systemic reaction which is also determined under OAR 436-035-0450. Contact dermatitis for a body part other than the upper or lower extremities is rated under OAR 436-035-0440. Impairments may or may not show

signs or symptoms of skin disorder upon examination but are rated according to the following classes:

(a) Class 1: 3% for the leg, foot, or toe if treatment results in no more than minimal limitations in the performance of the activities of daily living (ADL), although exposure to physical or chemical agents may temporarily increase limitations.

(b) Class 2: 15% for the leg, foot, or toe if intermittent treatments and prescribed examinations are required, and the worker has some limitations in the performance of ADL.

(c) Class 3: 38% for the leg, foot, or toe if regularly prescribed examinations and continuous treatments are required, and the worker has many limitations in the performance of ADL.

(d) Class 4: 68% for the leg, foot, or toe if continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of ADL.

(e) Class 5: 90% for the leg, foot, or toe if continuous prescribed treatment is required. The treatment necessitates having the worker stay home or permanently admitting the worker to a care facility, and the worker has severe limitations in the performance of ADL.

(f) Full thickness skin loss of the heel is valued at 10% of the foot, even when the area is successfully covered with an appropriate skin graft.

(7) The following ratings are for vascular dysfunction of the leg. The impairment values are determined according to the following classifications:

(a) Class 1: 3% when any of the following exist:

(A) Loss of pulses in the foot.

(B) Minimal loss of subcutaneous tissue.

(C) Calcification of the arteries (as revealed by x-ray).

(D) Transient edema.

(b) Class 2: 15% when any of the following exist:

(A) Limping due to intermittent claudication that occurs when walking at least 100 yards.

(B) Vascular damage, as evidenced by a healed painless stump of a single amputated toe, with evidence of chronic vascular dysfunction or a healed ulcer.

(C) Persistent moderate edema which is only partially controlled by support hose.

(c) Class 3: 35% when any of the following exist:

(A) Limping due to intermittent claudication when walking as little as 25 yards and no more than 100 yards.

(B) Vascular damage, as evidenced by healed amputation stumps of two or more toes on one foot, with evidence of chronic vascular dysfunction or persistent superficial ulcers on one leg.

(C) Obvious severe edema which is only partially controlled by support hose.

(d) Class 4: 63% when any of the following exist:

(A) Limping due to intermittent claudication after walking less than 25 yards.

(B) Intermittent pain in the legs due to intermittent claudication when at rest.

(C) Vascular damage, as evidenced by amputation at or above the ankle on one leg, or amputation of two or more toes on both feet, with evidence of chronic vascular dysfunction or widespread or deep ulcers on one leg.

(D) Obvious severe edema which cannot be controlled with support hose.

(e) Class 5: 88% when either of the following exists:

(A) Constant severe pain due to claudication at rest.

(B) Vascular damage, as evidenced by amputations at or above the ankles of both legs, or amputation of all toes on both feet, with evidence of persistent vascular dysfunction or of persistent, widespread, or deep ulcerations on both legs.

(f) If partial amputation of the lower extremity occurs as a result of vascular dysfunction, the impairment values are rated separately. The amputation value is then combined with the impairment value for the vascular dysfunction.

(8) Injuries to unilateral spinal nerve roots with resultant loss of strength in the leg or foot are rated based on the specific nerve root supplying (innervating) the weakened muscle(s), as described in the following table and modified under OAR 436-035-0011(7).

(a)	**Spinal nerve root**	**Leg impairment**
	L-2	20%
	L-3	20%
	L-4	34%
	L-5	37%
	S-1	20%

(b) Loss of strength in bilateral extremities results in each extremity being rated separately.

(9) When a spinal nerve root or lumbosacral plexus are not injured, valid loss of strength in the leg or foot is valued as if the peripheral nerve supplying (innervating) the muscle(s) demonstrating the decreased strength was impaired, as described in the following table and as modified under OAR 436-035-0011(7).

	Foot impairment
Common peroneal	39%
deep (above mid-shin)	28%
deep (below mid-shin)	6%
superficial	11%
Tibial nerve	
posterior tibial (mid-calf & knee)	28%
below mid-calf	17%
lateral plantar branch	6%
medial plantar branch	6%
Peripheral nerve	**Leg impairment**
Femoral (Below the iliacus nerve)	30%
Nerves to obturator internus & piriformis	10%
Nerves to quadratus femoris muscle/nerve to superior gemellus muscle/obturator	10%
Superior gluteal	20%
Inferior gluteal	25%
Sciatic (above hamstring innervation)	75%
Sciatic (hamstring loss only)	40%
Tibial nerve (medial popliteal or internal popliteal above knee)	35%

Example 1: A worker suffers a knee injury requiring surgery. Upon recovery, the attending physician reports 4/5 strength of the quadriceps femoris. The quadriceps femoris is innervated by the femoral nerve which has a 30% impairment value. 4/5 strength, under OAR 436-035-0011(7), is 20%. Final impairment is determined by multiplying 30% by 20% for a final value of 6% impairment of the leg.

Example 2: A worker suffers a laceration of the deep branch of the common peroneal nerve above mid-shin. Upon recovery, the attending physician reports 3/5 strength of the calf. The deep common peroneal above mid-shin has a 28% impairment value. Under OAR 436-035-0011(7), 3/5 strength is 50%. Impairment is determined by multiplying 28% by 50% for a final value of 14% impairment of the foot.

(a) Loss of strength due to an injury in a single toe receives a value of zero, unless the strength loss is due to a compensable condition that is proximal to the digit.

(b) Decreased strength due to an amputation receives no rating for weakness in addition to that given for the amputation.

(c) Decreased strength due to a loss in range of motion receives no rating for weakness in addition to that given for the loss of range of motion.

(10) For motor loss to any part of a leg which is due to brain or spinal cord damage, impairment is valued as follows:

(a) Class 1: 23% when the worker can rise to a standing position and can walk but has difficulty with elevations, grades, steps, and distances.

(b) Class 2: 48% when the worker can rise to a standing position and can walk with difficulty but is limited to level surfaces. There is variability as to the distance the worker can walk.

(c) Class 3: 76% when the worker can rise to a standing position and can maintain it with difficulty but cannot walk without assistance.

(d) Class 4: 100% when the worker cannot stand without a prosthesis, the help of others, or mechanical support.

(e) When a value is granted under this section, additional impairment values in the same extremity are not allowed for strength loss, chronic condition, reduced range of motion, or limited ability to walk/stand for two hours or less because they have been included in the impairment values shown in this section.

(f) For bilateral extremity loss, each extremity is rated separately.

(11) If there is a diagnosis of Grade IV chondromalacia, extensive arthritis or extensive degenerative joint disease and one or more of the following are present: secondary strength loss; chronic effusion; varus or valgus deformity less than that specified in section (4) of this rule, then one or more of the following rating values apply:

(a) 5% of the foot for the ankle joint; or

(b) 5% of the leg for the knee joint.

(12) For a diagnosis of degenerative joint disease, chondromalacia, or arthritis which does not meet the criteria noted in section (11) of this rule, the impairment is determined under the chronic condition rule (OAR 436-035-0019) if the criteria in that rule is met.

(13) Other impairment values, e.g., weakness, chronic condition, reduced range of motion, etc., are combined with the value granted in section (11) of this rule.

(14) When the worker cannot be on ~~his or her~~their feet for more than two hours in an 8-hour period, the award is 15% of the leg.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0380 Cardiovascular System

(1) Impairments of the cardiovascular system are determined based on objective findings that result in the following conditions: valvular heart disease, coronary heart disease, hypertensive cardiovascular disease, cardiomyopathies, pericardial disease, or cardiac arrhythmias. Each of these conditions will be described and quantified. In most

circumstances, the physician should observe the patient during exercise testing.

(2) Valvular Heart Disease: Impairment resulting from work related valvular heart disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has evidence by physical examination or laboratory studies of valvular heart disease, but no symptoms in the performance of ordinary daily activities or even upon moderately heavy exertion; and

The worker does not require continuous treatment, although prophylactic antibiotics may be recommended at the time of a surgical procedure to reduce the risk of bacterial endocarditis; and

The worker remains free of signs of congestive heart failure; and

There are no signs of ventricular hypertrophy or dilation, and the severity of the stenosis or regurgitation is estimated to be mild; or

In the worker who has recovered from valvular heart surgery, all of the above criteria are met.

Class 2 (20% Impairment)

The worker has evidence by physical examination or laboratory studies of valvular heart disease, and there are no symptoms in the performance of ordinary daily activities, but symptoms develop on moderately heavy physical exertion; or

The worker requires moderate dietary adjustment or drugs to prevent symptoms or to remain free of the signs of congestive heart failure or other consequences of valvular heart disease, such as syncope, chest pain and emboli; or

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation, and the severity of the stenosis or regurgitation is estimated to be moderate, and surgical correction is not feasible or advisable; or

The worker has recovered from valvular heart surgery and meets the above criteria.

Class 3 (40% Impairment)

The worker has signs of valvular heart disease and has slight to moderate symptomatic discomfort during the performance of ordinary daily activities; and

Dietary therapy or drugs do not completely control symptoms or prevent congestive heart failure; and

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation, the severity of the stenosis or regurgitation is estimated to be moderate or severe, and surgical correction is not feasible; or

The worker has recovered from heart valve surgery but continues to have symptoms and signs of congestive heart failure including cardiomegaly.

Class 4 (78% Impairment)

The worker has signs by physical examination of valvular heart disease, and symptoms at rest or in the performance of less than ordinary daily activities; and

Dietary therapy and drugs cannot control symptoms or prevent signs of congestive heart failure; and

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation; and the severity of the stenosis or regurgitation is estimated to be moderate or severe, and surgical correction is not feasible; or

The worker has recovered from valvular heart surgery but continues to have symptoms or signs of congestive heart failure.

(3) Coronary Heart Disease: Impairment resulting from work related coronary heart disease is rated according to the following classes:

Class 1 (5% Impairment)

This class of impairment should be reserved for the worker with an equivocal history of angina pectoris on whom coronary angiography is performed, or for a worker on whom coronary angiography is performed for other reasons and in whom is found less than 50% reduction in the cross sectional area of a coronary artery.

Class 2 (20% Impairment)

The worker has history of a myocardial infarction or angina pectoris that is documented by appropriate laboratory studies, but at the time of evaluation the worker has no symptoms while performing ordinary daily activities or even moderately heavy physical exertion; and

The worker may require moderate dietary adjustment or medication to prevent angina or to remain free of signs and symptoms of congestive heart failure; and

The worker is able to walk on the treadmill or bicycle ergometer and obtain a heart rate of 90% of ~~his or her~~their predicted maximum heart rate without developing significant ST segment shift, ventricular tachycardia, or hypotension; or

The worker has recovered from coronary artery surgery or angioplasty, remains asymptomatic during ordinary daily activities, and is able to exercise as outlined above. If the worker is taking a beta adrenergic blocking agent, ~~he or she~~the worker should be able to walk on the treadmill to a level estimated to cause an energy expenditure of at least 10 METS* as a substitute for the heart rate target.

*METS is a term that represents the multiples of resting metabolic energy used for any given activity. One MET is 3.5ml/(kg x min).

Class 3 (40% Impairment)

The worker has a history of myocardial infarction that is documented by appropriate laboratory studies, or angina pectoris that is documented by changes on a resting or exercise ECG or radioisotope study that are suggestive of ischemia; or

The worker has either a fixed or dynamic focal obstruction of at least 50% of a coronary artery, demonstrated by angiography; and

The worker requires moderate dietary adjustment or drugs to prevent frequent angina or to remain free of symptoms and signs of congestive heart failure, but may develop angina pectoris or symptoms of congestive heart failure after moderately heavy physical exertion; or

The worker has recovered from coronary artery surgery or angioplasty, continues to require treatment, and has the symptoms described above.

Class 4 (78% Impairment)

The worker has history of a myocardial infarction that is documented by appropriate laboratory studies or angina pectoris that has been documented by changes of a resting ECG or radioisotope study that are highly suggestive of myocardial ischemia; or

The worker has either fixed or dynamic focal obstruction of at least 50% of one or more coronary arteries, demonstrated by angiography; and

Moderate dietary adjustments or drugs are required to prevent angina or to remain free of symptoms and signs of congestive heart failure, but the worker continues to develop symptoms of angina pectoris or congestive heart failure during ordinary daily activities; or

There are signs or laboratory evidence of cardiac enlargement and abnormal ventricular function; or

The worker has recovered from coronary artery bypass surgery or angioplasty and continues to require treatment and have symptoms as described above.

(4) Hypertensive Cardiovascular Disease: Impairment resulting from work related hypertensive cardiovascular disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has no symptoms and the diastolic pressures are repeatedly in excess of 90 mm Hg; and

The worker is taking antihypertensive medications but has none of the following abnormalities: (1) abnormal urinalysis or renal function tests; (2) history of hypertensive cerebrovascular disease; (3) evidence of left ventricular hypertrophy; (4) hypertensive vascular abnormalities of the optic fundus, except minimal narrowing of arterioles.

Class 2 (20% Impairment)

The worker has no symptoms and the diastolic pressures are repeatedly in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any of the following abnormalities: (1) proteinuria and abnormalities of the urinary sediment, but no impairment of renal function as measured by blood urea nitrogen (BUN) and serum creatinine determinations; (2) history of hypertensive cerebrovascular damage; (3) definite hypertensive changes in the retinal arterioles, including crossing defects or old exudates.

Class 3 (40% Impairment)

The worker has no symptoms and the diastolic pressure readings are consistently in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any of the following abnormalities: (1) diastolic pressure readings usually in excess of 120 mm Hg; (2) proteinuria or abnormalities in the urinary sediment, with evidence of impaired renal function as measured by elevated BUN and serum creatinine, or by creatinine clearance below 50%; (3) hypertensive cerebrovascular damage with permanent neurological residual; (4) left ventricular hypertrophy based on findings of physical examination, ECG, or chest radiograph, but no symptoms, signs or evidence by chest radiograph of congestive heart failure; or (5) retinopathy, with definite hypertensive changes in the arterioles, such as "copper" or "silver wiring," or A-V crossing changes, with or without hemorrhages and exudates.

Class 4 (78% Impairment)

The worker has a diastolic pressure consistently in excess of 90 mm Hg; and

The worker is taking antihypertensive medication and has any two of the following abnormalities; (1) diastolic pressure readings usually in excess of 120 mm Hg; (2) proteinuria and abnormalities in the urinary sediment, with impaired renal function and evidence of nitrogen retention as measured by elevated BUN and serum creatinine or by creatinine clearance below 50%; (3) hypertensive cerebrovascular damage with permanent neurological deficits; (4) left ventricular hypertrophy; (5) retinopathy as manifested by hypertensive changes in the arterioles, retina, or optic nerve; (6) history of congestive heart failure; or

The worker has left ventricular hypertrophy with the persistence of congestive heart failure despite digitalis and diuretics.

(5) Cardiomyopathy: Impairment resulting from work related cardiomyopathies is rated according to the following classes:

Class 1 (5% Impairment)

The worker is asymptomatic and there is evidence of impaired left ventricular function from physical examination or laboratory studies; and

There is no evidence of congestive heart failure or cardiomegaly from physical examination or laboratory studies.

Class 2 (20% Impairment)

The worker is asymptomatic and there is evidence of impaired left ventricular function from physical examination or laboratory studies; and

Moderate dietary adjustment or drug therapy is necessary for the worker to be free of symptoms and signs of congestive heart failure; or

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the above criteria.

Class 3 (40% Impairment)

The worker develops symptoms of congestive heart failure on greater than ordinary daily activities and there is evidence of abnormal ventricular function from physical examination or laboratory studies; and

Moderate dietary restriction or the use of drugs is necessary to minimize the worker's symptoms, or to prevent the appearance of signs of congestive heart failure or evidence of it by laboratory study; OR

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the criteria described above.

Class 4 (78% Impairment)

The worker is symptomatic during ordinary daily activities despite the appropriate use of dietary adjustment and drugs, and there is evidence of abnormal ventricular function from physical examination or laboratory studies; or

There are persistent signs of congestive heart failure despite the use of dietary adjustment and drugs; or

The worker has recovered from surgery for the treatment of hypertrophic cardiomyopathy and meets the above criteria.

(6) Pericardial Disease: Impairment resulting from work related pericardial disease is rated according to the following classes:

Class 1 (5% Impairment)

The worker has no symptoms in the performance of ordinary daily activities or moderately heavy physical exertion, but does have evidence from either physical examination or laboratory studies of pericardial heart disease; and

Continuous treatment is not required, and there are no signs of cardiac enlargement, or of congestion of lungs or other organs; or

In the worker who has had surgical removal of the pericardium, there are no adverse consequences of the surgical removal and the worker meets the criteria above.

Class 2 (20% Impairment)

The worker has no symptoms in the performance of ordinary daily activities, but does have evidence from either physical examination or laboratory studies of pericardial heart disease; but

Moderate dietary adjustment or drugs are required to keep the worker free from symptoms and signs of congestive heart failure; or

The worker has signs or laboratory evidence of cardiac chamber hypertrophy or dilation; or

The worker has recovered from surgery to remove the pericardium and meets the criteria above.

Class 3 (40% Impairment)

The worker has symptoms on performance of greater than ordinary daily activities despite dietary or drug therapy, and the worker has evidence from physical examination or laboratory studies, of pericardial heart disease; and

Physical signs are present, or there is laboratory evidence of cardiac chamber enlargement or there is evidence of significant pericardial thickening and calcification; or

The worker has recovered from surgery to remove the pericardium but continues to have the symptoms, signs and laboratory evidence described above.

Class 4 (78% Impairment)

The worker has symptoms on performance of ordinary daily activities in spite of using appropriate dietary restrictions or drugs, and the worker has evidence from physical examination or laboratory studies, of pericardial heart disease; and

The worker has signs or laboratory evidence of congestion of the lungs or other organs; or

The worker has recovered from surgery to remove the pericardium and continues to have symptoms, signs, and laboratory evidence described above.

(7) Arrythmias: Impairment resulting from work related cardiac arrhythmias* is rated according to the following classes:

Class 1 (5% Impairment)

The worker is asymptomatic during ordinary activities and a cardiac arrhythmia is documented by ECG; and

There is no documentation of three or more consecutive ectopic beats or periods of asystole greater than 1.5 seconds, and both the atrial and ventricular rates are maintained between 50 and 100 beats per minute; and

There is no evidence of organic heart disease.

* If an arrhythmia is a result of organic heart disease, the arrhythmia should be rated separately and combined with the impairment rating for the organic heart disease.

Class 2 (20% Impairment)

The worker is asymptomatic during ordinary daily activities and a cardiac arrhythmia* is documented by ECG; and

Moderate dietary adjustment, or the use of drugs, or an artificial pacemaker, is required to prevent symptoms related to the cardiac arrhythmia; or

The arrhythmia persists and there is organic heart disease.

Class 3 (40% Impairment)

The worker has symptoms despite the use of dietary therapy or drugs or of an artificial pacemaker and a cardiac arrhythmia* is documented with ECG; but

The worker is able to lead an active life and the symptoms due to the arrhythmia are limited to infrequent palpitations and episodes of light-headedness, or other symptoms of temporarily inadequate cardiac output.

Class 4 (78% Impairment)

The worker has symptoms due to documented cardiac arrhythmia* that are constant and interfere with ordinary daily activities; or

The worker has frequent symptoms of inadequate cardiac output documented by ECG to be due to frequent episodes of cardiac arrhythmia; or

The worker continues to have episodes of syncope that are either due to, or have a high probability of being related to, the arrhythmia. To fit into this category of impairment, the symptoms must be present despite the use of dietary therapy, drugs, or artificial pacemakers.

(8) For heart transplants an impairment value of 50% is given. This value is combined with any other findings of impairment of the heart.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-035-0385 Respiratory System

(1) For the purpose of this rule, the following definitions apply:

(a) FVC is forced vital capacity.

(b) FEV1 is forced expiratory volume in the first second.

(c) Dco refers to diffusing capacity of carbon monoxide.

(d) VO2 Max is measured exercise capacity.

(2) Lung impairment is rated according to the following classes:

(a) Class 1: 0% for FVC greater than or equal to 80% of predicted, and FEV1 greater than or equal to 80% of predicted, and FEV1/FVC greater than or equal to 70%, and Dco greater than or equal to 80% of predicted; or VO2 Max greater than 25 ml/(kg x min).

(b) Class 2: 18% for FVC between 60% and 79% of predicted, or FEV1 between 60% and 79% of predicted, or FEV1/FVC between 60% and 69%, or Dco between 60% and 79% of predicted, or VO2 Max greater than or equal to 20 ml/(kg x min) and less than or equal to 25 ml/(kg x min).

(c) Class 3: 38% for FVC between 51% and 59% of predicted, or FEV1 between 41% and 59% of predicted, or FEV1/FVC between 41% and 59%, or Dco between 41% and 59% of predicted, or VO2 Max greater than or equal to 15 ml/(kg x min) and less than 20 ml/(kg x min).

(d) Class 4: 75% for FVC less than or equal to 50% of predicted, or FEV1 less than or equal to 40% of predicted, or FEV1/FVC less than or equal to 40%, or Dco less than or equal to 40% of predicted, or VO2 Max less than 15 ml/(kg x min).

(3) Lung cancer - All persons with lung cancers as a result of a compensable industrial injury or occupational disease are to be considered Class 4 impaired at the time of diagnosis. At a re-evaluation, one year after the diagnosis is established, if the person is found to be free of all evidence of tumor, then ~~he or she~~the person should be rated under the physiologic parameters in OAR 436-035-0385(2). If there is evidence of tumor, the person is determined to have Class 4 impairment.

(4) Asthma - Reversible obstructive airway disease is rated under the classes of respiratory impairment described in section (2) of this rule. The impairment is based on the best of three successive tests performed at least one week apart at a time when the patient is receiving optimal medical therapy. In addition, a worker may also have impairment determined under OAR 436-035-0450.

(5) Allergic respiratory responses - For workers who have developed an allergic respiratory response to physical, chemical, or biological agents refer to OAR 436-035-0450. Methacholine inhalation testing is permitted at the discretion of the physician. Where methacholine inhalation testing leaves the worker at risk, level of impairment may be based on review of the medical record.

(6) Impairment from air passage defects is determined according to the following classes:

Class 1 (5% Impairment)

Dyspnea does not occur at rest.

Dyspnea is not produced by walking or climbing stairs freely, performance of other usual activities of daily living, stress, prolonged exertion, hurrying, hill climbing, or recreation requiring intensive effort or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, bronchi, or complete obstruction of the nose (bilateral), or nasopharynx.

Class 2 (20% Impairment)

Dyspnea does not occur at rest.

Dyspnea is not produced by walking freely on the level, climbing at least one flight of ordinary stairs, or the performance of other usual activities of daily living.

Dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, recreation except sedentary forms, or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, bronchi; or complete obstruction of the nose (bilateral), or nasopharynx.

Class 3 (40% Impairment)

Dyspnea does not occur at rest.

Dyspnea is produced by walking more than one or two blocks on the level or climbing one flight of ordinary stairs even with periods of rest; performance of other usual activities of daily living, stress, hurrying, hill-climbing, recreation or similar activity.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, or bronchi.

Class 4 (78% Impairment)

Dyspnea occurs at rest, although worker is not necessarily bedridden.

Dyspnea is aggravated by the performance of any of the usual activities of daily living beyond personal cleansing, dressing, grooming or its equivalent.

Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to 4th ring), lower trachea, or bronchi.

(7) Residual impairment from a lobectomy is valued based on the physiological parameters found under section (2) of this rule.

(8) For injuries that result in impaired ability to speak, the following classes are used to rate the worker's ability to speak in relation to: audibility (ability to speak loudly enough to be heard); intelligibility (ability to articulate well enough to be understood); and functional efficiency (ability to produce a serviceably fast rate of speech and to sustain it over a useful period of time).

(a) Class 1: 4% when speech can be produced with sufficient intensity and articular quality to meet most of the needs of everyday speech communication; some hesitation or slowness of speech may exist; certain phonetic units may be difficult or impossible to produce; listeners may require the speaker to repeat.

(b) Class 2: 9% when speech can be produced with sufficient intensity and articular quality to meet many of the needs of

everyday speech communication; speech may be discontinuous, hesitant or slow; can be understood by a stranger but may have many inaccuracies; may have difficulty being heard in loud places.

(c) Class 3: 18% when speech can be produced with sufficient intensity and articular quality to meet some of the needs of everyday speech communication; often consecutive speech can only be sustained for brief periods; can converse with family and friends but may not be understood by strangers; may often be asked to repeat; has difficulty being heard in loud places; voice tires rapidly and tends to become inaudible after a few seconds.

(d) Class 4: 26% when speech can be produced with sufficient intensity and articular quality to meet few of the needs of everyday speech communication; consecutive speech limited to single words or short phrases; speech is labored and impractically slow; can produce some phonetic units but may use approximations that are unintelligible or out of context; may be able to whisper audibly but has no voice.

(e) Class 5: 33% for complete inability to meet the needs of everyday speech communication.

(9) Workers with successful permanent tracheostomy or stoma should be rated at 25% impairment of the respiratory system.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
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436-035-0390 Cranial Nerves/Brain

(1) Impairment of the first cranial nerve (olfactory) resulting in either complete inability to detect odors or alteration of the sense of smell is 3% impairment.

(2) Ratings given for impairment of the second cranial nerve (optic) are rated based on their effects on vision under OAR 436-035-0260.

(3) Ratings given for impairment in the third cranial nerve (oculomotor), fourth cranial nerve (trochlear), and sixth cranial nerve (abducens) are rated based on their effects on ocular motility under OAR 436-035-0260.

(4) Ratings given for impairment of the fifth cranial nerve (trigeminal) are as follows:

(a) For loss or alteration of sensation in the trigeminal distribution on one side: 10%; on both sides: 35%.

(b) The rating given for loss of motor function for each trigeminal Nerve is 5%.

(c) The rating given for loss of motor function of both trigeminal Nerves is determined under OAR 436-035-0385 and 436-035-0420.

(5) Ratings given for impairment of the sixth cranial nerve (abducens) are described in section (3) of this rule.

(6) Ratings given for impairment of the seventh cranial nerve (facial) are as follows:

(a) No rating is given for loss of sensation from impairment of one or both facial nerves.

(b) If impairment of one or both facial nerves results in loss or alteration of the sense of taste, the rating is 3%.

(c) Motor loss on one side of the face due to impairment of the facial nerve is rated at 15% for a complete loss, or 5% for a partial loss.

(d) Motor loss on both sides of the face due to impairment of the facial nerve is rated at 45% for a complete loss, or 20% for a partial loss.

(7) Ratings given for impairment of the eighth cranial nerve (auditory) are determined according to their effects on hearing under OAR 436-035-0250. Other ratings for loss of function most commonly associated with this nerve include the following:

(a) For permanent disturbances resulting in disequilibrium which limits activities the impairment is rated under the following:

(A) Class 1: 8% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living (ADL) are performed without assistance.

(B) Class 2: 23% when signs of disequilibrium are present with supporting objective findings and the usual activities of daily living can be performed without assistance, and the worker is unable to operate a motor vehicle.

(C) Class 3: 48% when signs of disequilibrium are present with supporting objective findings and the usual ADL cannot be performed without assistance.

(D) Class 4: 80% when signs of disequilibrium are present with supporting objective findings and the usual ADL cannot be performed without assistance, and confinement to the home or other facility is necessary.

(b) Tinnitus which by a preponderance of medical opinion requires job modification is valued at 5%. No additional impairment value is allowed for "bilateral" tinnitus.

(8) Ratings given for impairment of the ninth cranial nerve (glossopharyngeal), tenth cranial nerve (vagus), and eleventh cranial nerve (cranial accessory) are as follows:

(a) Impairment of swallowing due to damage to the ninth, tenth, or eleventh cranial nerve is determined under OAR 436-035-0420.

(b) Speech impairment due to damage to the ninth, tenth, or eleventh cranial nerve is rated under the classifications in OAR 436-035-0385(8).

(9) Ratings given for impairment of the twelfth cranial nerve (hypoglossal) are as follows:

(a) No rating is allowed for loss on one side.

(b) Bilateral loss is rated as in section (8) of this rule.

(10) Impairment for injuries to the brain or head is determined based upon a preponderance of medical opinion which applies or describes the following criteria.

(a) The existence and severity of the claimed residuals and impairments must be objectively determined by observation or examination or a preponderance of evidence, and must be within the range reasonably considered to be possible, given the nature of the original injury, based upon a preponderance of medical opinion.

(b) Emotional disturbances which are reactive to other residuals, but which are not directly related to the brain or head injury, such as frustration or depressed mood about memory deficits or work limitations, are not included under these criteria and must be addressed separately.

(c) The distinctions between classes are intended to reflect, at their most fundamental level, the impact of the residuals on two domains: impairment of ADL, and impairment of employment capacity.

(d) Where the residuals from the accepted condition and any direct medical sequelae place the worker between one or more classes, the worker is entitled to be placed in the highest class that describes the worker's impairment. There is no averaging of impairment values when a worker falls between classes.

(e) As used in these rules, episodic neurologic disorder refers to and includes any of the following:

(A) Any type of seizure disorder;

(B) Vestibular disorder, including disturbances of balance or sensorimotor integration;

(C) Neuro-ophthalmologic or oculomotor visual disorder, such as diplopia;

(D) Headaches.

CLASS 1
(10% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 9 or 10; (e.g., the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker is independent in ADL. If there are cognitive or memory deficits, they are no more than minimal or "nuisance" level, and do not materially impair ADL, or the type of work the worker may perform.

Language: If there is a language deficit, it is no more than minimal (e.g., language comprehension or production might be less than normal, but it is adequate for daily living).

Emotions/behavior: If there are emotional disturbances or personality changes, they are minimal and occur only transiently during stressful situations and events.

Sleep/alertness: If there are episodic sleep disturbances, fatigue, or lethargy, they are minimal (e.g., any sleeping irregularity, fatigue, or lethargy does not interfere with daily living).

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is completely controlled and does not interfere with daily living.

The fundamental intent of this class is as follows: (1) ADL: The worker has "nuisance" level residual effects of head injury, which may slightly impact the manner in which ADL are performed, or the subjective ease of performance, but the worker remains fully independent in all ADL; (2) Work capacity: The "nuisance" level residuals may impact the manner in which the worker performs work tasks, or the subjective ease of performance, but the worker is not materially limited in the types of work which can be performed, as compared with pre-injury abilities.

CLASS 2
(30% Impairment)

Cognition: The worker functions at the equivalent Rancho Los Amigos Scale-Revised level of 8 (e.g., the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker can perform all ADL independently, but due to mild cognitive or memory deficits, may need to use compensatory strategies or devices such as multiple written reminders, alarms, or digital devices; or may sometimes require more time than normal to complete ADL; or may use occasional reminders, prompts, or minor assistance by others as a compensatory strategy, but is not dependent on others. For example, a spouse may be asked to double-check financial transactions for errors, but the worker can manage all transactions independently if necessary, and is not fundamentally dependent on the spouse for this activity. The cognitive or memory deficits limit the worker's ability to perform some types of jobs, for example, mild attention deficits may preclude work in a busy, multi-taking environment, but the worker is still employable.

Language: Language deficit is mild (e.g., language comprehension or production might occasionally interfere with daily living or limit the worker's ability to perform some types of jobs, but the worker is still employable).

Emotion/behavior: Emotional or behavioral disturbances or personality changes are mild. While they may be disproportionate to the stress or situation, they do not significantly impair the worker's ability to relate to others, or to live with others. They may limit the worker's ability to perform some types of jobs, for example, irritability may preclude jobs with high public contact; but the worker is still employable.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are mild (e.g., any sleeping irregularity, fatigue, or lethargy only occasionally interferes with daily living). Sleep disturbance, or mild or episodic fatigue or lethargy, may limit the worker's ability to perform some types of jobs, for example, shift work or commercial driving; but the worker is still employable.

Episodic neurologic disorder: Any episodic neurologic disorder is not completely controlled, and results in limits in ADL performance or types of work that may be performed, but the worker is still independent in ADL and is employable. For example, headaches may intermittently interfere with daily living; diplopia which worsens with fatigue may cause the worker to have driving restrictions; vestibular symptoms may limit the worker's ability to operate industrial machinery or cause the worker to avoid heights.

The fundamental intent of this class is as follows: (1) ADL: The worker is independent in all ADL, but may require significant adaptations or modifications in normal patterns or means of ADL in order to achieve ADL-independence; (2) Work capacity: The residuals result in some type of limitation on the worker's employment capacity, restricting the range of

employment options that were previously available to the worker, but the worker remains employable in most jobs for which ~~s/he~~the worker was qualified prior to injury.

CLASS 3
(50% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 7 (e.g., the worker is alert and oriented, behavior is appropriate but the worker has mild to moderate impaired judgment or mild to moderate, functionally significant cognitive or memory deficits). The judgment, cognitive, or memory deficits result in impairment sufficient that the worker regularly requires assistance or supervision in order to perform some ADL. The deficits restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Language: Language deficit is mild to moderate (e.g., language comprehension or production deficits frequently interfere with ADL or restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate, disproportionate to the stress or situation, are present at all times and significantly impair the worker's ability to relate to others or to live with others. The disturbances restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate. They frequently interfere with daily living, or restrict the worker to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is not completely controlled. It markedly interferes with daily living. The worker cannot operate industrial machinery, and is restricted to a limited range of jobs, at a level significantly below the worker's pre-injury employment capacity.

The fundamental intent of this class is as follows: (1) ADL: The worker is not completely independent in all ADL, and requires some type of supervision, assistance, or guidance from another person at some times for some aspects of ADL; (2) Work capacity: The residuals result in major limitations on the worker's employment capacity with major restrictions or limitations on the worker's range of employment options.

CLASS 4
(75% Impairment)

Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 6 (e.g., the worker has impaired judgment or significant memory deficit, such that the worker needs assistance and supervision to perform most ADL and can work only in a sheltered setting).

Language: Language deficit is moderate (e.g., language comprehension is often impaired or language production is often inappropriate or unintelligible).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate to severe, disproportionate to the stress or situation, are present at all times, require the worker to be supervised, or seriously limit the worker's ability to live with others. The worker can work, if at all, only in a sheltered setting.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate-severe (e.g., they require supervision for daily living). The worker can work, if at all, only in a sheltered setting.

Episodic neurologic disorder: If there is episodic neurologic disorder, it is of such severity and constancy that activities have to be limited and supervised. The worker needs to live in a supervised setting such as a foster home, care facility, or supervised semi-independent residence.

The fundamental intent of this class is as follows: (1) ADL: The worker is basically dependent on others for most aspects of ADL, although the worker may not need direct supervision at all times. (2) Work capacity: The worker is incapable of competitive employment and can work, if at all, only in a sheltered setting.

CLASS 5
(85% Impairment)

The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 4-5 (e.g., the worker's behavior is inappropriate, the worker is confused, not reliably oriented to time and place; the worker may be agitated and has a severe memory deficit) and the worker requires assistance and supervision to perform all ADL. Total supervision is required. The worker is incapable of any employment.

CLASS 6
(95% Impairment)

The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 1-3. The worker is comatose or the worker's responses to stimuli are localized, inconsistent or delayed.

(11) For the purpose of section (10) of this rule, the Rancho Los Amigos-Revised levels are based upon the "Eight States Levels of Cognitive Recovery" developed at the Rancho Los Amigos Hospital and co-authored by Chris Hagen, PhD, Danese Malkumus, M.A., and Patricia Durham, M.S., in 1972. These levels were revised by Danese Malkumus, M.A., and Kathryn Standenip, O.T.R., in 1974, revised by Chris Hagen, PhD, in 1999 to include ten levels, referred to as Rancho-R.

(12) For brain or head injuries that have resulted in the loss of use or function of any upper or lower extremities, a value may be allowed for the affected body part(s). Refer to the appropriate section of these standards for that determination.

(13) Headaches that are not a direct result of a brain or head injury (e.g., cervicogenic, sensory input issues, etc.) are given a value of 10% when they interfere with the activities of daily living, affect the worker's ability to regularly perform work, and require continued prescription medication or therapy. If a value for headaches is granted under section (10) of this rule,

the value in this section is not granted because it is included in the impairment value for the episodic neurological disorder.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.005, 656.214, 656.268, 656.726
Hist.: Amended 11/21/12 as WCD Admin. Order 12-061, eff. 1/1/13

436-060-0075 Payment of Death Benefits

If death results from a worker's compensable injury or occupational disease, benefits must be paid as follows:

(1) Final disposition of the body and funeral expenses.

(a) The insurer must pay the cost of final disposition of the body and funeral expenses, up to the maximum benefit under ORS 656.204(1); and

(b) The worker's estate, beneficiaries, or other parties may submit bills related to final disposition of the body and funeral up to 60 days after the date of death or date of claim acceptance, whichever is later. Any portion of the benefit that remains unpaid after this period must be paid to the worker's estate.

(2) Payments to surviving beneficiaries.

The following applies to benefits paid under sections (3) through (5) of this rule:

(a) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;

(b) Unless otherwise specified, monthly benefits to beneficiaries must be paid up to the date of any status change; and

(c) Payments must be paid within the timeframes established in OAR 436-060-0150(6).

(3) Benefit to surviving spouse.

If a worker is survived by a spouse, the insurer must pay monthly benefits in an amount equal to 4.35 times 66-2/3 percent of the state average weekly wage to the surviving spouse. Benefits under this section must be paid through the end of the month in which the spouse is no longer eligible to receive benefits under ORS 656.204(2).

(4) Benefit to surviving child.

If a worker is survived by a child under 19 years of age, the insurer must pay a monthly benefit to each child equal to 4.35 times 25 percent of the state average weekly wage, subject to the following:

(a) Total monthly benefits paid under this section must not exceed 4.35 times 133-1/3 percent of the state average weekly wage. If the sum of the individual benefits exceeds this maximum, the insurer must reduce the benefit for each child proportionally;

(b) The insurer may make payment of benefits due under this section to the child's parent, legal guardian, or person having custody of the child. If the child becomes sui juris, the insurer must begin making payment of benefits directly to the child immediately upon the child's written request; and

(c) The insurer must send each child Form 5332, "Notice to Beneficiary of Entitlement to Benefits" at least 90 days before their 18th birthday, informing the child of ~~his or her~~their right to receive benefit payments directly under subsection (b), and of ~~his or her~~their entitlement to higher education benefits.

(5) Benefit to surviving dependent.

If a worker is survived by a dependent, the insurer must pay a monthly benefit to each dependent that is equal to 50 percent of the average monthly support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury, subject to the following:

(a) Payments to the dependent must continue until:

(A) The dependent becomes 19 years of age, if the dependent is under the age of 19 years at the time of the accidental injury; or

(B) The time the dependency would have terminated had the injury not happened, if the dependent is 19 years of age or older at the time of the accidental injury;

(b) Within five business days after the date of receipt of a request for benefits from an eligible dependent, the insurer must mail the dependent a request for verifiable documentation of the support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury. The request must:

(A) Inform the dependent what verifiable documentation the dependent must submit to the insurer to calculate the dependent's benefit; and

(B) Clearly state that if the insurer does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the dependent's monthly benefit based only on the information in the insurer's possession;

(c) Upon receipt of verifiable documentation or the expiration of the 60-day period in paragraph (5)(b)(B) of this rule, the insurer must:

(A) Determine the dependent's monthly benefit and begin payment under OAR 436-060-0150(6); or

(B) Notify the dependent that the information in the insurer's possession was not sufficient to determine the dependent's monthly benefit and provide information about how the dependent may appeal this decision; and

(d) As used in this section, "verifiable documentation" means any written record of financial support provided to the dependent by the worker including, but not limited to, receipts, billing statements, bank account statements, or signed affidavits.

(6) Benefit to child or dependent attending higher education.

The insurer must pay up to 48 months of benefits during any period in which an eligible child or dependent is between the ages of 19 and 26 and is completing secondary education, is obtaining a general educational development certificate, or is attending a program of higher education, including vocational or technical training.

(a) Benefits under this section must be paid for an entire month. The child or dependent may claim a full month's benefit

for any month in which the child is completing secondary education, obtaining a general educational development certificate, or attending a program of higher education for at least one day.

(b) The child or dependent must provide the insurer with documentation that enables the insurer to determine the child's or dependent's eligibility for monthly benefits.

(A) As used in this section, "documentation" includes, but is not limited to, verification of enrollment in a secondary school, general education development certificate program, or program of higher education.

(B) The child or dependent may use Form 5332, "Notice to beneficiary of entitlement to benefits," to satisfy the requirements of this section.

(7) Death during permanent total disability.

If a worker dies during a period of permanent total disability:

(a) The insurer must pay the costs of final disposition of the body and funeral expenses in the same manner and same amounts as provided in section (1) of this rule, subject to the following:

(A) For claims with a date of injury before July 1, 1973, burial benefits are due only if death results from the accidental injury causing the permanent total disability; and

(B) For claims with a date of injury on or after July 1, 1973:

(i) Burial benefits are due if death results from the accidental injury causing the permanent total disability; or

(ii) Burial benefits are due regardless of the reason for death, if the worker was survived by an eligible beneficiary;

(b) The insurer must pay benefits to surviving beneficiaries in the same manner and same amounts as provided in sections (2) through (6) of this rule:

(A) Permanent total disability benefits must be paid through the date of death. Benefits under this section begin to accrue the following calendar day; and

(B) Benefits payable for a partial month must be calculated by dividing the monthly benefit by the actual number of days in the month and multiplying that result by the number of days payable;

(c) The insurer is not required to reopen and close the claim to begin making payments under this section; and

(d) The insurer may not recover an overpayment of permanent total disability benefits from benefits payable to a beneficiary other than the beneficiary that received the overpayment.

Statutory authority: 656.726(4)
Statutes implemented: ORS 656.204, 656.208, and 656.268(14)
Hist: Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-105-0520 Assistance Available from the Employer-at-Injury Program

(1) General provisions.

(a) The Employer-at-Injury Program may be used only once per worker per claim opening or request for reopening. If a nondisabling claim becomes a disabling claim after one year from the date of acceptance, the disabling claim is considered a new opening and the Employer-at-Injury Program may be used again.

(b) Assistance available includes wage subsidy, worksite modification, and purchases.

(c) Any modification and other purchases must be ordered before the end of the Employer-at-Injury Program.

(2) Wage subsidy. Wage subsidy provides reimbursement of 50 percent of the worker's gross wages for the wage subsidy period. Wage subsidy benefits are subject to the following conditions:

(a) A wage subsidy may not exceed 66 workdays and must be completed within a 24-consecutive month period;

(b) A wage subsidy may not start or end with paid leave;

(c) If the worker has hourly restrictions, reimbursable paid leave cannot exceed the maximum number of hours of the worker's hourly restrictions. Paid leave exceeding the worker's hourly restrictions will not be reimbursed; and

(d) Any day during which the worker exceeds ~~his or her~~their injury-caused limitations will not be reimbursed. If, however, an employer uses a time clock, a reasonable time of up to 30 minutes per day will be allowed for the worker to get to and from the time clock and the worksite without exceeding the worker's hourly restrictions.

(3) Worksite modification.

(a) Worksite modification is altering a worksite by renting, purchasing, modifying, or supplementing equipment to:

(A) Enable a worker to perform the transitional work within the worker's limitations that resulted in the worker's Employer-at-Injury Program eligibility;

(B) Prevent a worsening of the worker's compensable injury or occupational disease; or

(C) If the claim has not been accepted or denied, to prevent a worsening of the claimed workers' compensation injury or occupational disease.

(b) For purposes of the Employer-at-Injury Program, a "worksite" is a primary work area available for a worker to use to perform the required job duties. The worksite may be the employer's, client's, or worker's premises, property, or equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job.

(c) Worksite modification assistance is subject to the following conditions:

(A) The insurer must determine the appropriate worksite modifications for the worker;

(B) The insurer must document its reasons for approving the modifications; and

(C) Worksite modification items become the employer's property at the end of the Employer-at-Injury Program.

(4) Employer-at-Injury Program purchases. Employer-at-Injury Program purchases are limited to:

(a) Tuition, books, fees, and materials required for skills building or to meet the requirements of the transitional work position. Maximum expenditure is $1,000. Tuition, books, fees, and required materials will be provided under the following conditions:

(A) The insurer must determine the class or course of instruction will help the worker enhance an existing skill or develop a new skill, and must document its decision; and

(B) The worker must begin participation in the class or course of instruction while eligible for the Employer-at-Injury Program;

(b) Clothing required for the job, except clothing the employer normally provides. Clothing becomes the worker's property. Maximum expenditure is $400; and

(c) Tools and equipment required for the worker to perform transitional work, including consumables required to support the functioning of the tools or equipment. These purchases become the employer's property.

(5) Other conditions for worksite modifications and purchases.

(a) Worksite modification and purchases of tools and equipment are limited to a combined maximum reimbursement of $5,000.

(b) Extended warranties that are in addition to the standard or manufacturer's warranty are not reimbursable under the Employer-at-Injury Program.

(c) All modifications and purchases made by the employer in good faith are reimbursable, even if the worker refuses to return to work, or if the worker agreed to take part in training and then later refused to attend training.

Statutory authority: ORS 656.622, 656.726(4)
Statutes implemented: ORS 656.622
Hist: Amended 12/17/19 as WCD Admin. Order 19-059, eff. 1/1/20

436-110-0350 Worksite Modification – General Provisions

(1) Worksite modification defined.

(a) Worksite modification means altering a worksite by purchasing, modifying, or supplementing equipment, or changing the work process, to enable a worker to work within the restrictions caused by a compensable injury or occupational disease.

(b) For purposes of the Preferred Worker Program, "worksite" means a primary work area that is in Oregon, already constructed, and available for a worker to use to perform the required job duties. The worksite may be the employer's, client's, or worker's premises, property, or equipment used to conduct business under the employer's or client's direction and control. A worksite may include a worker's personal property or vehicle if required to perform the job. If the worksite is mobile, it must be available in Oregon for inspection and modification.

(2) Conditions for use.

Conditions for the use of worksite modification assistance are as follows:

(a) Modifications must allow the worker to perform the job duties within the worker's injury-caused permanent restrictions. In order to determine appropriate worksite modifications, the division worksite modification consultants have discretion to use reports by a medical service provider specific to the worker, specific documented "best practices" described by a medical service provider or authority, and their own professional judgment and experience;

(b) A job analysis that includes the duties and physical demands of the job before and after modification may be required to show how the modification will overcome the worker's restrictions. The job analysis may be submitted to the attending physician for approval before the modification is performed;

(c) Except as provided in OAR 436-110-0351(2) for employer at injury activated modifications, modifications can be used up to a maximum of $50,000 per eligibility period, with each use limited to $35,000. If the worker has an exceptional disability, a modification more than $35,000 may be provided;

(d) Modifications not to exceed $2,500 may be provided that would reasonably be expected to prevent further injury or exacerbation of the compensable injury or occupational disease, including any disability resulting from the compensable injury or occupational disease. A division worksite modification consultant will determine the appropriateness of this type of modification based upon ~~his or her~~the consultant's professional judgment and experience, reports by a medical service provider specific to the worker, or specific documented "best practices" described by a medical service provider or authority. Costs of the modifications are included in the calculation of the total worksite modification costs;

(e) Modifications are limited to $2,500 for on-the-job training under OAR 436-120, "Vocational Assistance to Injured Workers," or other similar on-the-job training program when the trainer is not the employer at injury. A modification will not be approved for any other type of training;

(f) Modifications up to $2,500 may be provided to protect the items approved in the worksite modification agreement from theft or damage from the weather. Insurance policy premiums will not be paid;

(g) When a vehicle is being modified, the vehicle owner must provide proof of ownership and insurance coverage. The worker must have a valid driver license with any applicable classification or endorsement;

(h) Rented or leased vehicles and other equipment will not be modified;

(i) Modifications must be reasonable, practical, and feasible, as determined by the director;

(j) When the director determines the appropriate form of modification and the worker or employer requests a form of modification equally appropriate but with a greater cost, upon director approval, funds equal to the cost of the form of modification identified by the director may be applied toward the cost of the modification desired by the worker or employer;

(k) A modification may include rental of tools, equipment, fixtures, or furnishings to determine the feasibility of a modification. It may also include consultative services necessary to determine the feasibility of a modification, or to recommend or design a worksite modification;

(l) Rental of worksite modification items and consultative services require director approval and are limited to a cost of up to $5,000 each. The cost for rental of worksite modification items and consultative services does not apply toward the total cost of a worksite modification;

(m) Modification equipment will become the property of the employer, worker, or client on the end date of the worksite modification agreement, or when the worker's employment ends, whichever occurs first. The director will determine ownership of worksite modification equipment before approving an agreement and has the final authority to assign property;

(n) The director may request a physical capacities evaluation, work tolerance screening, or review of a job analysis to quantify the worker's injury-caused permanent restrictions. The cost of temporary lodging, meals, public transportation, and use of a personal vehicle necessary for a worker to participate in one or more of these required activities will be reimbursed at the rate published in Bulletin 112. The cost of the services described in this subsection must be paid by the insurer;

(o) If the property provided for the modification is damaged, in need of repair, or lost, the director will not repair or replace the property;

(p) The employer must not dispose of the property provided for the modification or reassign it to another worker while the worker is employed in work for which the modification is necessary or before the end of the agreement without director and worker approval. Failure to repair or replace the property, or inappropriate disposal or reassignment of the property, may result in sanctions under OAR 436-110-0900; and

(q) The worker must not dispose of the property provided for the modification while employed in work for which the modification is necessary or before the end of the agreement without director approval. Failure to repair or replace the property, or inappropriate disposal of the property, may result in sanctions under OAR 436-110-0900.

(3) Requests for assistance, payment, and reimbursement.

(a) A worker, employer, or the worker's or employer's representative, may request worksite modification assistance.

(b) A division worksite modification consultant will determine if competitive quotes are required.

(c) The director must create and approve a completed and signed worksite modification agreement before any reimbursement or payment.

(d) Costs of approved worksite modifications will be paid by reimbursement or other instrument of payment approved by the director.

(e) The director will provide payment but will not otherwise assume responsibility for worksite modifications.

(f) The person or entity that purchased the items may request reimbursement by submitting to the division proof of payment for the items purchased. Reimbursement will be made for only those items and costs approved and paid.

(g) All requests for reimbursement must be made within one year of the date the worksite modification agreement ends. No specific form is required.

(h) Reimbursed costs may not be charged by the insurer to the employer as claims costs or by any other means.

Statutory authority: ORS 656.726(4), 656.622
Statutes implemented: ORS 656.622
Hist: Amended 11/28/16 as WCD Admin. Order 16-057, eff. 1/1/17

436-120-0115 Vocational Eligibility Evaluation

(1) Purpose of eligibility evaluation.

An eligibility evaluation is done to determine whether the worker is or is not eligible for vocational assistance.

(2) When an eligibility evaluation is not required.

An eligibility evaluation is not required if:

(a) The worker's claim is reopened under Own Motion under ORS 656.278;

(b) The worker is receiving permanent total disability benefits; or

(c) The worker is deceased.

(3) When an eligibility evaluation is required.

Except as provided in OAR 436-120-0117, the insurer is required to begin an eligibility evaluation for workers with accepted disabling claims within five days of any of the following conditions:

(a) The insurer receives information such as medical or investigative reports that indicate, before the worker is medically stationary, the worker is likely eligible for vocational assistance;

(b) The worker is medically stationary, is not currently receiving vocational assistance, and:

(A) Has not returned to or been released to regular employment; or

(B) Has not returned to other suitable employment with the employer at the time of injury or aggravation; or

(c) Eligibility was previously determined under the current opening of the claim and the insurer has accepted a new condition.

(4) Services may be provided at any time.

Nothing in these rules prevents an insurer from finding a worker eligible and providing vocational assistance at any time.

(5) Worker request for vocational assistance.

If the insurer receives a request for vocational assistance from the worker and the insurer is not required to do an eligibility evaluation, the insurer may not deny eligibility for assistance, but must notify the worker in writing within 14 days of the request of:

(a) The reasons an eligibility evaluation is not required;

(b) The circumstances that require an eligibility evaluation; and

(c) Instructions to contact the division with questions about vocational assistance eligibility requirements and procedures.

(6) The eligibility evaluation process.

(a) The eligibility evaluation must be done by a counselor.

(b) At the insurer's request, the worker must provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(c) The insurer must provide the counselor with all relevant vocational and medical information.

(d) The eligibility evaluation process, including notifying the worker of the results under section (9) of this rule, must be completed within 30 days of when the process began under section (3) of this rule, unless extended under section (7) of this rule.

(e) Either the insurer or the counselor may notify the worker of the results of the eligibility evaluation under section (9) of this rule.

(7) Extension of time.

(a) The counselor may extend the time frame in section (6) of this rule for completing the eligibility evaluation if the counselor is unable to obtain needed information from the worker, employer, or medical provider.

(b) An extension of time may be for no more than 30 days.

(c) The counselor must notify the worker of the extension under section (8) of this rule, and submit a copy of the letter to the division.

(8) Notice of extension of time.

The letter informing the worker that the time frame for completing the eligibility evaluation process has been extended must:

(a) Clearly indicate the purpose of the letter;

(b) Explain the reason for the extension of time;

(c) Explain what information is necessary to complete the eligibility evaluation process;

(d) State when the eligibility evaluation process is expected to be completed;

(e) Be mailed to the worker within five days of the date the counselor determines an extension is needed under subsection (7)(a) of this rule; and

(f) Include the following language in bold type:

"If you have questions about the vocational assistance process, contact [use appropriate reference to the insurer]. If you still have questions contact the Workers' Compensation Division's toll free number 1-800-452-0288."

(9) Results of the eligibility evaluation.

The results of the eligibility evaluation must be mailed to the worker following the requirements for the appropriate notice under subsection (a) or (b) of this section.

(a) The NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE must:

(A) Include the worker's responsibilities, as specified in OAR 436-120-0197(2) and 436-120-0520(1);

(B) Include the following statement in bold type:

"You have the right to request a return-to-work plan conference if the insurer does not approve a return-to-work plan within 90 days of determining you are entitled to a training plan, or within 45 days of determining you are entitled to a direct employment plan. The purpose of the conference will be to identify and remove all obstacles to return-to-work plan completion and approval. The insurer, the worker, the counselor, and any other parties involved in the return-to-work process must attend the conference. The insurer or the worker may request a conference with the division if other delays in the vocational assistance process occur. Your request for this conference should be directed to the Employment Services Team of the Workers' Compensation Division. The address and telephone number of the division are: Employment Services Team, Workers' Compensation Division, P.O. Box 14480, Salem, Oregon 97309-0405; 1-800-452-0288.";

(C) Explain that the worker and the insurer must agree on the selection of a counselor, and:

(i) Provide instructions for the worker to access the list of providers on the division's website (wcd.oregon.gov/rtw/Pages/voc-assistance.aspx);

(ii) Include a phone number for the worker to call to request a paper copy of the list; and

(iii) Include the following language in bold type:

"If you have questions about the vocational counselor selection process, contact [use appropriate reference to the insurer]. If you still have questions, call the Workers' Compensation Division at 1-800-452-0288.";

(D) Include information about the Preferred Worker Program;

(E) Explain what the worker can do if ~~he or she~~the worker disagrees with something the insurer does; and

(F) Explain direct employment services and state the worker is not entitled to training, if the worker is entitled to direct employment services but not training.

(b) The NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE must include:

(A) Information about services that may be available at no cost from the Oregon Employment Department or the Office of Vocational Rehabilitation Services;

(B) A brief description of the Preferred Worker Program benefits and contact information. The information can be part of the notice or a separate document attached to the notice; and

(C) A list of suitable occupations the worker can perform without being retrained, if the notice is based on a finding that the worker does not have a substantial handicap to employment.

(10) Multiple claims.

Vocational assistance may only be provided for one claim at a time. If the worker is eligible for vocational assistance under

two or more claims, the claim for the injury with the most severe vocational impact is the claim that gave rise to the need for vocational assistance. The parties may agree to provide services for more than one claim at a time, and extend time and fee limits beyond those allowable in these rules.

Statutory authority: ORS 656.340, ORS 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0145 Vocational Assistance Eligibility

(1) A worker whose permanent total disability benefits have been terminated by a final order is eligible for vocational assistance.

(2) A worker is eligible for vocational assistance if all of the following conditions are met:

(a) The worker is authorized to work in the United States;

(b) The worker is available in Oregon or within commuting distance of Oregon, unless:

(A) The worker states in writing that within 30 days of being determined eligible for vocational assistance the worker will move back to Oregon, or within commuting distance of Oregon, at the worker's expense;

(B) The worker did not work and live in Oregon at the time of the injury;

(C) The worker needs to live outside of Oregon due to financial hardship, family circumstances over which the worker has no control, or other similar situation; or

(D) The training program or supporting labor market for a specific vocational goal is only available outside of Oregon;

(c) As a result of the limitations caused by the injury or aggravation, the worker:

(A) Is not able to return to regular employment;

(B) Is not able to return to suitable and available work with the employer at injury or aggravation; and

(C) Has a substantial handicap to employment and requires assistance to overcome that handicap;

(d) The worker was not employed in suitable employment for at least 60 days after the injury or aggravation;

(e) The worker did not refuse or fail to make a reasonable effort in available light-duty work intended to result in suitable employment. Before finding the worker ineligible, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer at injury offers such employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(f) The worker is available for vocational assistance. If the worker is not available, the insurer must determine if the reasons are for reasonable or unreasonable cause before finding the worker ineligible. If the reason was for incarceration, this reason must be stated in the notice to the worker. Declining vocational assistance to accept modified or new employment that results from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause; and

(g) The worker did not refuse or otherwise relinquish ~~his or her~~their rights to vocational assistance in writing.

(3) Individuals covered under ORS 656.033, 656.046, 656.135, or 656.138 (work experience program participants, apprentices, trainees), are eligible for vocational assistance if they otherwise meet the eligibility requirements in section (2) of this rule. For purposes of vocational assistance:

(a) The employer at injury is the district, college, or school conducting the program or project in which the individual was injured;

(b) Regular employment is the job for which the individual was being trained at the time of the injury; and

(c) The assumed wage upon which premium was based, but in no event less than minimum wage, should be used to determine suitable wage under OAR 436-120-0147.

(4) The worker must participate in the vocational assistance process and must provide relevant information. If the worker does not participate, or fails to provide relevant information, the insurer must issue a written warning before finding the worker ineligible under this rule.

(5) The worker must not misrepresent a matter material to evaluating eligibility.

Statutory authority: ORS 656.340, ORS 656.726(4)
Statutes implemented: ORS 656.206, 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0157 Determining Substantial Handicap to Employment

(1) A counselor must do a substantial handicap evaluation as part of the eligibility evaluation when applicable.

(2) To complete the substantial handicap evaluation the counselor must submit a report documenting the following information about the worker:

(a) Relevant work history for at least the preceding five years;

(b) Level of education, proficiency in spoken and written English or other languages, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage and suitable wage;

(d) Permanent limitations due to the injury;

(e) An analysis of the worker's transferable skills, if any;

(f) A list of physically suitable jobs for which the worker has the knowledge, skills, and abilities, that pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g);

(g) An analysis of the worker's labor market using standard labor market reference materials, including but not limited to information provided by the Employment Department's Oregon Labor Market Information System (OLMIS) and Oregon Wage Information (OWI) (available on the Oregon Employment Department's website at www.qualityinfo.org/). When using OWI data, the presumed standard will be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate; and

(h) Consideration of the vocational impact of any limitations that existed before the injury.

(3) When determining the worker's eligibility for vocational assistance, the insurer may consider any knowledge, skills, and abilities the worker gained after the date of injury or aggravation that resulted from training provided by the employer; however, the insurer may not include any knowledge, skills, or abilities the worker gained at ~~his or her~~their own expense after the date of injury or aggravation.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.340(5) and (6)
Hist: Amended and renumbered 11/28/16 from 436-120-0340, as Admin. Order 16-058, eff. 1/1/17

436-120-0165 End of Eligibility for Vocational Assistance

(1) Reasons for ending eligibility.

A worker's eligibility for vocational assistance ends when any of the following conditions apply:

(a) Based on **new information** that did not exist or that could not have been obtained with reasonable effort at the time the insurer determined eligibility, the worker no longer meets the eligibility requirements;

(b) The worker has been employed in **suitable employment** for at least 60 days after the date of injury or date of aggravation;

(c) The worker has been employed in suitable employment that is modified or new employment resulting from an **employer-at-injury activated use of the Preferred Worker Program** under OAR 436-110 and:

(A) If there are no worksite modifications, premium exemption has been effective for 12 months;

(B) If there is a worksite modification, 12 months have passed since the director determined it to be complete; or

(C) During the 12-month period in paragraph (A) or (B), the worker is terminated for cause or voluntarily resigns for a reason unrelated to the work injury;

(d) The worker, before beginning an authorized return-to-work plan, **refused an offer of suitable employment**. If the employer-at-injury offers employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(e) The worker, before beginning an authorized return-to-work plan, **left suitable employment** after the injury or aggravation for a reason unrelated to the limitations caused by the injury;

(f) The worker, before beginning an authorized return-to-work plan, **refused or failed to make a reasonable effort in available light-duty work** intended to result in suitable employment. Before ending eligibility, the insurer must document the existence of one or more suitable jobs that would be available for the worker after completion of the light-duty work. If the employer at injury offers such employment to a worker who is not medically stationary, the offer must be made in accordance with OAR 436-060-0030;

(g) The worker, after completing an authorized training plan, **refused an offer of suitable employment;**

(h) The worker **declined or became unavailable** for vocational assistance.

(A) The insurer must determine if the reasons are for reasonable or unreasonable cause before ending the worker's eligibility.

(B) If the reason was for incarceration, this reason must be stated in the notice to the worker.

(C) Declining vocational assistance to accept modified or new employment that results from an employer-at-injury activated use of the Preferred Worker Program, under OAR 436-110, is reasonable cause;

(i) The worker **refused a suitable training site** after the counselor and worker have agreed in writing upon a return-to-work goal;

(j) The worker **failed after written warning to participate in the development or implementation** of a return-to-work plan. No written warning is required if the worker fails to attend two consecutive training days and fails, without reasonable cause, to notify the counselor or the insurer by the close of the next business day;

(k) The worker's lack of suitable employment **cannot be resolved by providing vocational assistance**. This includes circumstances in which the worker cannot benefit from, or participate in, vocational assistance because of medical conditions unrelated to the injury;

(l) The worker **misrepresented information** relevant to providing vocational assistance;

(m) The worker **refused after written warning to return property** provided by the insurer or reimburse the insurer as required. No vocational assistance will be provided under subsequent openings of the claim until the worker returns the property or reimburses the funds;

(n) The worker **misused funds** provided for the purchase of property or services. No vocational assistance will be provided under subsequent openings of the claim until the worker reimburses the insurer for the misused funds;

(o) After written warning the worker continues to **harass** any participant to the vocational process. This subsection does not apply if such behavior is the result of a documented medical or mental condition;

(p) The worker entered into a **claim disposition agreement** and disposed of vocational rights. The parties may agree in writing to suspend vocational assistance pending approval of the agreement by the Workers' Compensation Board. The insurer must end eligibility when the Workers' Compensation Board approves the claim disposition agreement that disposes of vocational assistance rights. No notice regarding the end of eligibility is required; or

(q) The worker received **maximum direct employment services** and is not entitled to other categories of vocational assistance.

(2) Notice of end of eligibility.

When an insurer ends a worker's eligibility for vocational assistance, the insurer must mail to the worker a NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE

within five days of the end of eligibility date. The notice must include:

(a) The date when eligibility ended. The effective date is the worker's last date of eligibility; and

(b) The reason the worker's eligibility for vocational assistance is ending. However, notice is not required if the insurer is ending the worker's eligibility because the worker has given up ~~his or her~~their vocational assistance rights through a claim disposition agreement.

(3) Report to director.

When an insurer ends a worker's eligibility for vocational assistance, the insurer must submit to the division, within 30 days after the date eligibility ends, Form 2800, "Vocational Closure Report." The report must include:

(a) The effective date for the end of eligibility;

(b) The reason for the end of eligibility; and

(c) Return-to-work and provider information.

Statutory authority: ORS 656.340, ORS 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0175 Redetermining Eligibility for Vocational Assistance

If a worker was previously determined ineligible for vocational assistance or the worker's eligibility for vocational assistance ended, the insurer must redetermine eligibility within 30 days of notification of a change of any of these circumstances:

(1) The worker, for reasonable cause, was unavailable for vocational assistance and is now available;

(2) The worker's lack of suitable employment could not be resolved by providing vocational assistance. The insurer may require the worker to provide evidence that circumstances have changed;

(3) The worker declined vocational assistance to accept modified or new employment that resulted from an employer at injury activated use of preferred worker benefits under OAR 436-110. If the job was not suitable, the worker must request redetermination within 30 days of termination of the employment for which preferred worker benefits were provided;

(4) The worker was not available for vocational assistance in Oregon or within commuting distance of Oregon. The worker must request redetermination within six months of receiving the insurer's notice that ~~he or she~~the worker was not eligible for this reason;

(5) The worker, who was not authorized to work in the United States, is now authorized to work in the United States. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker has applied for authorization to work in the United States and is awaiting a decision by the U.S. Citizenship and Immigration Services (USCIS). The worker must provide the insurer with a copy of any decision by the USCIS within 30 days of receipt. The insurer must redetermine eligibility upon receipt of documentation of the worker's authorization to work in the United States;

(6) Before claim closure, the worker's limitations due to the injury became more restrictive;

(7) Before claim closure, the insurer accepts a new condition that was not considered in the original determination of the worker's eligibility; or

(8) The worker's average weekly wage is redetermined and increased.

Statutory authority: ORS 656.340, ORS 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0443 Training - General

(1) Training services include but are not limited to plan development, training, monthly monitoring of training progress, and job placement services.

(2) The training plan must be developed and monitored by a counselor.

(3) The selection of plan objectives and the kind of training must attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment.

(4) If there are any changes made to the original training plan, an addendum to Form 1081, "Training Plan," must be completed, signed by all parties, and submitted to the division.

(5) Basic education may be offered, with or without other training components, to raise the worker's education to a level to enable the worker to obtain suitable employment.

(6) On-the-job training prepares the worker for permanent, suitable employment with the training employer and for employment in the labor market at large. On-the-job training must be considered first in developing a training plan.

(7) Occupational skills training is offered through a community college, based on a predetermined curriculum, at the training employer's location.

(8) Formal training may be offered through a vocational school licensed by an appropriate licensing body, community college, or other post-secondary educational facility that is part of a state system of higher education.

(9) Rehabilitation facilities training provides evaluation, training, and employment for severely disabled individuals.

(10) Notwithstanding OAR 436-120-0145(2)(b), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate, or cost effective than other alternatives.

(11) Training status continues during the following breaks:

(a) A regularly scheduled break of not more than six weeks between fixed school terms;

(b) A break of not more than two weeks between the end of one kind of training and the start of another for which the starting date is flexible; or

(c) A period of illness or recuperation of the worker that does not prevent completion of the training by the planned date.

(12) The insurer must pay the worker temporary disability compensation, under ORS 656.268 and 656.340, when the worker is actively engaged in an approved training plan and there is a Form 1081, "Training Plan," signed by the worker, the insurer, and the counselor who developed the plan.

(13) Temporary disability compensation is limited for each eligibility period to 16 months unless extended to 21 months by the insurer or ordered by the director when the worker provides good cause. Good cause may include but is not limited to the reasons given under section (14) of this rule. In no event may temporary disability compensation during training be paid for more than 21 months.

(14) Training costs may be paid for periods longer than 21 months. Reasons for extending training may include but are not limited to:

(a) Reasons beyond the worker's control;

(b) The worker has an exceptional disability, which is a disability equal to or greater than the complete loss, or loss of use, of both legs, or a brain injury that results in impairment equal or greater than Class 3 as defined in OAR 436-035-0390; or

(c) The worker has an exceptional loss of earning capacity, which exists when no suitable training plan of 18 months or less will eliminate the worker's substantial handicap to employment. The extension must allow the worker to obtain, at the time of completion of the training program, a wage that is as close as possible to the worker's adjusted weekly wage and greater than could be expected with a shorter training program.

(15) An eligible worker is entitled to four months of job placement assistance after completion of training.

(16) When the worker returns to work following training, the insurer must monitor the worker's progress for at least 60 days to assure the suitability of the employment before ending eligibility.

(17) If the worker chooses a training plan period ~~of~~ longer than ~~he or she~~the worker is entitled to receive under these rules, the worker may supplement training provided by the insurer by completing self-sponsored training or studies. For the purpose of this rule, self-sponsored means the worker is obligated to pay for the training.

(a) The first day of training provided by the insurer will be considered the training start date and the last day of training provided by the insurer will be the training end date.

(b) All self-sponsored training must be completed before the training start date unless the parties otherwise agree.

(c) During self-sponsored training, the insurer may provide optional services under OAR 436-120-0187, including but not limited to payment of expenses for tuition, fees, books, and supplies.

(d) The training plan support document must describe how the worker-sponsored training and the training provided by the insurer will combine to prepare the worker for suitable employment.

(18) The insurer must provide further training to a worker if the initial plan will not be or was not successful to prepare the worker for suitable employment.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17

436-120-0820 Renewal of Certification

(1) Required documentation.

A certified individual must renew ~~his or her~~their certification every five years by submitting the following documentation to the division no later than 30 days before the end of the certification period:

(a) Current certification by the Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC); or

(b) Verification of a minimum of 60 hours of continuing education units under this rule within the five years before renewal.

(2) Continuing education.

(a) The director will accept continuing education units for:

(A) Training approved by the CRCC, CCMC, or CDMSC;

(B) Courses in or related to psychology, sociology, counseling, or vocational rehabilitation, if given by an accredited institution of higher learning;

(C) Training presented by the division pertaining to OAR 436-120, 436-105, or 436-110;

(D) Teaching a class or making a formal presentation to a group on a topic related to vocational rehabilitation; and

(E) Any continuing education program certified by the director for providers. Sixty minutes of continuing education will count as one unit, except as noted in subsection (b) of this section.

(b) In the case of college course work, the director will grant credit only for grades of C or above and will multiply the number of credit hours by six to establish the number of continuing education units.

Statutory authority: ORS 656.340(9), 656.726(4)
Statutes implemented: ORS 656.340
Hist: Amended 11/28/16 as Admin. Order 16-058, eff. 1/1/17