

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Claims Administration
PROPOSED Oregon Administrative Rules
Chapter 436, Division 060,
Rules 0035 & 0095

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Proposed revisions are marked as follows:

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

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
 A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services,
 Workers' Compensation Division

OAR CHAPTER 436

Agency and Division	Administrative Rules Chapter Number
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RULE CAPTION

Proposed amendment of workers' compensation rules affecting injured workers, employers, medical providers, insurers, and others.

May 22, 2006	10:00 a.m.*	Room 260 (2 nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

***NOTE: The hearing will begin at 10:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through May 26, 2006.**

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

RULEMAKING ACTION

ADOPT: None

AMEND: OAR

436-010-0005	436-010-0230	436-010-0275	436-055-0070	436-060-0035
436-010-0210	436-010-0240	436-010-0280	436-055-0085	436-060-0095
436-010-0220	436-010-0265	436-055-0008	436-055-0110	436-070-0020

REPEAL: 436-055-0120

ORS 656.726(4)
 Stat. Auth.

Other Authority

ORS chapter 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, ch. 26;
 ORS 656.325, Enrolled SB 311 – OL 2005, ch. 675
 Stats. Implemented

RULE SUMMARY

Proposed substantive amendments affect:

- (OAR 436-010-0220) Referrals to a specialist physician by an attending physician or authorized nurse practitioner – the authority of the specialist physician to provide services and treatment without specific authorization by the attending physician or nurse practitioner (specialist physician is defined in OAR 436-010-0005(38));
- (OAR 436-010-0230) Informed consent for attendance by an employer representative at a worker's medical exam – requirement that the consent form be written in a way that enables the worker to understand it; the worker has the right to refuse such attendance;
- (OAR 436-010-0230) Reimbursement for medications dispensed by physicians and authorized nurse

Notice of Proposed Rulemaking Hearing

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- practitioners – removal of the 10-day supply limitation;
- (OAR 436-010-0265) Independent medical examinations (IMEs) – criteria for addition to the list of qualified physicians; exemptions; criteria for removal from list; training curriculum requirements;
- (OAR 436-010-0265) IMEs - consequences for failing to use a qualified provider from the director’s list or obtaining more than three examinations without the director’s approval;
- (OAR 436-010-0265) Seven-day time frame for IME provider to send examination report to the insurer – elimination of time frame;
- (OAR 436-010-0265 & 436-060-0095) Survey of injured worker’s IME experience – requirements that the insurer send an IME survey form: (1) to the worker with the appointment notice and (2) to the IME provider with the invasive procedure authorization form; requirement that the IME provider give a survey form to the worker to complete after the examination; the survey to be a postage-paid (by the State of Oregon) self-mailer, for delivery to the Workers’ Compensation Division;
- (436-010-0275) Insurer-managed care organization (MCO) communication – requirement that the insurer pass along information to the MCO if the information was sent to the insurer in error;
- (OAR 436-055-0008) Hearings on workers’ compensation matters currently processed by the Office of Administrative Hearings – transfer to the Workers’ Compensation Board.
- (OAR 436-055-0085) Training for renewal of claims examiner certification - for director approval, a training curriculum does not need to cover all of the components listed in OAR 436-055-0085(2);
- (OAR 436-070-0020, making some temporary changes permanent) Failure to File Notice or Notice of Audit Findings – criteria for issuance of a Failure to File Notice or Notice of Audit Findings.

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

Address questions to:

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

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

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

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

May 26, 2006

Last Day for Public
Comment

John L. Shilts

Authorized Signer and Date

4-13-06

John L. Shilts, Administrator, Workers’ Compensation Division

Printed name

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

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

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

OAR CHAPTER 436
Administrative Rules Chapter Number

In the Matter of
The Amendment of OAR:)
436-010, Medical Services)
436-055, Certification of Claims Examiners)
436-060, Claims Administration)
436-070, Workers' Benefit Fund Assessment)

Rule Caption:

Proposed amendment of workers' compensation rules affecting injured workers, employers, medical providers, insurers, and others.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, ch. 26; ORS 656.325, Enrolled SB 311 – OL 2005, ch. 675

Need for the Rule(s): The majority of the proposed rule changes are for implementation of 2005 legislation, especially Senate Bill 311, affecting independent medical examinations. Section 5 of SB 311 becomes operative on July 1, 2006. The agency proposes additional changes based on recommendations from customers and stakeholders, experience with disputed issues, and the goals of regulatory streamlining.

Documents Relied Upon, and where they are available: "Issues" documents as presented to stakeholder advisory committees; advisory committee meeting minutes; written advisory committee input in response to the agency's request for input on potential amendments.

Fiscal and Economic Impact, including Statement of Cost of Compliance: (References to "insurer" in this analysis mean the workers' compensation insurer or self-insured employer; "agency" means the Department of Consumer and Business Services and the Workers' Compensation Division; "workers' compensation system" means the agency, employers, injured workers, insurers, medical providers, vocational providers, and others in any way involved in or affected by workers' compensation laws and rules.)

The following is a list of significant changes and their estimated fiscal and economic impact on persons and organizations affected by proposed changes to chapter 436:

- **(OAR 436-010-0220) Referrals to a specialist physician by an attending physician or authorized nurse practitioner – the authority of the specialist physician to provide services and treatment without specific authorization by the attending physician or nurse practitioner**

The proposed rule change does not affect common industry practices. However, some recently disputed cases reflect uncertainty about the authority of specialist physicians. The agency projects this clarification will not have a significant fiscal impact for insurers or for medical providers. To the extent this clarification prevents an acceleration of litigation, it will avert an increase in litigation costs within the workers' compensation system.

- **(OAR 436-010-0230) Informed consent for attendance by an employer representative at a worker's medical exam – requirement that the consent form be written in a way that enables the worker to understand it; the worker has the right to refuse such attendance**

The proposed rule change does not affect common industry practices. Most insurers recognize and take steps to overcome language and cultural barriers.

The agency projects that this rule change is cost-neutral. Any increased costs associated with this rule change should be offset by enhanced efficiency in claims handling and reduced litigation.

- **(OAR 436-010-0230) Reimbursement for medications dispensed by physicians and authorized nurse practitioners – removal of the 10-day supply limitation**

The agency projects that the proposed rule change will have a minor negative fiscal impact on Oregon pharmacists and a minor (equivalent) positive impact on Oregon physicians and nurse practitioners. At a 2003 Pharmacy Fee Advisory Task Force meeting, a pharmacy representative estimated that workers' compensation pharmacy represented about 1% of total pharmacy in Oregon. According to expert advice from members of the rulemaking advisory committee, probably only a small number of medical providers will choose to dispense medications, and then generally limit dispensing to a few drugs for inflammation and pain control. **Therefore, the agency projects** the extent of any impact to be less than 1/10th of one percent of pharmacy sales.

Insurers who use pharmacy benefit managers (PBMs) may incur some increased costs due to physician dispensing, to the extent their PBMs bill at less than 88% of the average wholesale price under OAR 436-009-0090. **The agency projects** that such impact will be minor, but cannot project specific costs because we do not know how much physician dispensing will occur and whether affected workers will (later in the claim) use the PBM services offered.

The proposed rule change will reduce out-of-pocket expenses for injured workers who obtain medications directly from their physicians. Reportedly, some workers do not fill their prescriptions at pharmacies because they cannot afford to pay for the drugs out-of-pocket. Lack of appropriate medication affects treatment outcomes. To the extent the proposed change will encourage early treatment, it should improve outcomes and reduce overall medical and claim costs for insurers.

The agency projects that the proposed change will have a small positive fiscal and economic impact on the workers' compensation system as a whole.

- **(OAR 436-010-0265) Independent medical examinations (IMEs) – criteria for addition to the list of qualified physicians; exemptions; criteria for removal from list; training curriculum requirements**

ORS 656.325, as revised by Enrolled Senate Bill 311 (2005), requires the director to develop training requirements and educational materials for IME providers. Private companies and the agency will provide training required for a provider to be added to the director's list of authorized IME providers. The cost for training now available is \$0 to \$325, though the higher dollar amount is for a two-day educational conference*, of which IME training is just one component. In 2004, the agency identified 407 IME providers for the purpose of a survey, but the true number of IME providers for Oregon workers is likely closer to 500. If the average cost of initial training is \$100, the dollar cost to providers will be approximately \$50,000. In addition, providers will have to take about four hours away from their practices, though some training is offered in the evening or on videotape. At \$100 per hour for time away, the cost for 500 IME providers would be \$100 x 4 hours x 500 = \$200,000. The agency will require continuing education for IME providers, but the time and extent of such training will vary depending on whether relevant laws and rules are changed. The options for continuing education will be less costly and less demanding on time away from medical practice, in part because pre-recorded and possibly web-based training will be available. The annual cost of continuing education should be less than \$50,000.

*The May 2006 educational conference will be presented by the Workers' Compensation Division and the International Workers' Compensation Foundation, a nonprofit corporation dedicated to workers' compensation research and education. 19 providers have registered as of 3/27/06. Prior to 4/1/06, the cost is \$225. After 3/31/06, the cost is \$275. Late registration cost is \$325.

The agency projects direct and indirect dollar cost to IME providers for initial IME training of approximately \$250,000 during the first year, and no more than \$50,000 per year in subsequent years. With the exception of the educational conference, the agency will not charge for training. Other training providers to date are themselves Oregon medical providers or associations of providers; for these trainers the fiscal impact may be positive, depending on the trainer's cost of providing the training.

The agency projected in its analysis of Senate Bill 311 (when SB 311 was being considered by the Oregon Legislature) increased agency costs for administration of IME programs of \$525,608 for the 2005-07 biennium and \$635,090 for the 2007-09 biennium.

- **(OAR 436-010-0265) Independent medical examinations (IMEs) - consequences for failing to use a qualified provider from the director's list or obtaining more than three examinations without the director's approval**

The proposed rule changes will raise costs for insurers that do not comply with statutory limitations on independent medical examinations, because:

- a) In some cases, the claims processor may not be allowed to use an IME report to make decisions about the claim. However, the fiscal impact is limited, because the IME report may be used unless someone objects to its use and the director then finds that the insurer violated ORS 656.325(1).
- b) DCBS may issue civil penalties to insurers who violate ORS 656.325(1). ORS 656.745 provides for penalties up to \$2,000 per violation and up to \$10,000 in aggregate for a three-month period.

The agency projects that the increased costs for Oregon insurers who do not comply with ORS 656.325 will be offset by:

- a) Use of trained and authorized IME providers, with improved IME reports;
- b) Increased compliance with statutory IME limits.

- **(OAR 436-010-0265) Seven-day time frame for IME provider to send examination report to the insurer – elimination of the time frame**

The agency is rarely asked to enforce the existing time frame. Market forces will favor IME providers who report examination results to insurers within reasonable time frames.

The agency projects that this proposed rule change will have no fiscal or economic impact on any party.

- **(OAR 436-010-0265 & 436-060-0095) Survey of injured worker's IME experience – requirements that the insurer send an IME survey form: (1) to the worker with the appointment notice and (2) to the IME provider with the invasive procedure authorization form; requirement that the IME provider give a survey form to the worker to complete after the examination; the survey to be a postage-paid (by the State of Oregon) self-mailer, for delivery to the Workers' Compensation Division**

The agency will bear the costs of printing the survey and distribution to insurers and medical providers upon request. We estimate agency costs to be no more than \$5,000 annually.

Insurers must include the survey with each appointment notice (for the worker) and with each invasive procedure authorization form (for the medical provider). Based on information obtained from insurers and agency testing of mailing weights, inclusion of the survey with the appointment notice will sometimes increase mailing weight to greater than 1 oz (but less than 2 oz), depending on whether the appointment notice is printed on one or two sheets of paper. Some insurers may be able to hold mailings to one ounce by printing the appointment notice on one sheet of paper, front and back. However, the survey will potentially increase the cost of each mail piece by \$0.24 (the same postage increase whether regular or certified mail). 15,000 (estimated annual) IMEs x \$0.24 = \$3,600 annually.

We estimate a handling cost of \$0.25 per examination for insurers and an equal amount for IME providers. This would entail a cost to insurers of \$0.25 x 15,000 (estimated annual) IMEs = \$3,750 annually and a cost to IME providers of \$3,750 annually.

The agency projects that the proposed rule changes would increase postage and handling costs for insurers and medical providers by approximately \$11,100.

A key purpose of the survey is to gather data needed to monitor the effects of legislative reform. In addition, because the worker's evaluation of his or her IME experience will be mailed to the agency, use of the IME survey form may promote improvements in the quality of IMEs. Improvements could offset some or all of the survey costs by improving cooperation with the IME process and reducing litigation.

The agency projects that this proposed rule change would increase costs for insurers and medical providers by no more than the amounts listed above, and that the net economic impact to the workers' compensation system may be neutral or positive.

- **(436-010-0275) Insurer-managed care organization (MCO) communication – requirement that the insurer pass along information to the MCO if the information was sent to the insurer in error**

The agency projects that this proposed rule change will not have a significant fiscal impact on any party.

- **(OAR 436-055-0008) Hearings on workers' compensation matters currently processed by the Office of Administrative Hearings – transfer to the Workers' Compensation Board**

Proposed rules do not substantially alter the actions required of the parties to a hearing.

The agency projects that this proposed rule change will not have a significant fiscal impact on any party.

- **(OAR 436-055-0085) Training for renewal of claims examiner certification - for director approval, a training curriculum does not need to cover all of the components listed in OAR 436-055-0085(2)**

The agency projects that this proposed rule change will have a small positive fiscal impact on companies that provide training to claims examiners and to insurers who provide training in-house.

- **(OAR 436-070-0020, making some temporary changes permanent) Failure to File Notice or Notice of Audit Findings – criteria for issuance of a Failure to File Notice or Notice of Audit Findings**

The proposed change is important for the efficient administration of the Workers' Benefit Fund assessments collection program.

The agency projects that this proposed rule change will not have a significant fiscal impact on any party.

- **The agency estimates that additional proposed rule changes will not have any significant fiscal or economic impact on any persons or businesses, including small businesses.**

Cost of compliance effect on small businesses:

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

Medical providers who perform IMEs for Oregon injured workers.

Estimated number of small businesses subject to the proposed rule:

The agency does not have an exact count of medical providers in Oregon. Our data system only includes medical providers required to carry workers' compensation insurance and thus excludes sole proprietors who do not elect to be covered. However, based on available information, we estimate the number of small medical providers exceeds 8,200.

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

Record-keeping: The proposed rule changes do not impose record-keeping requirements. However, although the revised IME laws and related rules do not specify how medical offices are to keep track of staff who are authorized to provide IMEs, most offices will maintain records in order to monitor their own compliance with ORS 656.325(1). The agency will publish a list of authorized IME providers to its Web site.

Reporting: The proposed changes will require reporting of IME training attendance to the agency. The agency will use this information to verify completion of the training required for providers to be added to the director's list of authorized providers under ORS 656.325(1).

Administrative activities: The proposed changes would increase administrative activities related to handling of the IME survey, as well as the use of professional services in the form of IME training necessary to be added to the list of authorized IME providers under ORS 656.325(1).

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

Equipment: The proposed rule changes do not require equipment purchases or modifications.

Supplies: The proposed rule changes do not require increased purchase of supplies.

Labor: The proposed rule changes affect labor costs indirectly, by requiring medical providers to obtain IME training, and such training may require time away from the medical practice.

Increased administration: The proposed rule changes may result in some increased costs for administration in medical offices, primarily in order to monitor staff compliance with IME training requirements.

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

Representatives from small businesses participated in the stakeholder advisory committee. Small businesses affected by these rules are primarily medical providers.

Reduction of economic impact on small businesses:

After considering advice from the rulemaking advisory committees and the available data, the agency finds no basis to say that these impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impacts.

Administrative Rule Advisory Committee consulted:

Yes. The agency met with committees on February 24, 2006 and March 3, 2006 to discuss potential changes to OAR 436-010, 436-055, and 436-060. The agency conducted a telephone, e-mail, and facsimile survey of an advisory committee for OAR 436-070 during March 2006.

John L. Shilts *4-13-06*

Signature and Date

John L. Shilts, Administrator, Workers’ Compensation Division

Printed name

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

436-060-0035 Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) For the purpose of this rule:

(a) "Assigned processing administrator" is the company or business whom the director has selected and authorized to process and pay supplemental disability benefits on behalf of the director, when the insurer has elected not to process and pay these benefits.

(b) "Primary job" means the job at which the injury occurred.

(c) "Secondary job" means any other job(s) held by the worker in Oregon subject employment at the time of injury.

(d) "Temporary disability" means wage loss replacement for the primary job.

(e) "Supplemental disability" means wage loss replacement for the secondary job(s) that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210.

(f) "Verifiable documentation" means information which provides:

(A) Identification of the Oregon subject employer(s) and the time period that establishes the worker held the secondary job, in addition to the primary job, at the time of injury; and

(B) Adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.

(g) "Insurer" includes third party administrator.

(2) The insurer shall establish the temporary disability rate by multiplying the weekly wage, determined under OAR 436-060-0025, from the primary employer by 66 2/3% (.6667). If the result meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits.

(3) Within five business days of receiving notice or knowledge of employment in addition to the primary job on a claim on which the temporary disability rate for the primary job does not meet or exceed the maximum rate, the insurer must send a worker an initial notice informing the worker what type of information the insurer or the assigned processing administrator must receive to determine the worker's eligibility for supplemental disability. If the insurer has elected not to process and pay these benefits, the insurer must copy the assigned processing administrator with the notice to the worker. The notice must contain the name, address, and telephone number of the assigned processing administrator, and must also clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator.

(4) The initial notice in section (3) must also inform the worker that if the verifiable documentation is not received, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred. If the insurer later receives the documentation, the insurer must determine the worker's eligibility for supplemental disability benefits and, if the worker is found eligible, re-calculate the temporary disability rate. Additional benefits due, but not yet paid because of the worker's prior failure to provide documentation,

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Proposed CLAIMS ADMINISTRATION Rules

must be paid retroactively. Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this paragraph will not result in a penalty under ORS 656.262(11).

(5) Within 14 days of receiving the worker's verifiable documentation, the insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the decision to the worker and the worker's representative, if any, in writing. The letter must also advise the worker why he/she is not eligible when that is the decision and how to appeal the decision, if the worker disagrees with the decision.

(6) A worker is eligible if:

(a) The worker was employed at the secondary job by an Oregon subject employer at the time of the injury,

(b) The worker provides notification of a secondary job to the insurer within 30 days of the insurer's receipt of the initial claim, and

(c) The worker's temporary disability rate from wages at the primary job does not meet or exceed the maximum rate under section (2) of this rule.

(7) The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding all earnings the worker received from all subject employment, under ORS 656.210(2)(a)(B). In no case shall an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer.

(8) If the temporary disability rate from the primary employer does not meet or exceed the maximum rate, the insurer or the assigned processing administrator must combine the weekly wages, determined under OAR 436-060-0025, for each employer and multiply by 66 2/3% (.6667) to establish the combined disability rate up to the maximum rate. This is the base amount on which the worker's combined benefits will be calculated.

(9) No three-day waiting period applies to supplemental disability benefits.

(10) The worker's scheduled days off for the job at which the injury occurred shall be used to calculate and pay supplemental disability.

(11) To establish the combined partial disability benefits when the worker has post injury wages from either job, the insurer or the assigned processing administrator must use all post injury wages from both primary and all secondary employers. The insurer or the assigned processing administrator must calculate the amount due the worker based on the combined wages at injury and combined post injury wages using the temporary partial disability calculation in OAR 436-060-0030. The insurer or the assigned processing administrator must then calculate the amount due from the primary job based only on the primary wages at injury and the primary post injury wages. That amount shall be subtracted from the amount due the worker; the remainder is the supplemental disability amount.

(12) If the worker receives post injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due.

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Proposed CLAIMS ADMINISTRATION Rules

(13) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(14) Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job. The nondisabling claim will not change to disabling status due to payment of supplemental disability. When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(15) If the insurer has elected to process and pay supplemental disability under ORS 656.210(5)(a), the insurer must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability simultaneously with any temporary disability due. Reimbursement for supplemental disability paid will be made under OAR 436-060-0500.

(16) If the insurer has elected not to process and pay supplemental disability, the assigned processing administrator must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability due once each 14 days.

(17) A worker who is eligible for supplemental disability under section (5) of this rule has an on-going responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(18) If the insurer has elected not to process and pay supplemental disability, the insurer must cooperate and communicate with the assigned processing administrator and both must retain documentation of shared information, as necessary, to coordinate benefits due.

(19) Supplemental disability applies to occupational disease claims the same as injury claims. Supplemental disability benefits for an occupational disease shall be based on the worker's combined primary and secondary wages at the time there is medical verification the worker is unable to work because of the disability.

(20) When an insurer elects to pay supplemental disability under ORS 656.210(5)(a) and OAR 436-060-0010(20) and receive reimbursement under OAR 436-060-0500, the insurer must maintain a record of supplemental disability paid to the worker, separate from temporary disability paid as a result of the job at injury.

(21) If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing before the Hearings Division of the Workers' Compensation Board. If the worker chooses to request a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section ~~(4)~~**(5)** of this rule. Disputes that arise about the rate of supplemental disability may be resolved under OAR 436-060-0025(5) and may be submitted at any time. However, the insurer for the primary job is not required to contact the secondary job employer. The worker is

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responsible to provide any necessary documentation. By requesting resolution of the dispute under OAR 436-060-0025(5), the worker authorizes the Workers' Compensation Division to contact the secondary job employer to verify information provided by the worker to resolve the dispute.

(22) An insurer who elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(23) In the event of a third party recovery, previously reimbursed supplemental disability benefits are a portion of the paying agency's lien.

(24) Remittance on recovered benefits shall be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Stat. Auth: ORS 656.210, 656.704, and 656.726(4)

Stat. Implt: ORS 656.210, 656.325(5), 656.704, 656.726(4), and section 3 (2)(a), chapter 865, Oregon Laws 2001

Hist: Adopted 11/30/01 as WCD Admin. Order 01-061, eff. 1/1/02

Amended 4/19/02 as WCD Admin. Order 02-056, eff. 5/10/02 (Temp.)

Amended 10/2/02 as WCD Admin. Order 02-059, eff. 11/1/02

Amended 8/28/03 as WCD Admin. Order 03-060, eff. 9/2/03 (Temp.)

Amended 9/22/03 as WCD Admin. Order 03-061, eff. 9/22/03 (Temp.)

Amended 2/17/04 as WCD Admin. Order 04-051, eff. 2/29/04

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

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

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

436-060-0095 Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1). Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-010-0265. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) The division will consider requests to authorize suspension of benefits on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial.

(3) A worker must submit to independent medical examinations reasonably requested by the insurer or the director. **The insurer may request n**No more than three separate independent medical examinations ~~may be requested by the insurer~~ for each open period of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(7).

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(4) The insurer may contract with a third party to schedule independent medical examinations. If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice is required to be sent on the insurer's stationery and must conform with the requirements of OAR 436-060-0095(5).

(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be simultaneously notified in writing of the scheduled medical examination under ORS 656.331. The notice shall be sent at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, must contain the following:

(a) The name of the examiner or facility;

(b) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(c) The date, time and place of the examination;

(d) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the examination;

(f) That the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;

(g) That an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;

(h) That the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; and

(i) The following notice in prominent or bold face type:

“You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers’ compensation benefits may be suspended in accordance with the workers’ compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a \$100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.

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If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271."

(6) The insurer must ~~send~~ **include with each appointment notice it sends to the worker:**

(a) A form to for requesting reimbursement; and

(b) The director's brochure, Form 440-3923, "Important Information about Independent Medical Exams;" and

(c) Form 440-0858, "Worker Independent Medical Exam (IME) Survey." ~~to the worker with the appointment notice. The requirement to send the brochure applies when the brochure is available.~~

(7) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(8) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.325 and OAR 436-060-0095;

(b) The claim status and any accepted or newly claimed conditions;

(c) What specific actions of the worker prompted the request;

(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(h) A copy of the letter required in section (5) and a copy of any written verification received under subsection (8)(g);

(i) Any other information which supports the request; and

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(j) The following notice in prominent or bold face type:

“Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers’ Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized.”

(9) If the division consents to suspend compensation, the suspension shall be effective from the date the worker fails to attend an examination or such other date the division deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(10) The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker’s participation and reinstate compensation effective the date of the worker’s compliance.

(11) If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(7).

(12) If the division denies the insurer’s request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer’s request.

(13) The division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(14) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers’ Compensation Board.

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

Stats. Impemented: ORS 656.325, 656.704, and 656.726(4)

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