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OREGON ADMINISTRATIVE RULES
CHAPTER 436

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ADMINISTRATIVE ORDER NUMBERS: For each rule division, we have listed the most recent administrative order number at the top of the page. However, the reader should refer to the history references at the end of each rule to see which administrative orders revised that rule

HISTORY LINES: These rules include only recent “History” lines. The history line shows when the rule was last revised and its effective date. To obtain a comprehensive history for OAR chapter 436, please visit the division’s website: http://wcd.oregon.gov/policy/rules/history.html
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436-009-0001  Authority for Rules

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.248.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: Amended 3/6/01 as WCD Admin. Order 01-051, eff. 4/1/01

436-009-0002  Purpose

The purpose of these rules is to establish uniform guidelines for administering the payment for medical benefits to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10

436-009-0003  Applicability of Rules

(1) These rules apply to all services rendered on or after the effective date of these rules.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0004  Adoption of Standards


(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 21, Issue 12, 2011. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual is the controlling resource.

(4) To get a copy of the CPT® 2012 or the CPT® Assistant, contact the American Medical Association, 515 North State Street, Chicago, IL 60610, 800-621-8335, or on the web at: http://www.ama-assn.org.

(4)(a) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS) to be used when billing for services other than an MCO that facilitates transactions between hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills.

436-009-0005  Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made part of these rules.

(2) “Clinic” means a group practice in which several medical service providers work cooperatively.

(3) “Fee Discount Agreement” means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

(4) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; an assigned claims agent selected by the director under ORS 656.054; or, an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(5) “Provider network” means a health service intermediary other than an MCO that facilitates transactions between medical providers.
medical providers and insurers through a series of contractual arrangements.

(6) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) ANSI means the American National Standards Institute.
(b) CMS means Centers for Medicare & Medicaid Services.
(d) DME means durable medical equipment.
(e) EDI means electronic data interchange.
(f) HCPCS means Healthcare Common Procedure Coding System published by CMS.
(g) IAIABC means International Association of Industrial Accident Boards and Commissions.
(i) MCO means managed care organization certified by the director.
(j) NPI means National Provider Identifier.
(k) OSC means Oregon specific code.
(l) PCE means physical capacity evaluation.
(m) WCE means work capacity evaluation.

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.726(4)
Hist.: Amended 12/15/08 as Admin. Order 08-063, eff. 1/1/09
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11

436-009-0006 Administration of Rules
Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and OAR chapter 436, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.726(4)
Hist.: Amended 3/1/06 as WCD Admin Order 06-052, eff. 4/1/06

436-009-0008 Administrative Review Before the Director

(a) The director has exclusive jurisdiction to resolve all disputes concerning medical services including treatment, medical fees and non-payment of compensable medical bills. The director may, on the director's own motion, initiate a medical service review at any time. A party need not be represented to participate in the administrative review before the director.

(b) Any party may request the director provide voluntary alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, the director will put the agreement in writing; or the parties shall put any agreement in writing for approval by the director. If the dispute is not resolved through alternative dispute resolution, the director will issue an order.

(2) The medical provider, worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims where a party disagrees with an action or decision of the MCO, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 30 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. Administrative review by the director must be requested within 60 days of issuance of the MCO’s final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director.

(b) For all claims not enrolled in an MCO, or for disputes which do not involve an action or decision of the MCO:

(A) A worker must request administrative review by the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services.

(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee.

(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.

(D) Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

(c) An insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. The insurer must make the request within 180 days of the payment date. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

(d) Under ORS 656.704(3)(c), when there is a formal denial of the underlying condition or a denial of the causal relationship between the medical service and the accepted condition, the issue may first be decided by the Hearings Division of the Workers’ Compensation Board.

(3) Parties must submit requests for administrative review to the director in the form and format prescribed by the director. When an insurer or the worker’s representative submits a request without the required information, at the director’s discretion the administrative review may not be initiated until
the information is submitted. Unrepresented workers may contact the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker’s name, date of injury, insurer, and claim number.

(b) Specify the issues in dispute and the relief sought.

(c) Provide the specific dates of the unpaid disputed treatment or services.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original CMS bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that they have provided all involved parties a copy of:

(A) The request for review; and

(B) Any attached supporting documentation; and

(C) If known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(4) The division will investigate the matter upon which review was requested.

(a) The investigation may include, but not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider’s peers.

(b) Upon receipt of a written request for additional information, the party must respond within 14 days.

(c) A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement.

(5) The director may on the director’s own motion reconsider or withdraw any order that has not become final by operation of law. A party may also request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director’s sole discretion. A request must be mailed to the director before the administrative order becomes final.

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

(7) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers’ Compensation Board as described in OAR 436-010-0008(14).

(8) Director’s administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (7) of this rule, according to these rules, may request administrative review by the director as follows:

(a) A written request for review must be sent to the administrator of the Workers’ Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: Amended 12/15/08 as Admin. Order 08-052, eff. 7/1/09
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10

436-009-0010 General Requirements for Medical Billings

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

(2) Billings must include the worker’s full name and date of injury, the employer’s name and, if available, 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. All medical providers must submit bills to the insurer or, if provided by their contract for medical services, to the managed care organization. Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 form, except for:

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

(b) Pharmacy billings, which must be submitted on the most current National Council for Prescription Drug Programs (NCPDP) form; and

(c) EDI transmissions of medical bills under OAR 436-009-0030(3)(c).
(d) Computer-generated reproductions of forms referenced in subsections (2)(a) and (b) may also be used.

(3)(a) All original medical provider billings must be accompanied by legible chart notes documenting services that have been billed and identifying the person performing the service and license number of the person providing the service. Medical providers are not required to provide their license number if they are already providing a national identification number.

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) When billing for medical services, a medical service provider must use codes listed in CPT® 2012 or Oregon Specific Codes (OSC) that accurately describe the service. If there is no specific CPT® code or OSC, a medical service provider must use the appropriate HCPCS code, if available, to identify the medical supply or service. Pharmacy billings must use the National Drug Code (NDC) to identify the drug or biological billed.

(a) If there is no specific code for the medical service, the medical service provider must use the appropriate unlisted code from HCPCS or the unlisted code at the end of each medical service section of CPT® 2012 and provide a description of the service provided.

(b) Any service not identifiable with a code number must be adequately described by report.

(5) Medical providers must submit billings for medical services in accordance with this section.

(a) Bills must be submitted 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) A medical provider must establish good cause when submitting a bill later than outlined in subsection (a) of this section. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(c) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing. When a provider submits a bill over 12 months after the date of service, the bill is not payable, except when a provision of subsection (a) of this section is the reason the billing was submitted after 12 months.

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

(7) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to 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 which require providers to bill other than their usual fee.

(8) 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.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, costs must be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but no later than 30 days following receipt of the request. Thereafter, worker copies must be furnished during the regular billing cycle.
(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental.

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3).

(3) The medical provider may not charge a fee for the preparation of a written treatment plan and the supplying of progress notes that document the services billed as they are integral parts of the fee for the medical service.

(4) No fee is payable for the completion of a work release form or completion of a PCE form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or for a Worker Requested Medical Examination. Except as provided in OAR 436-009-0070(10)(d) and (11)(e), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider must be paid at 50 percent of the examination or testing fee.

(6) Under ORS 656.245(3), the director has excluded from compensability the following medical treatment. While these services may be provided, medical providers shall not be paid for the services or for treatment of side effects.

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

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface EMG (electromyography) 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 injured worker is 16 to 60 years old;

(C) The injured worker underwent unsuccessful conservative treatment;

(D) There is intraoperative visualization of the surgical implant level; and

(E) The procedure is not found inappropriate under OAR 436-010-0230(15) or (16).

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

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician or authorized nurse practitioner: once near the beginning, once near the middle, and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for 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.

(9)(a) When a physician or authorized nurse practitioner provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's or authorized nurse practitioner's office, such services must be identified by CPT® codes and paid according to the fee schedule.

(b) When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital fee schedule.

(10) Physician assistant, authorized nurse practitioner, or out-of-state nurse practitioner fees must be paid at the rate of 85 percent of a physician's allowable fee for a comparable service. The bills for services by these providers must be marked with modifier "81". Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.

(11) Except as otherwise provided in OAR 436-009-0070, when a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, an insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT® codes such as 99080. Refer to specific code definitions in the CPT® for other applicable codes. The billing should include documentation of the actual time spent reviewing the records or reports.
436-009-0018  Fee Discount Agreements

(1) An insurer may only apply the following discounts to a medical service provider’s or clinic’s fee:

(a) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(b) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(2) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule.

(3) An insurer may not apply a discount under a fee discount agreement until the medical service provider or clinic and the insurer have signed the fee discount agreement. Parties to the fee discount agreement must use Form 440-3659. The form must be reproduced on the medical service provider’s or clinic’s letterhead. The agreement must include the following:

(a) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;

(b) The effective and end dates of the agreement;

(c) The discount rate or rates under the agreement;

(d) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a worker receives;

(e) A statement that the agreement only applies to patients being treated for Oregon workers’ compensation claims;

(f) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties.

(g) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;

(h) The name and address of the singular insurer or self-insured employer that will apply the discounts;

(i) The National Provider Identifier for the provider or clinic; and

(j) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(4) Once the fee discount agreement has been signed by the medical service provider or clinic and the insurer, the insurer must report the fee discount agreement to the director by completing the director’s online form. The following information must be included:

(a) The insurer’s name that will apply the discounts under the fee discount agreement;

(b) The medical service provider’s or clinic’s name;

(c) The effective date of the agreement;

(d) The end date of the agreement;

(e) The discount rate under the agreement and;

(f) An indication that all the terms required under section (3) of this rule are included in the signed fee discount agreement.

(5) When the medical service provider or clinic and the insurer agree to changes under an existing fee discount agreement, the parties must enter into a new fee discount agreement. Bulletin 352 provides further information on the required form.

(6) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice. The insurer must report the termination to the director prior to the termination taking effect by completing the director’s online form. The following information must be reported:

(a) The insurer’s name;

(b) The medical service provider’s or clinic’s name; and

(c) The termination date of the agreement.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: Adopted 12/15/08 as WCD Admin. Order 08-063, eff. 1/1/09
Amended 5/21/09 as WCD Admin. Order 09-050, eff. 7/1/09

436-009-0020  Hospital Fees

(1) For the purposes of this rule:

(a) Hospital inpatient services include, but are not limited to, those bills coded “0111” through “0118” in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient services include, but are not limited to, those bills coded “0131” through “0138” in form locator #4 on the UB-04 billing form.

(2) Hospital inpatient bills must include:

(a) ICD-9-CM codes;

(b) When applicable, procedural codes;

(c) The hospital’s NPI; and

(d) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.

(3) Hospital outpatient bills must, when applicable, include the following:

(a) Revenue codes;

(b) ICD-9-CM diagnostic and procedural codes;

(c) CPT® codes and HCPCS codes; and

(d) The hospital’s NPI.

(4) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital’s adjusted cost/charge ratio (See Bulletin 290).

(5) The insurer must pay for hospital outpatient services as follows:

(a) For services by physicians and other medical service providers assigned a code under the CPT® and identified by the revenue codes indicating professional services (0960 through 0989), pay the lesser of:

(A) The amount assigned to the CPT® in the Facility Maximum column of Appendix B; or

(B) The amount charged.

(b) For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology) pay the lesser of:

(A) The amount assigned to the CPT® code or the Oregon Specific Code in the Non-Facility Maximum column of Appendix B; or

(B) The amount charged.

(c) For hospital outpatient services not paid under subsection (5)(a) or (b) of this rule, unless otherwise provided by contract, pay the amount charged multiplied by the hospital’s adjusted cost/charge ratio (See Bulletin 290).

(6) If a hospital qualifies for a rural exemption under (7)(k), the insurer may only apply an MCO contract to discount the fees calculated under this rule.

(7) Each hospital’s CMS 2552 form and financial statement shall be the basis for determining its adjusted cost/charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost/charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital’s last published cost/charge ratio or the hospital’s cost/charge ratio based on estimated data.

(a) The basic cost/charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (b), by the total patient revenues from Worksheet G-2.

(b) The net expenses for allocation derived from Worksheet A shall be modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(c) The basic cost/charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost/charge ratio calculated in subsection (7)(a) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital’s CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(e) The factors resulting from subsections (7)(c) and (7)(d) of this rule will be added to the ratio calculated in subsection (7)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(f) The adjusted cost/charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of their CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Management Division, Department of Consumer and Business Services. The adjusted cost/charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(g) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division shall determine an adjusted cost/charge ratio for the hospital based upon the adjusted cost/charge ratios of a group of hospitals of similar size or geographic location.

(h) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital’s adjusted cost/charge ratio to allow equitable payment.

(i) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost/charge ratio to reflect the data developed subsequent to the initial calculation.

(j) Notwithstanding subsections (c) through (i) of this section the payment to out-of-state hospitals, may be negotiated between the insurer and the hospital.

(A) Any agreement for payment less than the billed amount must be in writing and signed by a hospital and insurer representative.

(B) The agreement must include language that the hospital will not bill the worker any remaining balance and that the negotiated amount is considered payment in full.

(C) If the insurer and the hospital are unable to reach agreement within 60 days of the insurer’s receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(k) Notwithstanding sections (3), (4), and (5) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost/charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial
436-009-0025  Reimbursement of Related Services Costs

(1) The insurer shall notify the worker in writing at the time of claim acceptance that claim-related services, not otherwise addressed by these rules, paid by the worker will be reimbursed by the insurer as provided in this rule. The notification must include notice to the worker of the two year time limitation to request reimbursement.

(a) The worker must request reimbursement from the insurer in writing.

(b) The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed. 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.

(c) Notwithstanding subsections (a) and (b) of this section, in deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance and shall be paid within 14 days. In a claim for aggravation or a new medical condition, reimbursement of related services is not due and payable until the aggravation or new medical condition is accepted. If the claim is denied, requests for reimbursement shall be returned to the worker within 14 days.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle shall be reimbursed as provided in this section. The maximum rate of reimbursement is limited to the rate published in Bulletin 112. When a worker has documentation of the expense which includes the date of the expense, he or she may be entitled to reimbursement for:

(a) Any meal reasonably required by necessary travel to a claim-related appointment.

(b) Lodging based on the need for overnight travel to attend the appointment. Reimbursement may exceed the maximum rate where special lodging was required or where the worker was unable to find lodging at or below the maximum rate within 10 miles of the appointment location.
corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, does not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(b) Any service billed with a code number commanding a higher fee than the services provided must be returned to the medical provider for correction or paid at the value of the service provided.

(c) When a medical provider submits a bill electronically, it is considered "mailed" according to OAR 436-010-0005.

(4) The insurer or its representative must provide a written explanation of benefits being paid or denied. The insurer or its representative must send the explanation to the medical provider that billed for the services. All information on the explanation must be in 10 point size font or larger.

(5) The explanation of benefits must include:

(a) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(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 medical provider's payment question within 48 hours, excluding weekends and legal holidays;

(d) The following notice, web link, and phone number:

“To access information about Oregon’s Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.”;

(e) Space for a 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 Section, 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."

(6) The insurer or its representative must respond to a medical provider’s inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the medical provider’s inquiry. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(7) An insurer or its representative and a medical service provider may agree to send and receive payment information by e-mail. Electronic records sent by e-mail are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

(8) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(9) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(10) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code. Resolution of billing disputes, including possible overpayment disputes, must be made under OAR 436-009-0008, 436-010-0008 and 436-015.

(11) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(12) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills. The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(13) 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 disputed claim settlement (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.

(14) For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

436-009-0035 Interim Medical Benefits

(1) Interim medical benefits are not due on claims:

(a) When the worker is enrolled in an MCO prior to claim acceptance pursuant to ORS 656.245(4)(b)(B).

(b) When the insurer denies the claim within 14 days of the employer’s notice.

(c) With dates of injury prior to January 1, 2002.

(2) Interim medical benefits include:

(a) Diagnostic services required to identify appropriate treatment or prevent disability.

(b) Medication required to alleviate pain.

(c) Services required to stabilize the worker’s claimed condition and to prevent further disability. Examples of such services may include, but are not limited to: antibiotic or anti-inflammatory medication; physical therapy and other conservative therapies; and necessary surgical procedures.

(3) If the medical service provider has knowledge that the worker filed a work related claim, the medical service provider shall not collect health benefit plan co-payment from the worker.

(4) The medical service provider shall submit a copy of the bill to the workers’ compensation insurer in accordance with OAR 436-009-0010, and the health benefit plan(s) in accordance with the plan’s requirements.

(5) The insurer shall notify the medical service provider when an initial claim is denied.

(6) When the claim is denied, the medical service provider shall first bill the health benefit plan(s) with a copy of the workers’ compensation denial letter.

(7) After payment is received from the health benefit plan(s), the medical service provider may bill the workers’ compensation insurer, according to OAR 436-009-0010, for any remaining balance. The provider shall include a copy of the health benefit plan(s’) explanation of benefits with the bill. If the worker has no health benefit plan, the workers’ compensation insurer is not required to pay for interim medical benefits.

(8) The workers’ compensation insurer shall pay in accordance with the Oregon fee rules, any amount not reimbursed by the health benefit plan within 45 days of receipt of the bill with the health plan’s explanation of benefits, in accordance with OAR 436-009-0030(8).

436-009-0040 Calculating Medical Provider Fees

(1) Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay for medical services the lesser of:

(a) The maximum allowable payment amount for CPT® codes, HCPCS codes, and Oregon Specific Codes listed in Appendix B of these rules; or

(b) The provider’s usual fee.

(2) Unless otherwise provided by contract or fee discount agreement, the insurer must pay 80 percent of the provider’s usual fee when:

(a) Appendix B does not establish a maximum payment amount and the code is designated “80% of billed”; and

(b) The fee schedule does not establish a fixed, maximum payment amount (e.g., certain medical supplies); or

(c) The service is not covered by the fee schedule.

(3) Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay 90 percent of the provider’s usual fee for dental services billed with dental HCPCS codes.

(4) Unless otherwise provided by contract, the insurer must pay the provider’s usual fee for ambulance services billed with the following HCPCS codes: A0425, A0426, A0427, A0428, A0429, A0433, and A0434.

(5) For services payable under section (2), (3), or (4) of this rule, for hospital outpatient charges, or for services payable “as billed,” an insurer may only challenge the reasonableness of a provider’s billing on a case by case basis by asking the director to review the billing 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, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances.

(6)(a) When using Appendix B for calculating payment for CPT® codes, the maximum allowable payment column is determined by the location where the procedure is performed: If the procedure is performed inside the medical service provider’s office, use the Non-Facility Maximum column; if the procedure is performed outside the medical service provider’s office, use the Facility Maximum column. Use the Global Days column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Non-Facility Maximum column.

(b) When an Oregon specific code is assigned, the maximum allowable payment for multidisciplinary program and other services is found at the end of Appendix B, and in OAR 436-009-0060(5) and OAR 436-009-0070(13).
(7) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The anesthesia value includes the basic unit value, time units, and modifying units. The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $58.00.

(a) Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

(A) The maximum allowable payment amount for anesthesia codes; or

(B) The provider’s usual fee.

(b) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

(8) Surgery services.

(a) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(b) Anesthesia basic unit values are to be used only when the anesthesia is personally administered by either a licensed physician or certified nurse anesthetist. Anesthesia basic unit values are to be used only when the anesthesia is personally administered by either a licensed physician or certified nurse anesthetist who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

(c) When a regional anesthesia is administered by the attending surgeon, the value must be the "basic" anesthesia value only without added value for time.

(d) When the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the modifier "NT" (no time) must be noted on the bill.

(e) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the relative value unit for the surgical procedure.

(3) Surgery services.

(a) When a worker is scheduled for elective surgery, the preoperative visit, in the hospital or elsewhere, necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed global value of the surgical procedure. If the procedure is not elective, the physician is entitled to payment for the initial evaluation of the worker in addition to the global fee for the surgical procedure(s) performed.

(b) When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

(c) Multiple surgical procedures performed at the same session must be paid as follows:

(A) When multiple surgical procedures are performed by one surgeon, the principal procedure is paid at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures are paid at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid according to the rules.[

(B) When multiple arthroscopic procedures are performed, the major procedure must be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures paid at 50 percent of the value listed.

(C) When more than one surgeon performs surgery, each procedure must be billed separately. The maximum allowable fee for each procedure, as listed in these rules, must be reduced by 25 percent. When the surgeons assist each other throughout the operation, each is entitled to an additional fee of 20 percent of the other surgeon’s allowable fee as an assistant’s fee. When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant’s fee of 20 percent of the surgeons’ allowable fees.

(D) When a surgeon performs surgery following severe trauma that requires considerable time, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. Such a request must be accompanied by written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(E) The multiple surgery discount described in this subsection does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.

(F) When a surgical procedure is performed bilaterally, the modifier "50" must be noted on the bill for the second side, and paid at 50 percent of the fee allowed for the first side.

(G) When physician assistants or nurse practitioners assist a surgeon performing surgery, they must be paid at the rate of 15 percent of the surgeon's allowable fee for the surgical procedure(s). When physician assistants or nurse practitioners are the primary providers of a surgical procedure, they must be paid at the rate of 85 percent of a physician's allowable fee for a comparable service. Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.
(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician must be paid at the rate of 10 percent of the surgeon’s allowable fee for the surgical procedure(s). The operation report must document who assisted.

(4) Radiology services.

(a) In order to be paid, x-ray films must be of diagnostic quality and include a report of the findings. Billings for 14” x 36” lateral views shall not be paid.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), the technical component for the first area examined must be paid at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent under these rules. The discount applies to multiple studies done within 2 days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days. No reduction is applied to multiple areas for the professional component.

(5) Pathology and Laboratory services.

(a) The maximum allowable payment amount established in Appendix B applies only when there is direct physician involvement.

(b) Laboratory fees must be billed in accordance with ORS 676.310. If any physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.

(6) Medicine services.

(7) Physical Medicine and Rehabilitation services.

(a) Increments of time for a time-based CPT® code must not be prorated.

(b) Payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day. CPT® codes 97001, 97002, 97003, or 97004 are not subject to this limit. An additional unit of time (15 minute increment) for the same CPT® code is not counted as a separate code.

(c) All modality codes requiring constant attendance (97032, 97033, 97034, 97035, 97036, and 97039) are time-based. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day or the amount of time spent providing the treatment.

(d) CPT® codes 97010 through 97028 shall not be paid unless they are performed in conjunction with other procedures or modalities which require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by a machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by a machine, device, or table and there must be one charge.
The table below lists the Oregon specific codes for Multidisciplinary Services.

<table>
<thead>
<tr>
<th>OSC</th>
<th>Maximum Allowable Payment Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97642</td>
<td>$61.88</td>
<td>Physical conditioning - group - 1 hour Conditioning exercises and activities, graded and progressive</td>
</tr>
<tr>
<td>97643</td>
<td>$31.28</td>
<td>Each additional 30 minutes</td>
</tr>
<tr>
<td>97644</td>
<td>$98.60</td>
<td>Physical conditioning – individual 1 hour Conditioning exercises and activities, graded and progressive</td>
</tr>
<tr>
<td>97645</td>
<td>$49.64</td>
<td>Each additional 30 minutes</td>
</tr>
<tr>
<td>97646</td>
<td>$61.88</td>
<td>Work simulation - group 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors</td>
</tr>
<tr>
<td>97647</td>
<td>$31.28</td>
<td>Each additional 30 minutes</td>
</tr>
<tr>
<td>97648</td>
<td>$102.00</td>
<td>Work simulation - individual 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors</td>
</tr>
<tr>
<td>97649</td>
<td>$51.00</td>
<td>Each additional 30 minutes</td>
</tr>
<tr>
<td>97650</td>
<td>$55.08</td>
<td>Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals</td>
</tr>
<tr>
<td>97651</td>
<td>$27.88</td>
<td>Each additional 15 minutes</td>
</tr>
<tr>
<td>97652</td>
<td>$36.72</td>
<td>Therapeutic education - group 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals</td>
</tr>
<tr>
<td>97653</td>
<td>$19.04</td>
<td>Each additional 15 minutes</td>
</tr>
<tr>
<td>97654</td>
<td>$27.88</td>
<td>Professional Case Management – Individual 15 minutes Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician)</td>
</tr>
<tr>
<td>97655</td>
<td>$26.52</td>
<td>Brief Interdisciplinary Rehabilitation Conference - 10 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits</td>
</tr>
<tr>
<td>97656</td>
<td>$53.04</td>
<td>Intermediate Interdisciplinary Rehabilitation Conferences - 20 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits</td>
</tr>
<tr>
<td>97657</td>
<td>$91.80</td>
<td>Complex Interdisciplinary Rehabilitation Conferences – 30 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits</td>
</tr>
<tr>
<td>97658</td>
<td>$46.24</td>
<td>Each additional 15 minutes Complex conference-up to 1 hour maximum</td>
</tr>
<tr>
<td>97659</td>
<td>$116.96</td>
<td>Job site visit - 1 hour (includes travel) - must be preauthorized by insurer A work site visit to identify characteristics and physical demands of specific jobs</td>
</tr>
<tr>
<td>97660</td>
<td>$58.48</td>
<td>Each additional 30 minutes</td>
</tr>
<tr>
<td>97661</td>
<td>$157.76</td>
<td>Ergonomic consultation - 1 hour (includes travel) - must be preauthorized by insurer Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications</td>
</tr>
<tr>
<td>97662</td>
<td>$63.92</td>
<td>Vocational evaluation - 30 minutes Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options</td>
</tr>
<tr>
<td>97663</td>
<td>$31.96</td>
<td>Each additional 15 minutes</td>
</tr>
<tr>
<td>97664</td>
<td>$86.36</td>
<td>Nursing evaluation - 30 minutes Nursing assessment of medical status and needs in relationship to rehabilitation</td>
</tr>
<tr>
<td>97665</td>
<td>$42.84</td>
<td>Each additional 15 minutes</td>
</tr>
<tr>
<td>97666</td>
<td>$69.36</td>
<td>Nutrition evaluation - 30 minutes Evaluation of eating habits, weight and required modifications in relationship to rehabilitation</td>
</tr>
<tr>
<td>97667</td>
<td>$35.36</td>
<td>Each additional 15 minutes</td>
</tr>
<tr>
<td>97668</td>
<td>$72.76</td>
<td>Social worker evaluation - 30 minutes Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome</td>
</tr>
<tr>
<td>97669</td>
<td>$36.72</td>
<td>Each additional 15 minutes</td>
</tr>
<tr>
<td>97670</td>
<td>$455.60</td>
<td>Initial Multidisciplinary conference - up to 30 minutes</td>
</tr>
<tr>
<td>97671</td>
<td>$514.08</td>
<td>Initial Complex Multidisciplinary conference - up to 60 minutes</td>
</tr>
</tbody>
</table>

(1) Except for records required in OAR 436-009-0010(3), copies of requested medical records must be paid under OSC R0001.
(2) A brief narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status, and, if requested, brief answers to one to five specific questions related to the attending physician’s or authorized nurse practitioner’s current or proposed treatment, must be paid under OSC N0001.

(3) A complex narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, attending physician’s or authorized nurse practitioner’s treatment to date, current status, impairment, prognosis, and medically stationary information, must be paid under OSC N0002.

(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested and performed:

(a) FIRST LEVEL PCE: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE shall be paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.

(b) SECOND LEVEL PCE: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE must be paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.

(c) WCE: This is a residual functional capacity evaluation, which generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE must be paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to:

(A) The ability to perform essential physical functions of the job based on a specific job analysis as related to the accepted condition;
(B) The ability to sustain activity over time; and
(C) The reliability of the evaluation findings.

(5) A closing examination is a medical evaluation to measure impairment, which occurs when the worker’s condition is medically stationary.

(a) For the closing examination, bill using OSC CE001;
(b) For the closing report, use OSC CR001.

(6) When an attorney requires a consultation with a medical provider, the medical provider must bill under OSC D0001. Unless otherwise provided by contract, insurers must pay for attorney consultation time as billed.

(7) When an insurer requires a consultation with a medical provider, the medical provider must bill under OSC D0030. Unless otherwise provided by contract, insurers must pay for insurer consultation time as billed.

(8) The fee for a deposition must be billed under OSC D0002. This code should include time for preparation, travel, and deposition. Unless otherwise provided by contract, insurers must pay for deposition time as billed. Upon request of one of the parties, the director may limit payment of the provider’s hourly rate to a fee charged by similar providers.

(9) When an insurer obtains an Independent Medical Examination (IME):

(a) The medical service provider doing the IME must bill under OSC D0003. This code must be used for a report, addendum to a report, file review, or examination.

(b) Notwithstanding 436-009-0010(2), a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and the medical service provider.

(c) Unless otherwise provided by contract, insurers must pay for IMEs as billed.

(d) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. Billing should include documentation of time spent. Unless otherwise provided by contract, insurers must pay for medical service providers’ review and response to IME reports as billed.

(10) Fees for all arbiters and panel of arbiters used for director reviews under OAR 436-030-0165 will be established by the director. This fee determination will be based on the complexity of the examination, the report requirements, and the extent of the record review. The level of each category is determined by the director based on the individual complexities of each case as compared to the universe of claims in the medical arbiter process. When the examination is scheduled, the director will notify the medical arbiter and the parties of the authorized fee for that medical arbiter review based on a combination of separate components.

a) Level 1 OSC AR001 Exam
Level 2 OSC AR002 Exam
Level 3 OSC AR003 Exam
Limited OSC AR004 Exam

As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A
level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors. A limited exam generally involves a newly accepted condition, or some other partial exam.

b) Level 1 OSC AR011 Report
   Level 2 OSC AR012 Report
   Level 3 OSC AR013 Report

As determined by the director, a level 1 report generally includes standard questions. A level 2 report generally includes questions regarding complicating factors. A level 3 report generally includes questions regarding multiple complicating factors.

c) Level 1 OSC AR021 File Review
   Level 2 OSC AR022 File Review
   Level 3 OSC AR023 File Review
   Level 4 OSC AR024 File Review
   Level 5 OSC AR025 File Review

As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of a large record or disability evaluation without an exam. A level 4 file review generally includes an extensive record. A level 5 file review generally includes an extensive record with unique factors.

(d) The director will notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review. If a worker fails to appear for a medical arbiter examination without giving each medical arbiter at least 48 hours notice, each medical arbiter will be paid at 50 percent of the examination or testing fee. A medical arbiter must also be paid for any file review completed prior to cancellation.

e) If the director determines that a supplemental medical arbiter report is necessary to clarify information or address additional issues, an additional report fee may be established. The fee is based on the complexity of the supplemental report as determined by the director. The additional fees are established as follows:
   Limited OSC AR031
   Complex OSC AR032

(f) Prior to completion of the reconsideration process, the medical arbiter may request the director to redetermine the authorized fee by providing the director with rationale explaining why the physician believes the fee should be different than authorized.

(g) The director may authorize testing which must be paid under OAR 436-009.

(h) Should an advance of costs be necessary for the worker to attend a medical arbiter exam, a request for advancement must be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer must contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(11) A single physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report to the director, must be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician must be billed under OSC P0001 for the examination and under OSC P0003 for the report.

(b) Physicians selected under OAR 436-010-0008, to serve on a panel of physicians must each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. Each physician must bill for the record review and panel examination under OSC P0002. The panel member who prepares and submits the panel report must receive an additional payment under OSC-P0003.

(c) The director may, in a complex case requiring extensive review by a physician, pre-authorize an additional fee. Complex case review must be billed under OSC P0004.

(d) An insurer may not discount or reduce fees related to examinations or reviews performed by medical providers under OAR 436-010-0330.

(e) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician must bill under OSC P0005. The insurer must pay the physician for the appointment time and any time spent reviewing the record completed prior to the examination time. The billing must document the physician’s time spent reviewing the record.

(f) Should an advance of costs be necessary for the worker to attend an exam under ORS 656.327 or 656.260, a request for advancement must be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer must contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely, as required in this subsection.

(12) The fee for a Worker Requested Medical Examination must be billed under OSC W0001. This code must be used for a report, file review, or examination. Unless otherwise provided by contract, the insurer must pay the provider at the billed amount.
(13) The table below lists the Oregon specific codes for other services.

<table>
<thead>
<tr>
<th>OSC</th>
<th>Maximum Allowable Payment Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0001</td>
<td>$116.28</td>
<td>Copies of medical records when requested must be paid at $10.00 for the first page and $.50 for each page thereafter and identified on billings</td>
</tr>
<tr>
<td>N0001</td>
<td>$231.88</td>
<td>Brief narrative by the attending physician or authorized nurse practitioner</td>
</tr>
<tr>
<td>N0002</td>
<td>$163.20</td>
<td>Complex narrative by the attending physician or authorized nurse practitioner</td>
</tr>
<tr>
<td>99196</td>
<td>$54.10</td>
<td>First Level PCE</td>
</tr>
<tr>
<td>99197</td>
<td>$54.10</td>
<td>Second Level PCE</td>
</tr>
<tr>
<td>99198</td>
<td>$1088.00</td>
<td>WCE</td>
</tr>
<tr>
<td>99199</td>
<td>$54.40</td>
<td>Additional 15 minutes</td>
</tr>
<tr>
<td>CE001</td>
<td>80% of billed</td>
<td>Closing examination</td>
</tr>
<tr>
<td>CR001</td>
<td>80% of billed</td>
<td>Closing report</td>
</tr>
<tr>
<td>D0001</td>
<td>as billed</td>
<td>Attorney consultation time</td>
</tr>
<tr>
<td>D0002</td>
<td>as billed</td>
<td>Deposition time</td>
</tr>
<tr>
<td>D0003</td>
<td>as billed</td>
<td>Independent medical examination (IME), file review, report, or addendum to report</td>
</tr>
<tr>
<td>D0019</td>
<td>as billed</td>
<td>Medical service provider review and response to IME report</td>
</tr>
<tr>
<td>D0030</td>
<td>as billed</td>
<td>Insurer consultation time</td>
</tr>
<tr>
<td>AR001</td>
<td>$348.16</td>
<td>Level 1 arbiter exam</td>
</tr>
<tr>
<td>AR002</td>
<td>$463.76</td>
<td>Level 2 arbiter exam</td>
</tr>
<tr>
<td>AR003</td>
<td>$580.04</td>
<td>Level 3 arbiter exam</td>
</tr>
<tr>
<td>AR004</td>
<td>$174.08</td>
<td>Limited arbiter exam</td>
</tr>
<tr>
<td>AR011</td>
<td>$59.84</td>
<td>Level 1 arbiter report</td>
</tr>
<tr>
<td>AR012</td>
<td>$89.76</td>
<td>Level 2 arbiter report</td>
</tr>
<tr>
<td>AR013</td>
<td>$120.36</td>
<td>Level 3 arbiter report</td>
</tr>
<tr>
<td>AR021</td>
<td>$59.84</td>
<td>Level 1 arbiter file review</td>
</tr>
<tr>
<td>AR022</td>
<td>$150.28</td>
<td>Level 2 arbiter file review</td>
</tr>
<tr>
<td>AR023</td>
<td>$360.40</td>
<td>Level 3 arbiter file review</td>
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<tr>
<td>AR024</td>
<td>$695.64</td>
<td>Level 4 arbiter file review</td>
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<tr>
<td>AR025</td>
<td>$928.20</td>
<td>Level 5 arbiter file review</td>
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<tr>
<td>AR031</td>
<td>$59.84</td>
<td>Limited arbiter report</td>
</tr>
<tr>
<td>AR032</td>
<td>$120.36</td>
<td>Complex arbiter report</td>
</tr>
<tr>
<td>P0001</td>
<td>$290.36</td>
<td>Director single medical review/exam</td>
</tr>
<tr>
<td>P0002</td>
<td>$290.36</td>
<td>Director panel medical review/exam</td>
</tr>
<tr>
<td>P0003</td>
<td>$147.56</td>
<td>Director single medical review/report</td>
</tr>
<tr>
<td>P0004</td>
<td>$147.56</td>
<td>Director complex case review/exam</td>
</tr>
<tr>
<td>P0005</td>
<td>$147.56</td>
<td>Failure to appear director required examination</td>
</tr>
<tr>
<td>W0001</td>
<td>as billed</td>
<td>Worker requested medical examination and report</td>
</tr>
</tbody>
</table>

Stat. Auth.: ORS 656.726(4)
Stat. Implemented: ORS 656.726(4)
Hist: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11

**436-009-0080 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

(1) Durable medical equipment (DME) is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and not generally useful to a person in the absence of an illness or injury. For example: Transcutaneous Electrical Nerve Stimulation (TENS), MicroCurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc.

(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. For example: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc.

(3) An orthosis is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. For example: brace, splint, shoe insert or modification, etc.

(4) Supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

(a) NU for purchased, new equipment;
(b) UE for purchased, used equipment; and
(c) RR for rented equipment

(6) Unless otherwise provided by contract or sections (7) through (11), insurers must pay for DMEPOS according to the following table:
(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes):

<table>
<thead>
<tr>
<th>Code</th>
<th>Monthly Rate</th>
<th>Code</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0163</td>
<td>$26.33</td>
<td>E0849</td>
<td>$98.40</td>
</tr>
<tr>
<td>E0165</td>
<td>$30.24</td>
<td>E0900</td>
<td>$93.68</td>
</tr>
<tr>
<td>E0168</td>
<td>$27.28</td>
<td>E0935</td>
<td>$996.97</td>
</tr>
<tr>
<td>E0194</td>
<td>$3643.05</td>
<td>E0940</td>
<td>$52.20</td>
</tr>
<tr>
<td>E0261</td>
<td>$259.66</td>
<td>E0971</td>
<td>$5.68</td>
</tr>
<tr>
<td>E0277</td>
<td>$1135.64</td>
<td>E0990</td>
<td>$25.52</td>
</tr>
<tr>
<td>E0434</td>
<td>$35.31</td>
<td>E1800</td>
<td>$262.29</td>
</tr>
<tr>
<td>E0441</td>
<td>$86.85</td>
<td>E1815</td>
<td>$276.15</td>
</tr>
<tr>
<td>E0650</td>
<td>$1423.50</td>
<td>E2402</td>
<td>$2487.86</td>
</tr>
</tbody>
</table>

(8) For items rented, unless otherwise provided by contract:
(a) When an item is rented on a daily basis, the maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.
(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.
(c) The insurer may purchase a rental item anytime within the 13 month rental period, with a credit of 75 percent of the rental paid going towards the purchase.

(9) For items purchased, unless otherwise provided by contract:
(a) The provider is entitled to payment for any labor and reasonable expenses directly related to any subsequent modifications other than those performed at the time of purchase or repairs; The insurer must pay for labor at the provider's usual rate; or
(b) The provider may offer a service agreement at an additional cost.

(10)(a) Hearing aids must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist.
(b) Based on current technology, the preferred types of hearing aids for most workers are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multi channel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.
(c) Unless otherwise provided by contract, insurers must pay the provider’s usual fee for hearing services billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $5000 for a pair of hearing aids, or $2500 for a single hearing aid.

(11) Unless otherwise provided by contract, insurers must pay the provider’s usual fee for vision services billed with HCPCS codes V0000 through V2999.

(12) The worker may select the service provider, except for claims enrolled in a managed care organization (MCO) when service providers are specified by the MCO contract.

(13) Except as provided in subsection (10)(c) of this rule, the payment amounts established by this rule do not apply to a worker’s direct purchase of DMEPOS, and do not limit a worker’s right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

436-009-0090 Pharmacy Fees
(1) Except for hospital charges or unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider’s usual fee, or the amount set by the fee schedule, whichever is less.
(a) “AWP” means the Average Wholesale Price effective on the day the drug was dispensed.
(b) The maximum allowable fee is calculated according to the following table:

<table>
<thead>
<tr>
<th>If the drug dispensed is:</th>
<th>Then the maximum allowable fee is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A generic drug</td>
<td>83.5 % of the dispensed drug’s AWP plus a $2.00 dispensing fee</td>
</tr>
<tr>
<td>A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent</td>
<td>83.5 % of the dispensed drug’s AWP plus a $2.00 dispensing fee</td>
</tr>
<tr>
<td>A brand name drug and the prescribing health care provider has not prohibited substitution</td>
<td>83.5 % of the average AWP for the class of generic drugs plus a $2.00 dispensing fee</td>
</tr>
</tbody>
</table>

(2) All prescription medications are required medical services and do not require prior approval under the palliative care provisions of OAR 436-010-0290.

(3) Under ORS 689.515(2) licensed providers may dispense generic drugs to injured workers.

(4) (a)Unless the prescription is for five days or less, the prescribing provider must submit a clinical justification for the following drugs:
(A) Celebrex®
(B) Cymbalta®
(C) Fentora®
(D) Kadian®
(E) Lidoderm®
(F) Lyrica®
(G) OxyContin®

(b) The prescribing provider must fill out the clinical justification on Form 4909, Pharmaceutical Clinical Justification for Workers’ Compensation, and submit it to the insurer.

c) Insurers cannot challenge the adequacy of the clinical justification. However, they can challenge whether or not the medication is excessive, inappropriate, or ineffectual under ORS 656.327.

d) The prescribing provider is not required to fill out an additional Form 4909 for refills of that medication.

(5) Except in an emergency, drugs and medicine for oral consumption supplied by a physician’s or authorized nurse practitioner’s office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the requirements of the provider’s licensing board.

(6) Insurers must use the prescription pricing guide First DataBank published by Hearst Corporation, RED BOOK published by Thomson Reuters, or Medi-Span published by Wolters Kluwer for calculating payments to the licensed provider. Insurers must update their source at least monthly.

(7) The worker may select the pharmacy, except for claims enrolled in a managed care organization (MCO) where pharmacy service providers are specified by the MCO contract.

(8) Except for sections 2, 3, 4 and 7 of this rule, this rule does not apply to a worker’s direct purchase of prescription medications, and does not limit a worker’s right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(9) The insurer must pay the retail-based fee for over-the-counter medications.

(10) Drugs dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248
Hist.: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0095 Application of Fee Discounts

If a medical fee is covered by multiple contracts allowed under these rules, the insurer may apply only one discount to the provider’s fee. If a provider’s fee is covered by multiple contracts, and one of the contracts is with a certified managed care organization for services provided to an enrolled worker, only the discount under the managed care organization’s contract must be applied.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Hist.: Adopted 12/15/08 as Admin. Order 08-063, eff. 1/1/09

436-009-0110 Definitions for OAR 436-009-0110 through 436-009-0145

(1) “Interpreter” means a person who:
   (a) Provides oral or sign language translation; and
   (b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider’s employee, or a family member or friend of the patient.

(2) “Interpreter services” means the act of orally translating between a medical provider and a patient who speak different languages, including sign language. It includes time spent waiting at the location for the medical provider to examine or treat the patient.

(3) “Mileage” means the number of miles traveling from the interpreter’s starting point to the exam or treatment location.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 9/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0114 Who May Choose a Person to Provide Interpreter Services?

A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. The medical provider may disapprove of the worker’s choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Hist.: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/11

436-009-0115 Who Do Interpreters Bill for Providing Interpreter Services?

(1) Interpreters may only bill an insurer or, if provided by contract, a managed care organization.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 9/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0120 What May Interpreters Bill for?

(1) Interpreters may bill for:
   (a) Interpreter services; and
   (b) Mileage when the round-trip mileage is 15 or more miles.

(2) If the interpreter arrives at the provider’s office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage under section (1) of this rule even if:
   (a) The patient fails to attend the appointment; or
436-009-0125 When May Interpreters Not Bill?

When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if:

(a) The patient fails to attend the appointment; or
(b) The provider cancels or reschedules the appointment.

Stat. Auth.: ORS 656.626(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0130 How Do Interpreters Bill for Interpreter Services and Mileage?

Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code D0004 for interpreter services and D0041 for mileage.

Stat. Auth.: ORS 656.626(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0135 What Must Interpreter Include On An Invoice?

An interpreter’s invoice must include:

(1) The interpreter’s company name, billing address, and phone number;
(2) The patient’s name, address, and phone number;
(3) The patient’s workers’ compensation claim number, if known;
(4) The correct Oregon specific codes for the billed services (D0004 or D0041);
(5) The workers’ compensation insurer’s name, address, and phone number;
(6) The date interpreter services were provided;
(7) The name and address of the medical provider that conducted the exam or provided treatment;
(8) The total amount of time interpreter services were provided; and
(9) The mileage, if the round trip was 15 or more miles.

Stat. Auth.: ORS 656.626(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0140 How Much May an Interpreter Charge?

Interpreters must charge the usual fee they charge to the general public for the same service.

Stat. Auth.: ORS 656.626(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0145 When Must Interpreters Submit Their Invoice?

(1) Interpreters must send their invoice to the workers’ compensation insurer within 60 days of the later of:
(a) The first date of service listed on the invoice; or
(b) The date the interpreter knew or should have known the patient filed a workers’ compensation claim.
(2) If interpreters do not know the workers’ compensation insurer responsible for the claim, they may contact the Department of Consumer and Business Services’ Workers’ Compensation Division at 503-947-7814. They may also access insurance policy information at http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm.
(3) A bill is considered sent on the date the envelope is postmarked or the date the document is faxed.

Stat. Auth.: ORS 656.626(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0155 What are the Maximum Allowable Payment Amounts for Interpreter Services and Mileage?

(1) Insurers must use the following table to calculate the maximum allowable payment:

<table>
<thead>
<tr>
<th>For:</th>
<th>The maximum payment is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter services of an hour or less</td>
<td>$ 60.00</td>
</tr>
<tr>
<td>Interpreter services of more than one hour</td>
<td>$1.00 per minute</td>
</tr>
<tr>
<td>Mileage of less than 15 miles round trip</td>
<td>No payment allowed</td>
</tr>
<tr>
<td>Mileage of 15 or more miles round trip</td>
<td>$0.50 per mile</td>
</tr>
<tr>
<td>An examination required by the director or insurer which the patient fails to attend</td>
<td>$60.00 no show fee plus payment for mileage if 15 or more miles round trip</td>
</tr>
<tr>
<td>An examination required by the director or the insurer when the provider cancels or reschedules</td>
<td>$60.00 no show fee plus payment for mileage if 15 or more miles round trip</td>
</tr>
<tr>
<td>An interpreter who is the only person in Oregon able to interpret a specific language</td>
<td>The amount billed for interpreter services and mileage</td>
</tr>
</tbody>
</table>

Stat. Auth.: ORS 656.626(4)
Stats. Implemented: ORS 656.245, 656.248
Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0160 What Must the Insurer Pay for?

(1) When the medical exam or treatment is directed to an accepted claim or condition, the insurer must pay for:
(a) Interpreter services provided by an interpreter; and
(b) Mileage if the round-trip mileage is 15 or more miles.
(2) When the patient fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay:

(a) The no-show fee; and

(b) Mileage if the round-trip mileage is 15 or more miles.

Stats. Implemented: ORS 656.245, 656.248
Stat. Auth.: ORS 656.726(4)
Amended 3/1/11 as Admin. Order 11, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0165 How Much Do Insurers Have to Pay for Interpreter Services and Mileage?

Unless otherwise provided by contract, insurers must pay the lesser of:

(1) The maximum allowable payment amount; or

(2) The interpreter’s usual fee.

Stats. Implemented: ORS 656.245, 656.248
Stat. Auth.: ORS 656.726(4)
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0170 When Must the Insurer Pay for an Interpreter?

The insurer must pay the interpreter within:

(1) 45 days of receiving the invoice for an exam required by the insurer or director; or

(2) 14 days of the date of claim acceptance, or 45 days of receiving the invoice, whichever is later.

Stats. Implemented: ORS 656.245, 656.248
Stat. Auth.: ORS 656.726(4)
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0175 What If the Interpreter’s Bill Does Not Provide All the Information the Insurers Needs in Order to Process Payment?

If the insurer doesn’t receive all the information to process payment, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process payment.

Stats. Implemented: ORS 656.245, 656.248
Stat. Auth.: ORS 656.726(4)
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0177 What If the Insurer Disagrees With the Interpreter’s Bill?

If the insurer disagrees with the amount of the interpreter’s bill, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of either interpreter services or mileage.

Stats. Implemented: ORS 656.245, 656.248
Stat. Auth.: ORS 656.726(4)
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0180 What Must the Insurer Include on an Explanation of Benefits?

(1) The insurer must provide a written explanation for services paid or denied and must send the explanation to the interpreter that billed for the services. All the information on the explanation must be in 10 point size font or larger.

(2) The explanation must include:

(a) The payment amount for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(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 an interpreter’s payment questions within 48 hours, excluding weekends and legal holidays;

(d) The following notice, web link, and phone number:

“To access the information about Oregon’s Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606”;

(e) Space for a signature and date; and

(f) A notice of the 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 Section, 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.”

(3) The insurer or its representative must respond to an interpreter’s inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the interpreter’s inquiry. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.

(4) The insurer or its representative and an interpreter may agree to send and receive payment information by e-mail. Electronic records sent by e-mail are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 and federal law.

Stats. Implemented: ORS 656.245, 656.248
Stat. Auth.: ORS 656.726(4)
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0185 Does the Insurer Have to Pay for Interpreter Services That Are Not Provided by An Interpreter?

The insurer is not required to pay for interpreter services or mileage when the services are provided by:
(1) A family member or friend of the patient; or
(2) The medical provider or medical provider’s employee.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248
Amended 3/1/11 as Admin. Order 11
Hist.:

436-009-0199 Sanctions and Civil Penalties [Moved to
436-009-0998]

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist.: Amended 12/15/08 as Admin. Order 08-063, eff. 1/1/09
Amended and renumbered to 436-009-0998 3/1/11 as Admin. Order 11-050, eff. 4/1/11

Ambulatory Surgery Center Billing Procedures

436-009-0200 Definitions for OAR 436-009-0205
through 436-009-0240

(1) An “ambulatory surgery center” (ASC) means:
   (a) Any distinct entity licensed by the state of Oregon, and
   operated exclusively for the purpose of providing surgical
   services to patients not requiring hospitalization; or
   (b) Any entity outside of Oregon similarly licensed, or
   certified by Medicare or a nationally recognized agency as an
   ASC.

(2) Durable medical equipment (DME) is equipment that
   is primarily and customarily used to serve a medical purpose, can
   withstand repeated use, could normally be rented and used by
   successive patients, is appropriate for use in the home, and not
   generally useful to a person in the absence of an illness or
   injury. For example: transcutaneous electrical nerve
   stimulation (TENS), microcurrent electrical nerve stimulation
   (MENS), home traction devices, heating pads, reusable
   hot/cold packs, etc.

(3) A prosthetic is an artificial substitute for a missing body
   part or any device aiding performance of a natural function.
   For example: hearing aids, eye glasses, crutches, wheelchairs,
   scooters, artificial limbs, etc.

(4) An orthosis is an orthopedic appliance or apparatus used
   to support, align, prevent or correct deformities, or to improve
   the function of a moveable body part. For example: brace,
   splint, shoe insert or modification, etc.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist.: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0205 Who Does the ASC Bill for Providing
Medical Services?

The ASC must submit bills for medical services to the
insurer or, if provided by contract for medical services, to the
managed care organization.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist.: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0206 What Billing Form Must the ASC Use?

Unless the ASC submits medical bills electronically, the
ASC must bill on a CMS 1500 form. Computer-generated
reproductions of the CMS 1500 form may also be used.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254
Hist.: Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0207 How Does the ASC Fill Out the CMS 1500
Form?

Unless different instructions are provided in the table below,
the ASC must use the instructions provided in the National
Uniform Claim Committee 1500 Claim Form Reference
Instruction Manual.

<table>
<thead>
<tr>
<th>Box Reference Number</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>10d</td>
<td>May be left blank</td>
</tr>
<tr>
<td>11a, 11b, and 11c</td>
<td>May be left blank</td>
</tr>
<tr>
<td>17a</td>
<td>May be left blank if box 17b contains the referring provider’s NPI</td>
</tr>
<tr>
<td>22</td>
<td>May be left blank</td>
</tr>
<tr>
<td>23</td>
<td>Not used in Oregon workers’ compensation</td>
</tr>
</tbody>
</table>

24D The ASC must use the following codes to accurately describe the services rendered:
- CPT® codes listed in CPT® 2012;
- HCPCS codes;
- Oregon Specific Codes (OSCs).
If there is no specific code for the medical service:
- Use an appropriate unlisted code from CPT® 2012 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and
- Describe the service provided.
- The ASC must add a modifier “-SG” to identify the facility charges under the modifier column next to the code describing the service rendered.

24I (shaded area) See under box 24J shaded area.

24J (shaded area) Include the rendering provider’s NPI.

24J (shaded area) If the ASC includes the rendering provider’s NPI in the non-shaded 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.

(1) The ASC must bill the usual fee charged to the general public.
(2) For purposes of this rule, "general public" means any person who receives medical services, unless the law requires the ASC to bill a specific amount.

(3) When a patient with two or more separate compensable claims receives treatment for more than one injury or illness, the ASC must divide the charges accordingly.

(4) If the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the ASC should include the charges for the packaged services in the surgical charges.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0215 What Must Accompany the ASC’s Bill?
The ASC must submit legible chart notes with each bill, documenting the services that have been billed.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0220 What May the ASC Not Bill for?
The ASC may not bill for:

1. Providing chart notes with each bill.
2. Services that were not performed.
3. Treatment that falls outside the scope and field of the ASC’s license to operate.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0225 What Services Are Included In the ASC Facility Fee?

1. The following services are included in the ASC facility fee and the ASC may not be paid separately for them:
   a) Nursing, technical, and related services;
   b) Use of the facility where the surgical procedure is performed;
   c) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;
   d) Radiology services designated as packaged in Appendix D;
   e) Administrative, record-keeping, and housekeeping items and services;
   f) Materials for anesthesia; and
   g) Supervision of the services of an anesthetist by the operating surgeon.

2. Packaged services identified in Appendix C or D.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0230 What Services Are Not Included in the ASC Facility Fee?
The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician’s services, laboratory, x-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists’ services.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0235 When Must the ASC Submit a Bill?

1. Unless the ASC establishes good cause, the ASC must submit a bill within:
   a) 60 days of the date of service;
   b) 60 days of the date the ASC learns which insurer is responsible for the worker’s compensable claim; or
   c) 60 days after any litigation affecting the compensability of the services is final, if the ASC receives written notice of the final litigation from the insurer.

2. If an ASC does not know the workers’ compensation insurer responsible for the claim, the ASC may contact the Department of Consumer and Business Services’ Workers’ Compensation Division at 503-947-7814. The ASC may also access insurance policy information at http://www4.cbs.state.or.us/ex/wcdd/cov/index.cfm.

3. A bill is considered submitted on the date the envelope is postmarked, the date the document is faxed, or the date the document is transmitted electronically.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0240 Are There Specific Billing Requirements for Certain Services That the ASC Needs to Know?

1. If the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the ASC should include the charges for the packaged services in the surgical charges.

2. The ASC should not bill for packaged codes as separate line-item charges when the payment amount says “packaged” in Appendices C or D.

3(a) When the ASC’s cost for an implant is more than $100, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC’s cost of the implant.

(b) For the purpose of these rules, an implant is an object or material inserted or grafted into the body.

4. When a surgical procedure is performed bilaterally, the ASC must add the modifier “50” on the bill for the second side.

5. When a service is provided by a physician assistant or nurse practitioner, the ASC must add the modifier “81” to the appropriate code. The chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.
(6) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), the ASC must use the following modifiers, when applicable:
   (a) NU for purchased, new equipment;
   (b) UE for purchased, used equipment; and
   (c) RR for rented equipment

(7) When the ASC receives a request for medical records, the ASC should use the Oregon specific code R0001 to bill for the copies.

436-009-0245  Who is Responsible for Payments?
The insurer is responsible for paying an ASC for compensable medical services.

436-009-0255  What Does the Insurer Not Have to Pay for?
(1) The insurer is not required to pay for services that have been excluded from compensability under OAR 436-009-0015, or for treatment of any of the side effects caused by the excluded services. The following are excluded services:
   (a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
   (b) Intradiscal electrothermal therapy (IDET);
   (c) Surface EMG (electromyography) 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 injured worker is 16 to 60 years old;
      (C) The injured worker underwent a minimum of six months unsuccessful exercise based rehabilitation; and
      (D) The procedure is not found inappropriate under OAR 436-010-0230(13) or (14); and
   (h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:
      (A) The single level artificial disc replacement is between C3 and C7;
      (B) The injured worker is 16 to 60 years old;
      (C) The injured worker underwent unsuccessful conservative treatment;

(7) When the ASC receives a request for medical records, the ASC should use the Oregon specific code R0001 to bill for the copies.

Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12

Ambulatory Surgery Centers – Payment Calculation

436-009-0245  Who is Responsible for Payments?
The insurer is responsible for paying an ASC for compensable medical services.

436-009-0255  What Does the Insurer Not Have to Pay for?
(1) The insurer is not required to pay for services that have been excluded from compensability under OAR 436-009-0015, or for treatment of any of the side effects caused by the excluded services. The following are excluded services:
   (a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
   (b) Intradiscal electrothermal therapy (IDET);
   (c) Surface EMG (electromyography) 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 injured worker is 16 to 60 years old;
      (C) The injured worker underwent a minimum of six months unsuccessful exercise based rehabilitation; and
      (D) The procedure is not found inappropriate under OAR 436-010-0230(13) or (14); and
   (h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:
      (A) The single level artificial disc replacement is between C3 and C7;
      (B) The injured worker is 16 to 60 years old;
      (C) The injured worker underwent unsuccessful conservative treatment;

(7) When the ASC receives a request for medical records, the ASC should use the Oregon specific code R0001 to bill for the copies.

Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12

436-009-0250  What is the Payment Amount for Services Provided by an ASC?
Unless otherwise provided by contract, insurers must pay ASCs for services, equipment, and supplies according to this rule,

(1) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services at the lesser amount of:
   (a) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or
   (b) The ASC’s usual fee for surgical procedures and ancillary services.

(2) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid accordingly. The multiple surgery discount described in this subsection does not apply to codes listed in Appendix C with an “N” in the “Subject to Multiple Procedure Discounting” column.

(3) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.
(4) Notwithstanding section (5), insurers must pay implants at 110 percent of the ASC’s actual cost documented on a receipt of sale when the implant’s cost to the ASC is more than $100.

(5) Except as provided in sections (6) through (8), insurers must pay for durable medical equipment, prosthetics, orthotics, and supplies (DEMPOS) according to the following table:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Maximum Payment Amount</th>
<th>CPT® Code</th>
<th>Maximum Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>23350</td>
<td>$235.12</td>
<td>36410</td>
<td>$19.94</td>
</tr>
<tr>
<td>25246</td>
<td>$220.99</td>
<td>36416</td>
<td>80% of billed</td>
</tr>
<tr>
<td>27093</td>
<td>$304.90</td>
<td>36620</td>
<td>80% of billed</td>
</tr>
<tr>
<td>27370</td>
<td>$290.78</td>
<td>62284</td>
<td>$282.47</td>
</tr>
<tr>
<td>27648</td>
<td>$274.16</td>
<td>62290</td>
<td>$417.89</td>
</tr>
<tr>
<td>36000</td>
<td>$39.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(6) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (5) to determine the rental rates for these codes):

<table>
<thead>
<tr>
<th>Code</th>
<th>Monthly Rate</th>
<th>Code</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0163</td>
<td>$26.33</td>
<td>E0849</td>
<td>$98.40</td>
</tr>
<tr>
<td>E0165</td>
<td>$30.24</td>
<td>E0900</td>
<td>$93.68</td>
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<tr>
<td>E0168</td>
<td>$27.28</td>
<td>E0935</td>
<td>$996.97</td>
</tr>
<tr>
<td>E0194</td>
<td>$364.05</td>
<td>E0940</td>
<td>$52.20</td>
</tr>
<tr>
<td>E0261</td>
<td>$259.66</td>
<td>E0971</td>
<td>$5.68</td>
</tr>
<tr>
<td>E0277</td>
<td>$1135.64</td>
<td>E0990</td>
<td>$25.52</td>
</tr>
<tr>
<td>E0434</td>
<td>$35.31</td>
<td>E1800</td>
<td>$262.29</td>
</tr>
<tr>
<td>E0441</td>
<td>$86.85</td>
<td>E1815</td>
<td>$276.15</td>
</tr>
<tr>
<td>E0650</td>
<td>$1423.50</td>
<td>E2402</td>
<td>$2487.86</td>
</tr>
</tbody>
</table>

(a) When an item is rented on a daily basis, the maximum daily rental rate is one thirty (1/30) of the monthly rate established in sections (5) and (6) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13-month rental period, with a credit of 75 percent of the rental paid going towards the purchase.

(8) For items purchased:

(a) The ASC is entitled to payment for any labor and reasonable expenses directly related to any subsequent modifications other than those performed at the time of purchase or repairs (the insurer must pay for labor at the provider's usual rate); or

(b) The ASC may offer a service agreement at an additional cost.

(9) When the insurer requests copies of medical records from the ASC, the insurer must pay $10.00 for the first page and $0.50 for each page thereafter.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248; 656.252
Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 4/12/12 as Admin. Order 12-053, eff. 4/23/12 (temp)
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12

436-009-0265 What if the Insurer Doesn’t Receive All the Information Needed to Process Payment?
When the insurer receives a bill that cannot be processed because it is not submitted in the proper form or the form is not complete, the insurer must return the bill to the ASC within 20 days of receipt of the bill with a written explanation describing why the bill was returned. The insurer must provide specific information about what is needed in order to process the bill.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0270 What If The Insurer Disagrees With The Billing?
If the insurer disagrees with the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0275 What Discounts May The Insurer Apply Under This Fee Schedule?
(1) The insurer may apply a discount to the ASC’s fee if a written contract exists.

(2) If the insurer and the ASC have multiple contracts, only one discount may be applied.

(3) If the insurer has multiple contracts and one of the contracts is through a certified managed care organization for
services provided to an enrolled worker, the insurer may only apply the discount under the managed care organization’s contract.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0285 When Must the Insurer Pay the ASC?
The insurer must pay the ASC by whichever date is later:
(1) 45 days after the date the insurer receives the bill; or
(2) 14 days after any action causes the service to be payable.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0290 What Must the Insurer Include on an Explanation of Benefits?
(1) The insurer must provide a written explanation for services being paid or denied, and must send the explanation to the ASC that billed for the services. All information on the explanation must be in 10 point size font or larger.
(2) The explanation must include:
   (a) The payment amount for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;
   (b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;
   (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 an ASC’s payment questions within 48 hours, excluding weekends and legal holidays;
   (d) The following notice, web link, and phone number:
      “To access information about Oregon’s Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606”;
   (e) Space for a 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 Section, 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.”
(3) The insurer or its representative must respond to an ASC’s inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the ASC’s inquiry.

The insurer or its representative may not refer the ASC to another entity to obtain an answer.

(4) The insurer or its representative and an ASC may agree to send and receive payment information by e-mail. Electronic records sent by e-mail are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

Sanctions and Civil Penalties

436-009-0998 Sanctions and Civil Penalties
[Renumbered from 436-009-0199]

(1) The director may impose sanctions upon a medical provider or insurer for violation of these rules in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider’s bill that is incorrect, the insurer must pay the provider’s bill at the provider’s usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty.

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer’s behalf. If an insurer or someone acting on the insurer’s behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers’ fees under these rules, by an insurer or someone acting on the insurer’s behalf, the director may issue a civil penalty up to the amount allowed under ORS chapter 656.

(5) If a prescribing provider fails to submit Form 4909, Pharmaceutical Clinical Justification for Workers’ Compensation, to the insurer, in accordance with OAR 436-009-0090(4)(b) and (c), the insurer may file a complaint with the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist: Renumbered from 436-009-0100 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended and renumbered from 436-009-0199 3/1/11 as Admin. Order 11-050, eff. 4/1/11
### Appendix A

Oregon hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills under OAR 436-009-0020

<table>
<thead>
<tr>
<th>HOSPITAL NAME</th>
<th>NPI</th>
<th>ALT NPI</th>
<th>SECOND ALT NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Adventist Medical Center</td>
<td>1801887658</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Ashland Community Hospital*</td>
<td>1386644029</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Bay Area Hospital – Coos Bay</td>
<td>1225016561</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Good Samaritan Regional Medical Center - Corvallis</td>
<td>1962453134</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Holy Rosary Medical Center – Ontario*</td>
<td>1891891792</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Kaiser Sunnyside Medical Center</td>
<td>1124182902</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Legacy Emanuel Hospital &amp; Health Center</td>
<td>1831112358</td>
<td>1295756898</td>
<td></td>
</tr>
<tr>
<td>8 Legacy Good Samaritan Hospital &amp; Medical Center</td>
<td>1780608216</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Legacy Meridian Park Hospital</td>
<td>1184647620</td>
<td></td>
<td></td>
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<tr>
<td>10 Legacy Mt. Hood Medical Center</td>
<td>1255354700</td>
<td></td>
<td></td>
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<tr>
<td>11 McKenzie-Willamette Medical Center – Springfield</td>
<td>1568413573</td>
<td>1528003010</td>
<td></td>
</tr>
<tr>
<td>12 Mercy Medical Center – Roseburg*</td>
<td>1477590198</td>
<td>1134161391</td>
<td></td>
</tr>
<tr>
<td>13 Mid Columbia Medical Center – The Dalles*</td>
<td>1306842752</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Oregon Health &amp; Science University Hospital</td>
<td>1609824010</td>
<td>1376873570</td>
<td>1548272511</td>
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<tr>
<td>15 Providence Medford Medical Center</td>
<td>1689755670</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Providence Milwaukie Hospital</td>
<td>1366536963</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Providence Newberg Hospital*</td>
<td>1952482275</td>
<td></td>
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</tr>
<tr>
<td>18 Providence Portland Medical Center</td>
<td>1003991845</td>
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<tr>
<td>19 Providence St. Vincent Medical Center</td>
<td>1114015971</td>
<td>1083866933</td>
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<tr>
<td>20 Rogue Valley Medical Center – Medford</td>
<td>1770587107</td>
<td>1427277086</td>
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<tr>
<td>21 Sacred Heart Medical Center Riverbend – Springfield</td>
<td>1083888515</td>
<td>1881928067</td>
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<tr>
<td>22 Sacred Heart Medical Center University Dist. – Springfield</td>
<td>1346237971</td>
<td>1164596517</td>
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<tr>
<td>23 Salem Hospital</td>
<td>1265431829</td>
<td>1114197894</td>
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<tr>
<td>24 Samaritan Albany General Hospital</td>
<td>1154372340</td>
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<tr>
<td>25 Santiam Memorial Hospital – Stayton*</td>
<td>1154302214</td>
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<tr>
<td>26 Silverton Hospital</td>
<td>1669424354</td>
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<td>27 Sky Lakes Medical Center – Klamath Falls</td>
<td>1811130149</td>
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<td>28 St. Charles Medical Center – Bend</td>
<td>1982621447</td>
<td>1598839789</td>
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<tr>
<td>29 St. Charles Medical Center – Redmond*</td>
<td>1225056146</td>
<td></td>
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<tr>
<td>30 Three Rivers Community Hospital – Grants Pass*</td>
<td>1801891809</td>
<td>1598895690</td>
<td></td>
</tr>
<tr>
<td>31 Tuality Community Hospital – Hillsboro</td>
<td>1275591984</td>
<td>1336228659</td>
<td></td>
</tr>
<tr>
<td>32 Willamette Falls Hospital – Oregon City</td>
<td>1639108434</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 Willamette Valley Medical Center – McMinnville *</td>
<td>1346269982</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Denotes hospital as rural. All of the 25 OR Critical Access Hospitals are intentionally excluded from this list.
Appendix B through E

Oregon Workers’ Compensation Maximum Allowable Payment Amounts

The Workers’ Compensation Division no longer adopts the Federal Register that publishes Centers for Medicare and Medicaid Services’ (CMS) relative value units (RVUs). The division publishes the following Appendices to the division 009 of chapter 436.

Appendix B  (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers.  
[Effective April 1, 2012]

Appendix C  (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures.  
[Effective April 1, 2012]

Appendix D  (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure.  
[Effective April 1, 2012]

Appendix E  (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies.  
[Effective Oct. 20, 2012]

Note: If the above links do not connect you to the department’s website, click:  
http://www.cbs.state.or.us/external/wcd/policy/rules/disclaimer.html
If you have questions, call the Medical Section, 503-947-7606.

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CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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Link to the Maximum Allowable Payment Tables:  
http://www.cbs.state.or.us/wcd/policy/rules/disclaimer.html
Or, contact the division for a paper copy, 503-947-7717.
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 050
EMPLOYER/INSURER COVERAGE RESPONSIBILITY

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OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS’ COMPENSATION DIVISION
EMPLOYER/INSURER COVERAGE RESPONSIBILITY

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436-050-0001 Authority for Rules

These rules are adopted under the director’s authority contained in ORS 656.407, 656.430, 656.455, 656.726, 656.850, 656.855, and 731.475.

Stat. Auth.: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017, 656.018, 656.021, 656.023, 656.027, 656.029, 656.031, 656.037, 656.039, 656.127, 656.129, 656.140, 656.403, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.440, 656.443, 656.447, 656.455, 656.614, 656.745, 656.750, 656.850, 656.855, and 731.475
Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0002 Purpose

The purpose of these rules is to carry out the workers’ compensation law related to employers’ and insurers’
responsibilities to cover subject workers for compensable injuries and illnesses.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.017
Hist: Amended 6/20/03 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0003 Applicability of Rules

(a) ORS 656.017 - Employer required to pay compensation and perform other duties.
(b) ORS 656.029 - Independent contractor status.
(c) ORS 656.126 - Coverage while temporarily in or out of state.
(d) ORS 656.407 - Qualifications of insured employers.
(e) ORS 656.419 - Workers’ compensation insurance policies.
(f) ORS 656.423 - Cancellation of coverage by employer.
(g) ORS 656.427 - Cancellation of workers’ compensation insurance policy or surety bond liability by insurer.
(h) ORS 656.430 - Certification of self-insured employer.
(i) ORS 656.434 - Certification effective until canceled or revoked; revocation of certificate.
(j) ORS 656.443 - Procedure upon default by employer.
(k) ORS 656.447 - Sanctions against insurer for failure to comply with orders, rules, or obligations under workers’ compensation insurance policies.
(l) ORS 656.455 - Records location and inspection.
(m) ORS 656.745 - Civil penalties.
(n) ORS 656.850 and 656.855 - Worker leasing companies.
(o) ORS 731.475 - Insurer’s in-state location.

2 The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stats. Implemented: ORS 656.017, 656.029, 656.126, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.443, 656.447, 656.455, 656.745, 656.850, 656.855, and 731.475
Hist: Amended 6/20/03 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 9/17/08 as WCD Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0005 Definitions

For the purpose of these rules unless the context requires otherwise:
(1) “Audited financial statement” means a financial statement audited by an outside accounting firm.
(2) “Board” means the Workers’ Compensation Board of the Department of Consumer and Business Services.
(3) “Cancel” or “cancellation” of coverage means ending a policy at a date before its expiration date.
(4) “Client” means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.
(5) “Complete records” means written records required to be kept in Oregon as described in OAR 436-050-0110 and 0120 and OAR 436-050-0210 and 0220.
(6) “Controlling person” means a person having substantial ownership or who is an officer or director of a corporation; a member or manager of a limited liability company; a partner of a partnership; or an individual who has, directly or indirectly, the power to direct or cause the direction of the management, policies, or operation of a person offering worker leasing services.
(7) “Days” means calendar days unless otherwise specified.
(8) “Default” means failure of an employer, insurer, or self-insured employer to pay the moneys due the director under ORS 656.506, 656.612, and 656.614 at such intervals as the director directs.
(9) “Department” means the Department of Consumer and Business Services.
(10) “Director” means the director of the Department of Consumer and Business Services or the director’s delegate for the matter, unless the context requires otherwise.
(11) “Division” means the Workers’ Compensation Division of the Department of Consumer and Business Services.
(12) “Fiscal Year” means the twelve-month period beginning July 1 and ending June 30.
(13) “Governmental subdivision” means cities, counties, special districts defined in ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456, or regional council of governments created under ORS chapter 190.
(14) “Hearings Division” means the Hearings Division of the Workers’ Compensation Board.
(15) “Insurer” means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in Oregon.
(16) “Leased worker” means any worker provided by a worker leasing company on other than a “temporary basis” as described in OAR 436-050-0420.
(17) “Nonrenewal” means the insurer’s decision not to renew a policy at its expiration date.
(18) “Person” means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the state of Oregon.
(19) “Premium” means the monetary consideration for an insurance policy.
(20) “Premium assessments” means moneys due the director under ORS 656.612 and 656.614.
(21) “Process claims” is the determination of compensability and management of compensation by an Oregon certified claims examiner. Determining compensability and managing compensation must be done from within this state under ORS 731.475 and this definition. Insurers and self-insured
employers may receive claims reports at locations out-of-state as long as claims are forwarded to an Oregon location for processing. The act of making payment may be done from out-of-state as directed from the Oregon place of business.

(22) “Proof of coverage” for purposes of OAR 436-050 has the same meaning as defined in OAR 436-162-0005.

(23) “Renewal” or “renew” means the issuance of a policy succeeding a policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

(24) “Reinstatement” means the continuation or reestablishing of workers’ compensation insurance coverage, as noted by the effective date of the reinstatement, under a workers’ compensation insurance policy that was previously canceled.

(25) “Self-insured employer” means an employer who has been certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407.

(26) “Self-insured employer group” means five (5) or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer set out by ORS 656.407 and OAR 436-050-0260 through 436-050-0340.

(27) “State” means the State of Oregon.

(28) “Substantial ownership” means a percentage of ownership equal to or greater than the average percentage of ownership of all the owners, or ten percent, whichever is less.

(29) “Worker leasing company” means a “person,” as described in section (18) of this rule, who provides workers, by contract and for a fee, as established in ORS 656.850.

(30) “Written” means that which is expressed in writing, and includes electronic records.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0006 Administration of Rules

Any orders issued by the division in carrying out the director’s authority to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704 and 656.726(4)
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0008 Administrative Review and Contested Cases

(1) Any party as defined by ORS 656.005, including an assigned claims agent under ORS 656.054, aggrieved by an action taken under these rules in which a worker’s right to compensation or the amount thereof is directly in issue may request a hearing by the Hearings Division of the Workers’ Compensation Board under ORS chapter 656 and the board’s Rules of Practice and Procedure for Contested Cases under the workers’ compensation law except where otherwise provided in ORS chapter 656.

(2) Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued under ORS 656.254, 656.735, 656.745, or 656.750 may request a hearing by sending a written request to the Workers’ Compensation Division’s administrator within 60 days after the order was mailed.

(3) A hearing will not be granted if the request:

(a) Fails to state the specific grounds for which the party contests the proposed order or assessment; or

(b) Is mailed or delivered to the administrator more than 60 days after the order was mailed.

(4) Under ORS 656.704(2) and 731.240(1), any party that disagrees with an action or order of the director or division under these rules, other than as described in section (2), may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(5) Any party described in section (1) aggrieved by an action taken under these rules by another person except as described in sections (1) through (3) above may request administrative review by submitting a written request to the administrator. The request must specify the grounds upon which the action is contested and be received by the administrator within 90 days of the contested action unless the administrator determines there was good cause for delay or that substantial injustice may otherwise result.

Stat. Auth: ORS 656.704, 656.726(4), and 656.745
Stats. Implemented: ORS 656.254, 656.735, 656.740, 656.745, and 656.750
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0015 Suspension and Revocation of Authorization to Issue Workers’ Compensation Insurance Policies

(1) Under ORS 656.447, the director may suspend or revoke the insurer’s authority to renew or issue workers’ compensation insurance policies upon a determination that the insurer has failed to comply with its obligations under the policy or that it has failed to comply with the law, rules, or orders of the director.

(2) For the purpose of this rule:

(a) “Suspend” or “suspension” means a stopping by the director of the insurer’s authority to issue new workers’ compensation insurance policies for a specified period of time.

(b) “Revoke” or “revocation” means a permanent revocation by the director of an insurer’s authority to renew or issue workers’ compensation insurance policies.

(c) “Show-cause hearing” means an informal meeting with the director or designee in which the insurer will be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke an
insurer’s authority to issue workers’ compensation insurance policies.

(3) Suspension or revocation under this rule will not be made until the insurer has been given notice and the opportunity to be heard through a show-cause hearing before the director and show cause why it should be permitted to continue to issue workers’ compensation insurance policies.

(4) A show-cause hearing may be held at any time the director finds that an insurer has failed to comply with its obligations under a workers’ compensation insurance policy or has failed to comply with law, rules, or orders of the director.

(5) Following a show-cause hearing, the director may rescind the proposed order if the insurer establishes to the director’s satisfaction its ability and commitment to comply with ORS Chapter 656 and these rules.

(6) A suspension may be in effect for a period of up to 18 months. A suspended insurer may continue to serve existing accounts and renew any existing policy, unless the policy nonrenewes or is canceled during the period of suspension.

(7) After 12 months of the suspension has elapsed, the division may audit the performance of the insurer. If the insurer is in compliance, the administrator may request the director to lift the suspension before the 18 months has elapsed. If the insurer is not in compliance, the administrator may request the director revoke the insurer’s authority to issue workers’ compensation insurance policies.

(8) When an insurer’s authority to issue workers’ compensation insurance policies has been revoked, the insurer may serve an existing account only until the policy is canceled or until the next renewal date, whichever first occurs.

(9) After a revocation of an insurer’s authority to issue workers’ compensation insurance policies has been in effect for five years or longer, it may petition the director to restore its authority by submitting a plan demonstrating its ability and commitment to comply with the workers’ compensation law, these rules, and orders of the director.

(10) Appeal of proposed and final orders of suspension and revocation issued under this rule may be made as provided in OAR 436-050-0008.

(11) Any order of suspension or revocation issued under ORS 656.447 and this rule is a preliminary order subject to revision by the director.

436-050-0025 Service of the Notice of Civil Penalty Orders

When the director issues a civil penalty order, it will be served by certified mail, return receipt requested, or in any other manner provided by Oregon Rules of Civil Procedure (7)(D). Proof of service may include a hard copy signed receipt or electronic verification.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.704, 656.726, and 656.740
Hist: Adopted 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0040 Responsibility for Providing Coverage When a Contract Is Awarded

(1) In the operation of ORS 656.029 a subject employer who fails to comply with ORS 656.017 is a “noncomplying employer” as defined by ORS 656.005.

(2) For the purposes of this rule:

(a) “Assistance of others” means one or more individuals directly and immediately aiding in a common undertaking.

(b) “Normal and customary part or process of the person’s trade or business” refers to the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) Under ORS 656.037, a person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696 to a qualified real estate broker or qualified principal real estate broker, as defined in ORS 316.209, is not an employer of the qualified broker.

436-050-0045 Non-Subject Workers

(1) As used in ORS 656.027(1):

(a) “Private employment contract” means direct employment of the worker by the owner of the private home.

(b) As used in this rule, “owner of the private home” means any person who occupies and either owns, leases, or rents the private home, or any person related by blood, marriage, or an Oregon registered domestic partnership to that person, or any person who by direction of that person or by order of a court has become responsible for managing the household affairs of that person.

(2) As used in ORS 656.027(19):

(a) “A person performing foster parent duties” means any person certified by the Oregon Department of Human Services under ORS chapter 418 as a foster parent, or any person employed by that person in the operation of a foster home as defined in ORS chapter 418 and any rules promulgated thereunder.

(b) “A person performing adult foster care duties” means any person licensed by the Oregon Department of Human Services or Oregon Health Authority to operate an adult foster home, or any person employed by the operator to perform services of assistance to the residents of the adult foster home.

(3) As used in this rule, “adult foster home” means any family home or facility, licensed under ORS 443.705 to 443.825, in which room, board, and 24-hour care services are...
provided, for compensation, to five or fewer adults who are not related to the operator by blood or marriage.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.027
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0050  Corporate Officers, Partnerships; Limited Liability Company Members; Subjectivity

(1) Under ORS 656.027, a corporation, limited liability company, or partnership must elect in writing to its insurer to provide workers' compensation coverage for otherwise nonsubject workers. The election must be made at the inception of a coverage policy and remain in effect until a revised written designation is given to the insurer. A self-insured employer must file the election with the director. If an entity does not file its initial election, or is not in compliance under ORS 656.017 and 656.407, then those exempt individuals will be determined in the following order:

(a) For a corporation:
   (A) President;
   (B) Secretary, if any;
   (C) Vice President, if any;
   (D) Secretary/Treasurer, if any;
   (E) Treasurer, if any;
   (F) All other officers, if any.

(b) For a limited liability company or partners of a partnership:
   (A) The member or partner with the largest ownership interest;
   (B) The next largest ownership interest.

(c) If there is more than one person or the ownership interest is the same in any of the offices listed in subsections (a) and (b) of this rule, the sequence of those persons will be determined by whose birthday falls earlier in a year.

(2) Noncomplying corporations, noncomplying limited liability companies, or noncomplying partnerships, regardless of the number of employees, are limited to two exempt officers, members, or partners to be determined in accordance with section (1) of this rule.

(3) For purposes of clarifying terms used in ORS 656.027:

(a) “Commercial harvest of timber” means all commercial activities relating to harvest of timber from a parcel of property including, but not limited to, road building, marking of trees to be cut, timber falling, slash removal, and transportation of timber to the location where it will be processed into lumber or other products.

(b) “Director” means a person elected or appointed to a corporation’s board of directors in accordance with its articles of incorporation or bylaws.

(c) “Eligible officer” means a corporate officer who is also a director of the corporation and who has a substantial ownership interest in the corporation.

(d) “Eligible partner” or “eligible member” means a partner or member who has substantial ownership in the business entity.

(e) “Noncomplying” means an employing legal entity of subject workers which is in violation of ORS 656.017(1).

Stat. Auth: ORS 656.704 and ORS 656.726(3)
Stats. Implemented: ORS 656.027
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0055  Extraterritorial Coverage

(1) Criteria to be used in determining whether a worker is temporarily in or out of state under ORS 656.126 may include, but are not limited to:

(a) The extent to which the worker’s work within the state is of a temporary duration;

(b) The intent of the employer in regard to the worker’s employment status;

(c) The understanding of the worker in regard to the employer’s work assignment;

(d) The permanent location of the employer and its permanent facilities;

(e) The circumstances and directives surrounding the worker’s work assignment;

(f) The state laws and regulations to which the employer is otherwise subject;

(g) The residence of the worker;

(h) The extent to which the employer’s work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer’s work; and

(i) Other information relevant to the determination.

(2) Within 30 days after coverage of an Oregon employer is effective, the insurer providing the coverage must notify the employer in writing of the provisions of ORS 656.126 and this rule.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.126
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0060  Transition from Guaranty Contract Filings to Policy-Based Proof of Coverages

(1) Proof of coverage reporting requirements are prescribed by OAR 436-162.

(2) An active guaranty contract on file with the director on or after July 1, 2009 meets the Oregon proof of coverage requirement until it is replaced by a proof of coverage filing for renewal or new coverage effective on or after July 1, 2009, or until canceled under ORS 656.423 or 656.427. Active guaranty contracts on file with the director will not serve as proof of coverage on or after July 1, 2010.

(3) Filings for policies with a coverage effective date before July 1, 2009 create, endorse, cancel, or reinstate a guaranty contract. Filings for policies with a coverage effective date on or after July 1, 2009 establish, endorse, cancel, or reinstate proof of coverage filings.
(4) A guaranty contract in effect on or after July 1, 2009 is canceled the earliest of:
   (a) The employer obtaining other Oregon workers’ compensation coverage and causing the insurer to make a coverage filing with the director;
   (b) The employer providing the insurer 30 days written notice of cancellation; or
   (c) The insurer mailing notice of cancellation to the employer at least 45 days prior to the cancellation effective date, 90 days notice if the cancellation is based on an insurer’s decision not to offer insurance to employers with a specific premium category, or 10 days notice if the cancellation is based on nonpayment of premium.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.419, 656.427
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09

436-050-0110 Notice of Inurer’s Place of Business in State; Coverage Records Insurer Must Keep in Oregon

(1) Every insurer that is authorized to issue workers’ compensation coverage to subject employers as required by ORS chapter 656 must give the director notice of the location, mailing address, telephone number, and any other contact information in this state where the insurer processes claims and keeps written records of claims and proof of coverage as required by ORS 731.475. The insurer may not have more than eight locations at any one time where claims are processed or records are maintained. While the insurer may have more than one location in this state, the information provided to the director must reasonably lead an inquirer to a person who can respond to inquiries as to workers’ compensation insurance policy, claim filing, and claims processing location information and to access an in-state Oregon certified claims examiner who can respond within a reasonable time to specific claims processing inquiries. A response time of 48 hours or less, not including weekends or legal holidays, would satisfy a reasonable expectation.

(2) Notice under section (1) of this rule must be filed with the director within 30 days after the insurer becomes authorized and starts writing workers’ compensation insurance policies for Oregon subject employers, and must also include contact information for:
   (a) A designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director; and
   (b) A designated person or position within the company who can respond to workers’ compensation policy and proof of coverage filing inquiries.

(3) If an insurer elects to use a service company to satisfy the purposes of ORS 731.475 with respect to all or any portion of its business, the insurer must, prior to using the service company in Oregon, file with the director a copy of the agreement between the insurer and each company for approval, and must give the director notice of the location and mailing address of each service company. The service agreement must:
   (a) Be between the underwriting insurer and a service company that is incorporated in or authorized to do business in Oregon, and must not be between any other third parties;
   (b) Identify the insurer by company name, or if multiple insurers related by ownership, by the name of the group if it includes all affiliates;
   (c) Identify the service company by name;
   (d) Grant the service company a power of attorney to act for the insurer in workers’ compensation claims proceedings under ORS chapter 656; and,
   (e) Contain only those provisions for workers’ compensation activities that are allowed in Oregon.

(4) If the insurer’s or its service company’s place of business or contact information will change, the insurer must notify the director of the new location, mailing address, telephone number, and any other contact information at least 30 days before the effective date of the change.

(5) When an insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor. The insurer must also provide at least 10 days prior notice to the director of which claims will be transferred. The notice to the director must include:
   (a) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, mailing address, and physical address where the claims are to be processed;
   (b) Verification of whether the claims to be transferred include closed claims; and
   (c) A listing of the claims being transferred that identifies the underwriting insurer, employer, claimant name, date of injury, and sending processor’s claim number.

(6) For the purpose of this rule, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the insurer must include, but need not be limited to:
   (a) Processing and keeping complete records of claims for compensation;
   (b) Responding to specific claims processing inquiries;
   (c) Keeping records of payments of compensation;
   (d) Keeping records, including records of claims processed by prior service companies, in a written form, not necessarily original form, and making those records available upon request; and
   (e) Accommodating periodic in-state audits by the director.

(7) Records every insurer is required to keep in this state include all the written records of the insurer that show its insured employers have complied with ORS 656.017, including the records described by OAR 436-050-0120.

436-050-0120  Records Insurers Must Keep in Oregon; Removal and Disposition

(1) The records of claims for compensation that each insurer is required to keep in this state include:

(a) Written records used and relied upon in processing claims;

(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date, or an explanation of the time period between the date of issuance and mailing; and

(c) A written record as to whether supplemental temporary disability benefits, as required under ORS 656.210(5) for workers employed in more than one job, were approved or denied.

(2) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial has been affirmed by operation of law.

(3) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(4) When a denied claim is found to be compensable, the records of the claim are subject to section (3) of this rule.

(5) The insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker’s beneficiaries is gone.

(6) The records relating to proof of coverage that insurers are required to keep in the state include:

(a) A written record of each workers’ compensation insurance policy and related endorsements, reinstatements, or cancellations issued as required under the workers’ compensation law;

(b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the workers’ compensation law;

(c) Written records that segregate and show specifically for each employer the amounts due from the employer and all such money collected and paid by the insurer for premiums for insurance coverage, premium assessments, and any other moneys due the director or required to be remitted to the director.

(7) If all remittances have been made, proof of coverage records may be disposed of after the next Insurance Division examination under ORS 731.300 or the end of three full calendar years following the calendar year in which the workers’ compensation insurance policy cancels or is not renewed, whichever occurs later.

Stats. Implemented: ORS 731.475
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0150  Qualifications of a Self-Insured Employer

(1) To qualify as a self-insured employer, the employer must:

(a) Establish proof that the employer has an adequate staff qualified to process claims;

(b) Establish proof of the financial ability to make certain the prompt payment of all compensation and other payments due under ORS chapter 656;

(c) Obtain excess insurance coverage in the amounts approved by the director; and

(d) Be registered and authorized to do business in this state under ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648, as applicable.

(2) An employer establishes proof of an adequate staff qualified to process claims by:

(a) Employing and retaining at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the claims processing function; or

(b) Contracting the services of one or more service companies that employ at each claims processing location in this state, at least one person qualified in accordance with OAR 436-055-0070 and that is actually involved in the self-insured employer’s claims processing.

(3) An employer establishes proof of financial ability by providing a security deposit that the director determines is acceptable in accordance with OAR 436-050-0165, and in an amount as determined in accordance with OAR 436-050-0180.

(4) Failure of a certified self-insured employer to maintain the qualifications required in this rule will result in revocation of the employer’s self-insured certification. The employer will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the employer complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0160  Applying for Certification as a Self-Insured Employer

(1) An employer applying for certification as a self-insured employer must submit:

(a) A completed “Application for Self-Insurance” (Form 440-1868);

(b) Proof of the employer’s claims processing ability by employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or by contracting with a service company that
will have at least one person qualified in accordance with OAR 436-055-0070, that will be processing the employer’s claims in this state, under ORS 656.455(1);

(c) The employer’s audited financial statements or audited annual reports for the last three fiscal or calendar years. If the audited financial statements of a parent company are provided in lieu of statements for the employer, the director will not authorize the individual employer to be self-insured under its own program, unless a parental company guarantee can be obtained. Otherwise, it will be necessary for the parent company to be the self-insured employer or to separately insure the employer. In the context of this section, a parent company is a legal entity that owns a majority interest in the employer, or owns a majority interest in another entity or succession of entities that own a majority interest in the employer;

(d) The employer’s most recent experience rating modification worksheet and supporting documentation. Applicants with prior Oregon experience who do not submit this data will be assigned a 1.50 experience rating modification pending receipt of the data. All those without prior Oregon experience will be assigned a 1.00 experience rating modification;

(e) The type, retention, and limitation levels of excess workers’ compensation insurance the employer is planning to obtain as required by OAR 436-050-0170;

(f) If applicable, within 30 days after the date of certification, a service agreement between the employer and service company that has been signed by both parties. The agreement must also contain the location, mailing address, telephone number, and any other contact information of the service company;

(g) Evidence from a surety bond company admitted to do surety business in this state that they will issue a surety bond for the employer, as Principal, and notify the employer that the request for certification as a self-insured employer qualifies as a self

(b) Approval of the type, retention, and limitation levels of the excess insurance; or

(c) The type, retention, and limitation levels of excess insurance required.

(3) If approved, the certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(4) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (3) of this rule are met.

(5) Notwithstanding subsection (1)(c) of this rule, an employer making application may submit certified financial statements in lieu of audited financial statements or annual reports. However, the director may require the employer to submit audited financial statements if the certified financial statements submitted are insufficient to evaluate the employer’s financial status.

(i) An “Aaa”, “Aa”, or “A” long term certificate of deposit (CD) rating in the current quarterly edition or monthly Statistical Handbook” prepared by Moody’s Investors Service Inc., New York; or

(ii) An “AAA”, “AA” or “A” long term certificate of deposit (CD) rating in the current quarterly edition or monthly supplement of “Financial Institutions Ratings” prepared by Standard & Poor’s Corporation, New York.

436-050-0165 Security Deposit Requirements

(1) For the purposes of this rule:

(a) “Employer” includes employer groups;

(b) “Self-insured employer” includes self-insured employer groups; and

(c) “ISLOC” means irrevocable standby letter of credit.

(2) A self-insured employer is required to provide a security deposit that is acceptable to the director, to establish proof of its financial ability, and to be qualified and certified as a self-insured employer or to be certified as a self-insured employer group. In accordance with ORS 656.407, a surety bond or an irrevocable standby letter of credit (ISLOC) may be accepted for the required security deposit if it complies with the following conditions and requirements:

(a) An ISLOC may be approved by the director as all or part of the security deposit. The director may approve the ISLOC if the issuing bank and the ISLOC meet the requirements of this rule:

(A) The ISLOC must be issued by or confirmed by an Oregon state chartered bank or a federally chartered bank from which funds will be immediately payable on demand. The bank issuing the ISLOC must, at the time of issuance, have a credit rating as set forth below:

(i) An “Aaa”, “Aa”, or “A” long term certificate of deposit (CD) rating in the current monthly edition of “Moody’s Statistical Handbook” prepared by Moody’s Investors Service Inc., New York; or

(ii) An “AAA”, “AA” or “A” long term certificate of deposit (CD) rating in the current quarterly edition or monthly supplement of “Financial Institutions Ratings” prepared by Standard & Poor’s Corporation, New York.
(B) Federally chartered instrumentalities of the United States operating under authority of the Farm Credit Act of 1971 as amended, are acceptable without rating.

(C) An ISLOC issued by a bank that does not meet the credit rating set forth in paragraph (A) at the time of issuance will only be accepted with a confirming ISLOC issued by an Oregon state chartered bank or federally chartered bank meeting the credit criteria of paragraph (A). The confirming ISLOC must state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed.

(D) The issuing bank must use the Irrevocable Standby Letter of Credit, Form 440-3640, issued by the director.

(E) The ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date, the director is notified in writing by registered mail or overnight delivery, that the bank has elected not to extend the ISLOC for another period.

(F) If the issuing bank or any confirming bank is closed at the time of expiry of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation.

(G) The ISLOC can be called immediately if:
   (i) The self-insured employer has defaulted in payment of its workers’ compensation liabilities or obligations, or in payments due to the director under ORS chapter 656;
   (ii) The self-insured employer has filed for bankruptcy;
   (iii) The self-insured employer has failed to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or
   (iv) The beneficiary has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer, and that neither has been provided, notwithstanding written notice to the self-insured employer.

(H) The credit must be available by presentation of the beneficiary’s draft drawn at sight on the issuing bank, payable within three business days, when accompanied by one of the statements contained in 436-050-0165(2)(a)(G) signed by the director of the Department of Consumer and Business Services, or the administrator of the Workers’ Compensation Division, or their designated authorized representative.

(I) The ISLOC is not subject to any qualifications or conditions by the issuing bank or confirming bank and is each bank’s individual obligation, which is in no way contingent upon reimbursement.

(J) An ISLOC must include a statement that the funds provided by the ISLOC are not construed to be an asset of the self-insured employer and a statement that if legal proceedings are initiated by any party with respect to the payment of any ISLOC, it is agreed that such proceedings must be subject to the jurisdiction of Oregon courts and Oregon law.

(K) Payment of any amount under an ISLOC must be made only by wire transfer in the name of the “Department of Consumer and Business Services In Trust For [the legal name of the certified self-insured employer]” to a department account, with the State Treasurer, at a designated bank.

(L) An ISLOC is subject to the International Standby Practices 1998 (ISP98), ICC Publication No. 590, which is hereby incorporated by reference, and a reference to this publication must be included in the text of the ISLOC. ICC Publication 590 may be obtained from the International Chamber of Commerce website:

http://iccwbo.org/policy/banking/

(M) All bank charges for the ISLOC are for the account of the applicant.

(N) Any amendment to the ISLOC must be approved and accepted by the director before the amendment is effective.

(O) If a bank’s rating subsequent to the issuance of the ISLOC falls below the acceptable rating level as set forth in paragraph (A), the self-insured employer must, within 60 days of the publication of the lower credit rating:
   (i) Replace the ISLOC with a new ISLOC issued by an Oregon state chartered bank or with a federally chartered bank with an acceptable credit rating;
   (ii) Confirm the ISLOC by an Oregon state chartered bank or a federally chartered bank that has an acceptable credit rating; or
   (iii) Replace the ISLOC with a policy of insurance or a surety bond of equal amount that is approved by the director, as substitute security for the ISLOC, if the policy of insurance or surety bond covers all workers’ compensation liabilities and obligations that would have been covered by the ISLOC.

(P) Each self-insured employer that submits an acceptable ISLOC as its security deposit, must furnish a memorandum of understanding with the ISLOC, on the department’s Form 440-3529, that affirms the self-insured employer’s acceptance of all of the following requirements:
   (i) An ISLOC is furnished to the director instead of a surety bond or other forms of security that may be determined to be acceptable for certification as a self-insured employer or for continuing as a certified self-insured employer;
   (ii) The self-insured employer understands the ISLOC will be automatically extended without amendment for an additional one (1) year from the expiry date, or any subsequent expiry date, unless, at least 60 days before the expiry date, the director is notified in writing by the bank that the ISLOC will not be renewed;
   (iii) The ISLOC may be replaced with an ISLOC or surety bond of equal amount or a policy of insurance that is accepted by the director as substitute security for the ISLOC, if the new ISLOC or surety bond or policy of insurance covers all workers’ compensation liabilities and obligations that would have been covered by the ISLOC to be replaced;
(iv) The self-insured employer affirms that the ISLOC, in the amount required, is being offered with the understanding that the ISLOC can be called immediately, at the director’s discretion, if the director receives notice that the ISLOC will not be renewed; if the self-insured employer fails to pay its workers’ compensation liabilities, obligations, or payments due to the director under ORS chapter 656; or the self-insured employer files bankruptcy; or the self-insured employer fails to renew or provide acceptable substitute security by fifteen (15) days prior to the expiry date of the ISLOC; or the director has determined the existing security is deemed inadequate, that additional or replacement security must be provided by the self-insured employer and that neither has been provided, notwithstanding written notice to the self-insured employer; and

(v) If legal proceedings are initiated by any party with respect to payment of any ISLOC, then it is agreed that the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law.

(b) A surety bond may be accepted by the director as a security deposit or substitute security deposit for an ISLOC, government securities, monies, or time deposits. A surety bond may be accepted as all or part of the security deposit. The director, in each particular case, will determine if the surety bond submitted is acceptable, if the issuing surety is acceptable, and if its language and format are acceptable.

(A) The surety bond must be issued by a surety company authorized to transact surety business in Oregon;

(B) Surety Bond Form 440-824 must be used for all surety bonds;

(C) Surety bonds submitted for the self-insured employer’s security deposit must be continuous in form;

(D) Surety bonds may be terminated by the surety company by giving the director and the Principal written notice stating that on a date not less than thirty days after the date the notice is received by the director, such termination will be effective. Such termination in no way limits the liability of the Surety for subsequent defaults of the Principal’s liability and/or obligations incurred under ORS chapter 656 prior to the effective date of such termination;

(E) Surety Bond Rider Form 440-1810 must be used for all department required increases or authorized decreases in the penal sum of the surety bond. The surety bond rider is not effective until it is accepted by the department;

(F) Surety bonds and all riders to the surety bonds must be executed by the surety company’s attorney in fact and the attorney in fact’s appointment and power of attorney must accompany all surety bonds and riders submitted. The power of attorney must authorize the attorney in fact to execute the surety bond in the amount of the penal sum of the bond;

(G) The liability of a surety company under its surety bond may only be discharged in the event that:

(i) The Principal files acceptable substitute security as the security deposit that is accepted by the director as substitute security for the surety bond to be released, covering all past, present, existing, and potential liability of the Principal under ORS chapter 656 and covering all the Surety’s liability under the surety bond to be released, in an amount required by the director; and

(ii) The surety bond is released as documented in writing from the director or the administrator of the Workers’ Compensation Division, or their designated authorized representative.

(iii) A policy of insurance or an ISLOC of equal amount that is acceptable by the director may be accepted as substitute security for the surety bond if the policy of insurance or ISLOC covers all workers’ compensation liabilities and obligations that would have been covered by the surety bond.

(H) The surety company or its parent must have and maintain an acceptable credit rating in accordance with the following:

(i) Standard and Poors Insurer Financial Strength Rating of A or better rating, or

(ii) A.M. Best Company, Financial Strength Rating of B+ or better rating.

(I) A surety bond must be replaced by the self-insured employer with an acceptable type of security deposit within 30 days after notice from the department that the Surety has been placed in conservatorship, is seized, or declares insolvency, or the current credit rating is below the ratings required in subsection (H).

(c) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer’s or a self-insured employer group’s required security deposit prior to January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit, or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director. A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit must complete a “Security Agreement and Notice to Intermediary,” Form 440-4023, granting the department a security interest in and control over those financial assets.

(d) Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit or for employers whose self-insurance certification was granted after January 1, 2004.

436-050-0170 Excess Insurance Requirements

(1) A self-insured employer must have excess workers’ compensation insurance coverage appropriate for the employer’s potential liability under ORS 656.001 to 656.990 with an insurer authorized to do business in this state. The
policy providing such coverage and any endorsements thereto must be filed with the director not later than 30 days after the date the coverage is effective. A self-insured public utility with assets in excess of $500 million as reflected by the employer’s audited financial statement submitted in accordance with OAR 436-050-0160 or 436-050-0175, may obtain the required excess workers’ compensation insurance coverage from an eligible surplus lines insurer.

(2) The excess insurance:

(a) Must include a provision for reimbursement to the director of all expenses paid by the director on behalf of the employer under ORS 656.614 and 656.443 in the same manner as if the director were the insured employer, subject to the policy limitations or amounts and limits of liability to the insured employer; and

(b) Coverage must be continuous and remain in effect from the date of certification until the certification is revoked or canceled; and

(c) Coverage must be specific on a per occurrence basis; and

(d) Coverage may include aggregate excess insurance; and

(e) Coverage may include a deductible endorsement acceptable to the director.

(3) When an excess insurance policy is canceled by the excess insurer or the employer, a copy of such notice must be filed with the director 30 days prior to the effective date of cancellation.

(4) Changes in the self-insured retention level and policy limits of the excess insurance require prior approval of the director. The director may require a reduction in the self-insured retention level or an increase in the policy limits. Those items considered in determining and approving the retention and limitation levels of the excess insurance will be the employer’s:

(a) Financial status;

(b) Risk and exposure;

(c) Claim history; and

(d) The amount of the required security deposit.

(5) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to reduce the self-insured retention level or increase the policy limitation or amounts and limits of liability of the excess insurance.

(6) Excess insurance obtained under this section does not relieve any self-insured employer from full responsibility for claims processing and the payment of compensation required under ORS chapter 656 and these rules. Regardless of the types and amounts of excess coverage a self-insured employer must not transfer claims to the excess insurer(s) for processing.

(7) If a self-insured employer does not comply with the requirements of this section, the employer’s certification as a self-insured will be revoked. The employer will be given written notice of such revocation which will be effective 30 days from receipt of the notice. If the required excess insurance is obtained within the 30 days, the revocation will be canceled and certification will remain in effect.

436-050-0175 Annual Reporting Requirements

(1) To determine the financial status of a self-insured employer and to evaluate the employer’s continuity of operation, a self-insured employer must file annually with the director an audited financial statement or an annual report with audited financial statement, including SEC Form 10K if issued, for the just completed fiscal year. A self-insured employer that is not a municipality must make the filing within 120 days of the fiscal year end and a self-insured employer that is a municipality must make the filing within 180 days of the fiscal year end. All financial statements and annual financial reports filed, as required by this section, will be retained by the director for a period of at least three years. In lieu of an audited financial statement or annual report, a self-insured employer may file a financial statement certified by the employer that the financial statement is true and accurate and presents the employer’s financial condition and results of operations as of the date of the statement.

(2) Notwithstanding section (1) of this rule, the director may require an employer to submit an audited financial statement if the certified financial statement submitted is insufficient to evaluate the employer’s financial status.

(3) The self-insured employer must report claim loss data described in Bulletin 209 by March 1 of each year for the purposes of experience rating modification, retrospective rating calculations, and determining deposits.

(a) The report must be certified to be true and accurate by an authorized representative of the self-insured employer, and must include:

(A) A report of losses for each year in the experience rating period. The report must cover all claims incurred during the reporting period and must be valued as of January 1 of the current year. Reports must include:

(i) Contract medical expenses;

(ii) Total medical deductible;

(iii) Number of claims for which the medical deductible is claimed;

(iv) For claims with incurred losses of $5,000 or less, total paid, outstanding reserves, and total incurred losses;

(v) Number of claims with incurred losses of $5,000 or less; and

(vi) For each claim with incurred losses exceeding $5,000, worker’s name, date of injury, claim number, total paid, outstanding reserves, and total incurred losses. Claims must be listed in alphabetical order.

(B) A report of losses covering the self-insured period prior to the experience rating period. The report must list all open
claims and must be valued as of January 1 of the current year. The report must include:

(i) The worker’s name, listed in alphabetical order;
(ii) Date of injury;
(iii) Claim number;
(iv) Total paid;
(v) Outstanding reserves; and
(vi) Total incurred losses.

(C) Identification of claims involving catastrophes, Workers with Disabilities Program, permanent total disability or fatal benefits, third party recoveries, and claims where the total incurred has or is expected to exceed the self-insured employer’s excess insurance policy.

(D) The total annual paid losses for the previous four fiscal years valued as of January 1 of the current year.

(b) Bulletin 209 provides guidelines for self-insured employers and their authorized representatives to use in submitting the required data.

(c) Each self-insured city or county that is exempted from the security deposit requirements under ORS 656.407(3) and OAR 436-050-0185 must, in addition to the above, provide the procedures, methods, and criteria used in the process of determining the amount of their actuarially sound workers’ compensation loss fund, including procedures for determining the amount for injuries incurred but not reported.

(4) Notwithstanding section (3) of this rule, the director may require a self-insured employer to submit claim loss data more frequently if the nature of the self-insured employer’s business has changed since the last annual loss report for reasons including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, or incurred claims costs.

(5) If a self-insured employer fails to comply with the requirements of sections (1), (2), (3), or (4) of this rule, the director may impose any or all of the following sanctions:

(a) Require the self-insured employer to increase its deposit and premium assessments by 25%;
(b) Conduct an audit to obtain the necessary loss information at the self-insured employer’s expense;
(c) Assess civil penalties of up to $250 per day that the information is not provided beyond the deadline; or
(d) Revoke the employer’s certification as self-insured.

(6) To ensure each self-insured employer’s claims are valued appropriately for use in deposit, experience rating, and retrospective rating calculations, the director will perform routine test audits. If a self-insured employer’s total claims values are found to be 10 percent or more below the director’s determined values, the current experience rating will be recalculated using the director’s determined values and will be used in the security deposit and retrospective rating calculations. In addition, penalties may be assessed.

Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0180 Determination of Amount of Self-Insured Employer’s Deposit; Effective Date of Order to Increase Deposit

(1) The deposit a self-insured employer is required by ORS 656.407 to maintain with the director must be an amount not less than the greater of:

(a) $100,000; or
(b) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost, and the anticipated assessments payable to the director for the employer’s next fiscal year; or
(c) The annual incurred losses for the self-insured’s last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer’s next fiscal year.

(2) Notwithstanding section (1) of this rule, if the employer is applying for self-insurance, the amount of the deposit must not be less than the greater of:

(a) The anticipated assessments payable to the director for the employer’s next fiscal year, plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer’s Oregon operations for the employer’s next fiscal year; or
(b) $300,000 plus $30,000 additional for each $100,000 the employer’s net worth is below $2 million; or
(c) The amount of the approved self-insured’s excess workers’ compensation insurance.

(3) In determining the amount of deposit the director will take into consideration:

(a) The financial ability of the employer to pay compensation and other payments due;
(b) The employer’s probable continuity of operation;
(c) Retention and limitation levels of the employer’s excess insurance in relation to the employer’s financial status;
(d) Changes in the employer’s business including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, incurred claims costs, or material growth in self-insured exposure; and
(e) The balance of the Self-Insured Employers Adjustment Reserve.

(4) Assessments payable to the director referred to in this section include moneys and assessments due under ORS 656.506, 656.612, and 656.614.

(5) A self-insured employer will be allowed a period, not to exceed 30 days, within which to comply with an order of the director to the employer to increase the amount of its deposit.

(6) “Claims processing administrative cost” will be determined by developing a percentage rate to be applied against the employer’s unpaid losses. The rate will be based on
the information contained in Schedule P, Part 1D of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year. The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:

(a) “Loss expenses unpaid” for losses incurred in the latest eight years, divided by

(b) “Losses unpaid” for losses incurred in the latest eight years.

(7) “Incurred but not reported” (IBNR) will be calculated by applying a loss development factor against the employer’s annual paid losses. The loss development factor will be calculated annually by the director. An IBNR may be included in the security deposit calculation when the director identifies factors including, but not limited to, a decrease in the self-insured employer’s credit rating, a negative net worth, negative cash flow, high debt-to-equity ratio, or material growth in self-insured exposure.

Stat. Auth.: ORS 656.407, 656.704, and 656.726(4)

Stat. Implemented: ORS 656.407

Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04

Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0185 Deposit Exemption for Self-Insured Cities and Counties, Qualifications, Application Procedures, Conditions and Requirements, Revocation and Requalification

(1) A self-insured city or county may apply to be exempt from the security deposit requirements of ORS 656.407(2). Under ORS 656.407(3), the requirements to qualify for exemption are as follows:

(a) The city or county must be a certified self-insured employer, not a member of a self-insured employer group, in compliance with ORS 656.407(2) and OAR 436-050-0180 as an independently self-insured employer for the three consecutive years immediately prior to applying for the exemption; and

(b) The city or county must have in effect a workers’ compensation loss reserve account that is actuarially sound and that is adequately funded as determined by the annual audit under ORS 297.405 to 297.740 that identifies the actuarially sound funded amount in the dedicated workers’ compensation loss reserve if not previously filed as required by OAR 436-050-0175(1);

(b) A copy of the city’s or county’s current fiscal year’s approved budget that states the budgeted amount for the funded workers’ compensation loss reserve account;

(c) A resolution or ordinance passed by the city’s or county’s governing body that establishes an actuarially sound and adequately funded workers’ compensation loss reserve account that dedicates the workers’ compensation loss reserve account to and limits expenditures to only the payment of compensation and amounts due the director under ORS chapter 656. The resolution must also include the director’s first lien and priority rights to the full amount of the workers’ compensation loss reserve account required to pay the present discounted value of all present and future claims under ORS chapter 656; and

(d) A statement giving the amount of the current reserves for present and future liabilities, the amount funded in the workers’ compensation loss reserve account, the procedures, methods, and criteria used in the process of determining the amount funded in their actuarially sound workers’ compensation loss fund, including procedures for determining the amount for injuries incurred but not reported. The statement must include the city’s or county’s certification that the loss reserve account is actuarially sound and adequately funded if an actuarial study is not available.

(3) Within 45 days of receipt of all information required by section (2) of this rule, the director will review the application and supporting documentation and notify the city or county that the request for exemption under ORS 656.407(3) is approved or denied.

(a) If denied, the notice will provide the reasons for the denial, any requirements for reconsideration, and the right to administrative review as provided by OAR 436-050-0008.

(b) If approved, the notice will include:

(A) The confirmation of the effective date of exemption;

(B) Authorization for cancellation of any surety bond or ISLOC held as security under ORS 656.407(2) and OAR 436-050-0180; and

(C) Procedures for release of any government securities or time deposits held as security under ORS 656.407(2) and OAR 436-050-0180.

(4) Probable cause to believe the workers’ compensation loss reserve account is not actuarially sound includes but is not limited to the annual audited financial statement under ORS 297.405 to 297.740 not containing a statement by the auditor that the workers’ compensation loss reserve account is adequately funded, or containing a disclaimer regarding the auditor’s qualifications or ability to determine adequacy of the loss reserve account.

(5) A city or county that has been exempted from ORS 656.407(2) and desires to terminate its self-insurance certification or elects to discontinue maintaining an actuarially
sound and adequately funded workers’ compensation loss reserve must:

(a) Submit a written request to the director at least 60 days prior to the desired effective date the self-insured certification is requested to be terminated or 60 days prior to the effective date that the qualifying workers’ compensation loss reserve account is to be discontinued;

(b) If the self-insured certification is to be terminated, the request for termination must comply with OAR 436-050-0200. Prior to the effective date of termination the city or county must provide a security deposit, as required by the director, in an amount determined under OAR 436-050-0180 and ORS 656.443; and

(c) If the city or county desires to remain self-insured, the city or county must requalify for self-insurance certification by depositing, prior to the date the qualifying workers’ compensation loss reserve account is to be discontinued, a security deposit as required by the director under ORS 656.407(2) and OAR 436-050-0180. Under ORS 656.407(3)(e) failure to deposit the required security deposit with the director prior to the date of discontinuance of the qualifying workers’ compensation loss reserve account will cause the city’s or county’s self-insurance certification to be automatically revoked as of that date.

Stats. Implemented: ORS 656.407
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0190 Using Self-Insured Employers Security Deposit/Self-Insured Employers Adjustment Reserve/Self-Insured Employer Group Adjustment Reserve

(1) In the event a self-insured employer fails to or is unable to make all payments due under ORS chapter 656, the director will, on behalf of the employer, assure continued payments in accordance with ORS 656.407, 656.443, and 656.614 and in such a manner as to ensure minimum delay in the processing of injured workers’ claims.

(2) If a self-insured employer defaults and is being serviced by one or more service companies, the director will, on behalf of the employer, designate those service companies to continue processing claims in accordance with the contracts in effect. At least 90 days prior to the time the contract expires, the service company can submit a proposal to continue processing the claims. The director will consider such proposal along with other options which may include referral of the claims for processing to an assigned claims agent selected under ORS 656.054.

(3) If a self-insured employer defaults and is self-administering, the director will, on behalf of the employer, negotiate to have the employer’s claims processed or may refer the claims for processing to an assigned claims agent as secured under ORS 656.054.

(4) In the event a self-insured employer reorganizes its business, assumes additional liability, acquires new operations, buys an additional business, buys an additional business, files bankruptcy, emerges from bankruptcy, or otherwise changes its operation in any manner that affects its workers’ compensation claims liability, the self insured employer must notify the director of the modification of business within 30 days of the event.

(5) For the purposes of this rule:

(a) “Employer” includes employer groups.

(b) “Self-insured employer” includes self-insured employer groups.

Stats. Implemented: ORS 656.407, 656.443, and 656.614
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0195 Requirements for Self-Insured Entity Changes

(1) If there is any change in the legal entity, changes in addresses, telephone numbers, and points of contact, or ownership changes, a self-insured employer must notify the director in writing within 30 days after the change occurs.

(2) A self-insured employer must submit requests to add or delete entities under its self-insured certification by submitting a completed “Endorsement to Self-Insured Group Application” (Form 440-1869) signed by an officer of the company. Each entity to be approved for inclusion in a self-insured employer’s certification must enter into an agreement, signed by an officer of the entity being included in the self-insured employer’s certification, making the entity jointly and severally liable for the payment of any compensation and moneys due to the director by the certified self-insured employer or any other entity included in the self-insured employer’s certification.

(3) The director will determine, based on the information provided, the effect of the change on the deposit required and whether the entities can be combined for experience rating purposes.

(4) Failure to provide notification as required by this section may result in assessment of penalties or revocation of self-insurance certification, or both.

Stat. Auth: ORS 656.407, ORS 656.430, ORS 656.704 and ORS 656.726(3)
Stats. Implemented: ORS 656.407 and ORS 656.430
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0200 Self-Insured Certification Cancellation; Revocation

(1) A certification to a self-insurer issued by the director remains in effect until:

(a) Revoked as provided by OAR 436-050-0150 through 436-050-0230 and ORS 656.440; or

(b) Canceled by the employer with the approval of the director.

(2) If a self-insured employer wishes to cancel certification as a self-insured or cancel self-insurance for any legal entity included under the self-insurance certification, the employer must make written request to the director. Such a request must be submitted at least 60 days prior to the desired date of cancellation and include:
(a) What arrangements have been made to process present and future claims for which the employer is responsible;

(b) A statement of all present and future claims liabilities for all liabilities incurred during the period of self-insurance; and

(c) Any reports and moneys due the director under ORS 656.506, 656.612, and 656.614.

(3) If the employer will continue to have subject workers after the cancellation date, the employer must provide the director, prior to the desired date of cancellation, one of the following:

(a) An insurer filed proof of coverage for a workers’ compensation insurance policy under ORS 656.017 and 656.419;

(b) Evidence of a worker leasing arrangement as allowed under ORS 656.850; or

(c) An assigned risk binder that demonstrates compliance with ORS 656.052.

(4) If the self-insured employer fails to provide the director evidence of subsequent coverage under section (3) prior to the desired date of cancellation, the self-insurance certification, including reports and moneys due the director under ORS 656.506, 656.612, and 656.614, will remain in effect.

(5) If a workers’ compensation insurance policy is in effect and an active self insurance certification is on file with the director for the same employer for the same time period, the self-insured employer has the responsibility of processing claims occurring during the time period as provided under the self insurance certification.

(6) The certification of a self-insured employer may be revoked if:

(a) The employer fails to comply with ORS 656.407 or 656.430 and applicable rules; or

(b) The employer commits any violation for which a civil penalty could be assessed under ORS 656.745.

(7) Except as provided in OAR 436-050-0170 (7), notice of certificate revocation will be issued in accordance with the provision of ORS 656.440.

Stat. Auth: ORS 656.704 and 656.726(4)
Stat. Implemented: ORS 656.434 and 656.440
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 9/17/08 as WCD Admin. Order 08-056, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0205 Notice of Self-Insurer’s Personal Elections

When a person makes an election under ORS 656.039, 656.128, or 656.140, the self-insured must notify the director in writing of the election and of any cancellation of the election within 30 days of the effective date.

Stat. Auth: ORS 656.704 and 656.726(4)
Stat. Implemented: ORS 656.039, 656.128 and 656.140
Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0210 Notice of Self-Insurer’s Place of Business in State; Records Self-Insured Must Keep in Oregon

(1) Every employer certified as a self-insured employer must give the director notice of the location, mailing address, telephone number, and any other contact information of at least one location in this state where claims will be processed and claim records kept as well as other records as required by this rule and OAR 436-050-0220. The employer must give notice of the location, mailing address, telephone number, and any other contact information upon application for certification. The employer may not have at any one time more than three locations where claims are processed or records are maintained.

(2) Notice under section (1) of this rule must include contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director.

(3) With the approval of the director, a self-insured employer may use one or more service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer must file with the director a copy of the agreement entered into between the employer and each company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company.

(4) If a self-insured employer’s or its service company’s place of business or contact information will change, the self-insured employer must notify the director of the new location, mailing address, telephone number, and any other contact information 30 days before the effective date of the change.

(5) When a self-insured employer changes claims processing locations, service companies, or self-administration, the employer must provide at least 10 days prior notice to:

(a) Workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor;

(b) The director of which claims will be transferred. The notice must include:

(A) Contact information for both the sending processor and receiving processor of the claims to include a contact person, telephone number, and mailing address where the claims are to be processed;

(B) Verification of whether the claims to be transferred include closed claims; and

(C) A listing of the claims being transferred that identifies the sending processor’s claim number, claimant name, and date of injury.

(6) For the purpose of this rule, those activities conducted at designated in-state location(s) and by the authorized representative(s) of the self-insured employer must include, but need not be limited to:

(a) Processing and keeping complete records of claims for compensation;

(b) Responding to specific claims processing inquiries;
(c) Keeping records of payments for compensation;
(d) Keeping records, including records of claims processed by prior service companies, in a written form, not necessarily original form, and making those records available upon request; and,
(e) Accommodating periodic in-state audits by the director.
(7) Written records every self-insured employer is required to keep in this state include, but are not limited to, the records described by OAR 436-050-0220.
(8) Notwithstanding section (1) of this rule, the director may approve up to two additional claims processing locations, if the self-insured employer can show:
(a) That meeting the requirements of section (1) of this rule will impose a financial or operational hardship on the employer;
(b) That such additional locations will result in improved claims processing performance of the employer; and
(c) That the auditing functions of the director can be met without unnecessary expense to the director.
(9) If, upon review of a self-insured employer’s claims processing performance, the performance has not remained at the levels as described in OAR 436-060, approval for additional locations provided in section (6) will be withdrawn.
(10) Notwithstanding section (1) of this rule, a self-insured employer may, with the prior approval of the director, make compensation payments from a single location other than the designated claims processing location. Approval of such a location may be revoked if at any time:
(a) Timeliness of compensation payment falls below the minimum standards as established in OAR 436-060;
(b) Written record of compensation payments is not available; or
(c) There is not sufficient written documentation to support the issuance of a check for compensation.
(11) Notwithstanding section (1) of this rule, a self-insured employer may, with prior approval of the director, have one additional location, in or out of state, for maintaining payroll records pertaining to premium assessments and assessment/contributions.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.455
Hist: Amended 6/12/08 as Admin. Order 08-057, eff. 7/1/08
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0220 Records Self-Insured Employer Must Keep in Oregon; Period to be Retained, Removal and Disposition

(1) The written records self-insured employers are required to keep in this state to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 include:
(a) A record of payroll by National Council on Compensation Insurance classification; and
(b) Complete records of all assessments, employer and employee contributions, and all such money due the director.
(2) The self-insured employer must maintain at a place of business in this state, those written records relating to its safety and health program as required by ORS 656.430(10) and OAR 437-001.
(3) The records of claims for compensation that each self-insured employer is required to keep in this state include, but are not limited to:
(a) Written records used and relied upon in processing claims;
(b) A written record of all payments made as a result of any claim including documentation of the date the payment was mailed. Documentation may be the actual mailing date or an explanation of the time period between the date of issuance and mailing;
(c) A written record as to whether supplemental temporary disability benefits, as required under ORS 656.210(5) for workers employed in more than one job, were approved or denied; and
(d) A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments with cumulative totals. The record of disability payments should be limited to statutory benefits and not include any additional employer obligations. Expenses must not be included in any of the three columns required on the summary sheet. “Expenses” are defined in National Council on Compensation Insurance, Workers’ Compensation Statistical Plan, Part IV.
(4) Records of a denied claim may be removed from this state after all the appellate procedures have been exhausted and the denial is final by operation of law.
(5) Records of any claim for a compensable injury may be removed from this state after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.
(6) Notwithstanding sections (4) and (5) of this rule, if administrative or judicial review is requested, the claim records may not be removed from this state or disposed of until after either the review is concluded and the time for an appeal from such review has expired or at least one year after final payment of compensation has been made, whichever is the last to occur.
(7) During administrative or judicial review, if a denied claim is found to be compensable the records of the claim are subject to section (5) of this rule.
(8) The self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker’s beneficiaries is gone.
(9) Records retained as required by section (1) of this rule may be removed from the state or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Stat. Auth: ORS 656.455, 656.704 and 656.726(4)
Stats. Implemented: ORS 656.455
436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Notwithstanding OAR 436-050-0220, if a self-insured employer wishes to keep the claims records and process claims at a location outside this state, the employer may apply to the director for permission to do so. The application shall contain the reasons for the request and the location, mailing address, telephone number, and any other contact information where the records will be kept and the claims processed. The application must provide the director contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director. Upon receipt, the director will review the application and notify the employer that the request has been denied and the reason therefor; or, that the employer will be allowed to process claims from outside this state.

(2) The director may grant permission to the self-insured employer unless the employer has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of section (3) of this rule.

(3) A self-insured employer that keeps claims records and processes claims at a location outside this state must:
   (a) Process claims in an accurate and timely manner;
   (b) Make reports to the director promptly as required by ORS chapter 656 and the director’s administrative rules;
   (c) Pay to the director promptly all assessments and other money as it becomes due;
   (d) Increase or decrease its security deposit promptly when directed to do so by the director under ORS 656.407(2); and
   (e) Comply with the rules and orders of the director in processing and paying claims for compensation.

(4) After notice given as required by ORS 656.455(2), permission granted under this section will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of section (3) of this rule.

(5) A self-insured employer must provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

436-050-0260 Qualifications of a Self-Insured Employer Group

Five or more employers may qualify as a self-insured employer group if the employers as a group:

(1) Incorporate or are a cooperative under ORS chapter 60, 62, or 65. If the group is a governmental subdivision, it must have formed a governmental entity as provided under ORS 190.003 to 190.110;

(2) Designate a board of trustees and an administrator;

(3) Demonstrate a combined net worth of $1 million or more and have excess insurance with a retention of $100,000 or more; or the combined net worth of the employers as a group may be less than $1 million if the employers as a group obtain excess insurance with less than a $100,000 retention, in which case the net worth required may be reduced by the same percentage the retention is reduced below $100,000;

(4) Obtain excess insurance coverage of the type and amounts approved by the director;

(5) Demonstrate that accident prevention is likely to improve

(6) Engage an adequate staff under OAR 436-055-0070 qualified to process claims;

(7) Develop a method approved by the director to notify the director of:
   (a) The commencement or termination of membership by employers in the group, and the effect thereof on the net worth of the employers in the group; and
   (b) Whether an employer who terminates membership in the group continues to be a subject employer; and if the employer

(8) Establish a safety and health loss prevention program as required by OAR 437-001;

(9) Create a common claims fund approved by the director;

(10) Designate an entity within or for the group responsible for centralized claims processing, payroll records, safety requirements, recording and submitting assessments and contributions and making such other reports as the director may require. With the approval of the director, a self-insured employer group may use service companies as authorized by ORS 656.455 instead of establishing its own place of business in this state. To obtain approval or to change or add service locations, the employer group must file with the director a copy of the agreement entered into between the employer group and each company, and must give the director notice of the location, mailing address, telephone number, and any other contact information of each service company;

(11) Establish proof of financial ability by providing a security deposit that the director determines is acceptable in accordance with OAR 436-050-0165; and in an amount as determined in accordance with OAR 436-050-0180; and


(13) Every self-insured employer group must maintain at least one place of business in this state where the employer
processes claims, keeps written records of claims and other records as required by OAR 436-050-0210 to 436-050-0220.

(14) Failure of a certified self-insured employer group to maintain the qualifications required in this rule will result in revocation of the self-insured employer group’s certification. The group will be given 30 days written notice of the intent to revoke the self-insured certification, to be effective 30 days from the date of receipt of the revocation notice. If the self-insured employer group complies with the qualification requirements within the 30-day period, the revocation will be canceled and the certification will remain in effect.

Stats. Implemented: ORS 656.407 and 656.430
Hist: Amended 12/3/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0270 Applying for Certification as a Self-Insured Employer Group: Private Employers

(1) Employers applying for certification as a self-insured employer group must submit:

(a) A complete “Application to Become a Self-Insured Employer Group: Private Employers” (Form 440-1867);

(b) Proof in the form of a certificate from the Secretary of State’s Corporation Division showing the employer group as a corporation or cooperative;

(c) A copy of the bylaws or corporate minutes which include:

(A) Designation of specific individuals as trustees for the corporation or cooperative and naming an administrator to administer the financial affairs of the group who, as obligee, must furnish a fidelity bond with the group in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities; and

(B) The criteria utilized by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;

(d) A current financial statement of each member making application which taken collectively shows the following:

(A) The combined net worth of all members making application for coverage must not be less than $1 million unless the employers as a group have obtained excess insurance coverage with less than a $100,000 retention in which case the net worth will be reduced by the same percentage the retention is reduced below $100,000; and

(B) Working capital in an amount establishing financial strength and liquidity of the business;

(e) An individual report by employer showing the employer’s payroll by class and description and loss information for the last four calendar years;

(f) A completed “Group Self-Insured Indemnity Agreement” (Form 440-1866), or another form authorized by the director, that jointly and severally binds each member for the payment of any compensation and moneys due to the director by the group or any member of the group. Government subdivisions do not need to submit this agreement;

(g) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;

(h) Proof of an adequate staff qualified to process claims by:

(A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or

(B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is qualified in accordance with OAR 436-055-0070 and is actually involved in the self-insured employer’s claims processing. If one or more service companies are used, a service agreement between the employer group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted for approval of the director;

(i) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;

(j) A procedure for notifying the director of:

(A) The commencement or termination of employers within the group and the effect on the net worth of the group; and

(B) Arrangements made by an employer leaving the group to continue insurance coverage.

(k) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(L) The type of security deposit the employer group wishes to provide, with appropriate justification.

(2) Notwithstanding subsection (1)(d) of this rule, the director may require an audited financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the employer group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group. The notice must include:

(a) The amount of security deposit required;

(b) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and

(c) The type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit and the appropriate excess insurance binder.

(5) Unless a later date is specified by the applicant, the effective date of certification will be the first day of the month following the date the requirements of section (4) of this rule are met.

436-050-0280  Applying for Certification as a Self-Insured Employer Group; Governmental Subdivisions

(a) An application for the group applying for self-insurance in a form and format prescribed by the director;
(b) Proof that the governmental subdivisions have formed an intergovernmental entity as provided under ORS 190.003 to 190.110;
(c) An intergovernmental agreement which includes:
   (A) Designation of specific individuals as trustees for the group and naming an administrator to administer the financial affairs of the group who, as obligee, must furnish a fidelity bond with the group in an amount sufficient to protect the group against the misappropriation or misuse of any moneys or securities; and
   (B) The criteria to be used by the trustees and administrator when approving applications for new membership and requests for withdrawal by members of the group;
(d) A current financial statement of each member making application which taken collectively shows the combined net worth of all members making application for coverage must not be less than $1 million unless the employers as a group have obtained aggregate excess insurance coverage with less than a $100,000 retention in which case the net worth will be reduced by the same percentage the retention is reduced below $100,000;
(e) An individual report by employer showing the governmental subdivision’s payroll by class and description and loss information for the last four calendar years;
(f) A resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;
(g) Evidence of a safety and health loss prevention program designed to demonstrate that accident prevention will improve due to self-insurance;
(h) Proof of an adequate staff qualified to process claims by:
   (A) Employing and retaining at each claims processing location, at least one person that is actually involved in the claims processing function and is qualified in accordance with OAR 436-055-0070; or
   (B) Contracting the services of one or more service companies that employ, at each claims processing location, at least one person that is actually involved in the self-insured group’s claims processing, that is certified in accordance with OAR 436-055-0070. If service companies are used, a service agreement between the group and each service company, that meets the requirements of OAR 436-050-0260(10), must be submitted;
(i) The type, retention and limitation levels of excess insurance the employers as a group are planning to obtain in accordance with OAR 436-050-0170;
(j) A procedure for notifying the director of:
   (A) The commencement or termination of governmental subdivisions within the group and the effect on the net worth of the group; and
   (B) Arrangements made by a governmental subdivision leaving the group to continue insurance coverage;
(k) A program whereby each employer within the group contributes to a common claims fund in accordance with OAR 436-050-0300; and

(L) The type and amount of security deposit the group wishes to provide, with appropriate justification. In no case will the amount be less than $300,000.
(2) Notwithstanding subsection (1)(d) of this rule, the director may require an audited or certified financial statement before considering an application by a group for self-insurance.

(3) Within 60 days of receipt of all information required in section (1) of this rule, the director will review the application and notify the group that the request for certification as a self-insured employer group is denied and the reason therefore; or, that the group is qualified as a self-insured employer group.

The notice must include:
(a) The amount of the security deposit required; and
(b) Approval of the type, retention and limitation levels of the excess insurance as determined under OAR 436-050-0170; and the type, retention and limitation levels of excess insurance required.

(4) The certification of self-insurance will be issued upon receipt of the security deposit, the appropriate excess insurance binder and if applicable, a service agreement between the employer and service company that has been signed by both parties.

(5) Unless a subsequent date is specified by the applicant, the effective date of certification will be the date the certification is issued.
Self-Insured Group Application” (440-1869) or a form approved by the director, which must be accompanied by:

(a) A current financial statement of the employer applying;

(b) An agreement signed by the administrator of the self-insured group and the employer, making the employer jointly and severally liable for the payment of any compensation and moneys due to the director by the group or any member of the group; or, if a governmental subdivision self-insured group, a resolution by the governing body of each governmental subdivision binding it to be liable for the payment of any compensation and other amounts due to the director under ORS Chapter 656 incurred by that governmental subdivision during the period of group self-insurance;

(c) A statement showing the effect on the new worth of the group; and

(d) The employer’s payroll by class and description and loss information for the last four fiscal or calendar years.

(2) Incomplete submissions or incorrectly completed endorsements to add new members received by the director will not be considered filed. Failure to file a correct and complete endorsement with the required supporting documentation within 30 days of the effective date of membership may result in the assessment of civil penalties.

(3) Individual members may elect to terminate their participation in a self-insured group or be subject to cancellation by the group under the bylaws of the group. Such cancellation or termination will not be effective prior to approval by the director and only after the self-insured group has submitted the following information for review:

(a) A statement showing the effect of termination on the net worth of the group;

(b) Evidence that the employer requesting termination has made alternate arrangements for coverage if the employer continues to employ;

(c) Evidence that the employer requesting termination has been provided a written reminder about its potential future liability as described in section (1)(b) of this rule; and

(d) The requested date of cancellation or termination.

(4) Upon receipt of the required information, the director may approve the cancellation or termination of the employer provided:

(a) The cancellation or termination does not adversely affect the net worth of the group to the extent that the group would no longer qualify for a self-insured status; and

(b) Sufficient evidence has been presented to ensure that the employer, if employing, retains workers’ compensation coverage.

(5) Once approved, the group will be notified in writing of the effective date of cancellation or termination.

(6) An employer within a group must, if there is a change in the employing legal entity, again apply for membership within the group, in accordance with this rule. A change in legal entity includes, but is not limited to:

(a) When a partner joins or leaves the partnership;

(b) When the employer is a sole proprietorship, partnership, or corporation, and changes to a sole proprietorship, partnership, or corporation; or

(c) When an employer sells an existing business to another person(s), except in the case of a corporation.

(7) An employer within a group must, within 10 days after there is a change of address or assumed business name, notify the board of trustees or administrator of the change. The administrator or board of trustees must, within 10 days, submit to the director an endorsement as notice of the change. A change of address includes, but is not limited to:

(a) Establishment of a new or additional location; or

(b) Termination of an existing location.

(8) The endorsement required by section (7) of this rule must state specifically which location is being deleted or which is being added. It must also identify the type of address, whether it is mailing, operating, or the principal place of business.

(9) The employer group is responsible for maintaining coverage records relating to each member, to include:

(a) The employer’s application for membership in the group, with original signatures;

(b) The employer’s liability agreement under OAR 436-050-0270(1)(f), or resolution under OAR 436-050-0280(1)(f), with original signatures;

(c) Cancellation or termination notices;

(d) Reinstatement applications and notices; and

(e) Records on the whereabouts of employers that have been canceled or have terminated their participation in the group.

Stat. Auth: ORS 656.704 and 656.726(4)
Statute Implemented: ORS 656.434 and 656.440
Hist: Amended 12/5/03 as WCD Admin. Order 03-062, eff. 1/1/04
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0300 Self-Insured Employer Group, Common Claims Fund

(1) A self-insured employer group must establish, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all compensation and all other payments that may become due from such self-insured employer group under the workers’ compensation law.

(2) Except as provided in section (5) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 100 percent of the average of the group’s paid losses for the previous four years.

(3) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(4) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that the amount calculated in section (2) or (5) of this rule must be
included in the determination of the self-insured employer group’s security deposit under OAR 436-050-0180.

(5) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group’s yearly paid losses for the previous four years.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.430
Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0340 Group Self-Insurance Revocation

Notwithstanding ORS 656.440, the certification of a self-insured employer group may be revoked by the director after giving 30 days notice if:

(1) The employer group does not comply with ORS 656.430(7) or (8) or OAR 436-050-0260, 0270, 0280, 0290, or 0300;

(2) There are fewer than five employers within a group;

(3) The net worth of the group falls below that required by OAR 436-050-0260(3);

(4) The employer group commits any violation for which a civil penalty could be assessed under ORS 656.745; or

(5) The employer group or any member of the group submits any false or misleading information.

Stat. Auth: ORS 656.704 and 656.726(4)
Stats. Implemented: ORS 656.430 and 656.440
Hist: Amended 6/22/01 as WCD Admin. Order 01-054, eff. 7/1/01
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0400 Responsibility for Providing Coverage under a Lease Arrangement

(1) Every worker leasing company providing workers to a client must satisfy the requirements of ORS 656.017, 656.407, or 656.419.

(2) Every worker leasing company providing leased workers to a client must also provide workers’ compensation insurance coverage for any subject workers of the client, unless the client has an active workers’ compensation insurance policy that will provide workers’ compensation insurance coverage. The notice must be correct and complete, and must include:

(a) The client’s:
   (A) Legal name;
   (B) FEIN or other tax reporting number;
   (C) Type of ownership;
   (D) Primary nature of business;
   (E) Mailing address; and
   (F) Street address in Oregon;

(b) The worker leasing company’s:
   (A) Legal name;
   (B) Mailing address;
   (C) FEIN or other tax reporting number;
   (D) WCD worker leasing license number, if any;
   (E) Workers’ compensation insurer’s name (or “self-insured”);
   (F) Effective date of leasing contract;
   (G) Contact name and phone number; and
   (H) A signature of a representative of the worker leasing company.

(2) A worker leasing company may terminate its obligation to provide workers’ compensation coverage by giving to its insurer, its client, and the director written notice of the termination. A notice of termination must state the effective date and hour of termination, but the termination will be effective not less than 30 days after the notice is received by the director. Notice to the client under this section must be given by mail addressed to the client at its last known address.

Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0410 Notice to Director of Lease Arrangement; Termination

(1) Within 14 days after the effective date of the lease arrangement or contract, a worker leasing company must file written notice with the director and its insurer, using Form 440-2465, that it is providing leased workers to a client and workers’ compensation coverage. The notice must be correct and complete, and must include:

(a) The client’s:
   (A) Legal name;
   (B) FEIN or other tax reporting number;
   (C) Type of ownership;
   (D) Primary nature of business;
   (E) Mailing address; and
   (F) Street address in Oregon;

(b) The worker leasing company’s:
   (A) Legal name;
   (B) Mailing address;
   (C) FEIN or other tax reporting number;
   (D) WCD worker leasing license number, if any;
   (E) Workers’ compensation insurer’s name (or “self-insured”);
   (F) Effective date of leasing contract;
   (G) Contact name and phone number; and
   (H) A signature of a representative of the worker leasing company.

(2) A worker leasing company may terminate its obligation to provide workers’ compensation coverage by giving to its insurer, its client, and the director written notice of the termination. A notice of termination must state the effective date and hour of termination, but the termination will be effective not less than 30 days after the notice is received by the director. Notice to the client under this section must be given by mail addressed to the client at its last known address.

Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 9/17/08 as WCD Admin. Order 08-061, eff. 7/1/09
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13
Temporary Worker Distinguished from Leased Worker

(1) A person who provides a worker to work for a client will be considered to be providing the worker on a “temporary basis” only if there is contemporaneous written documentation that indicates the duration of the work to be performed and that the worker is provided for a client’s special situation under ORS 656.850(1)(b). Contemporaneous documentation means documents that are created at the time the temporary service provider and the client employer make the arrangements for placement of the worker. Upon the director’s request, the documentation must be provided to the director by either the temporary service provider or the client. Contemporaneous documentation in support of workers being provided on a temporary basis includes one or more of the following conditions:

(a) To cover employee absences or employee leaves, including but not limited to such things as maternity leave, vacation, jury duty, or illness from which the permanent worker will return to work;

(b) To fill a professional skill shortage, including but not limited to, professionals such as engineers, architects, electricians, plumbers, pharmacists, nurses, or other professions, whether licensed or not, to supplement or satisfy a shortage of that skill for a known duration. Supporting documentation may include license information and whether the worker is supplementing or satisfying a client employer’s need for the skill;

(c) To staff a seasonal or sporadic increase in workload, indicated by a temporary increase in demand upon an employer’s normal workload that requires additional assistance to meet the demand. When the increased demand ends, the additional positions are eliminated. Documentation must include what constitutes the demand establishing why this special situation is beyond the norm;

(d) To staff a special assignment or project outside of the routine activities of the business where the worker will be terminated or assigned to another temporary project upon completion. For example, a construction contractor may need assistance on a construction site to help clear branches and other debris after a windstorm so the regular construction crew can continue its work. Documentation must describe the project and why it is unusual;

(e) To hire a student worker that will be provided and paid by a school district or community college through a work experience program. Documentation must include the name of the school and the work experience program; or

(f) To cover special situations where the worker has a reasonable expectation of transitioning to permanent employment with the client employer and the client employer uses a pre-established probationary period in its overall employment selection program. Documentation must include copies of the client employer’s written program or other evidence supporting the pre-established probationary period and overall employment selection program.

(2) If a person provides workers, by contract and for a fee, to work for a client and any such workers are not provided on a “temporary basis,” that person will be considered a worker leasing company.

(3) If a person provides both leased workers and workers on a temporary basis, that person must maintain written records that show specifically which workers are provided on a temporary basis. If the written records do not specify which workers are provided on a temporary basis, all workers are deemed to be leased workers.

Qualifications, Applications, and Renewals for License as a Worker Leasing Company

(1) Each person applying for initial license or renewal as a worker leasing company must:

(a) Be either an Oregon corporation or other legal entity registered with the Oregon Secretary of State, Corporations Division to conduct business in this state;

(b) Maintain workers’ compensation coverage under ORS 656.017; and

(c) Upon application approval and prior to licensure, pay the required licensing fee of $2,050.

(2) Each person applying for initial license or renewal as a worker leasing company must submit an Application for Oregon Worker Leasing License Form 440-2466. The form and accompanying documentation must include:

(a) Legal name;

(b) Mailing address;

(c) In-state and out-of-state phone numbers;

(d) FEIN or other tax reporting number;

(e) Type of business;

(f) Physical address for Oregon principal place of business;

(g) Assumed business names;

(h) Name of workers’ compensation insurer (or “self-insured”) and policy number;

(i) Name(s) and contact information of the representative(s) at the Oregon location(s);

(j) List of controlling persons, and in the case of privately held entities all owners, including their names, titles, residence addresses, telephone numbers, email addresses, and dates of birth;

(k) For a person applying for an initial license, a list of all states where the person operates as a leasing company or professional employer organization (PEO), copies of licenses, registrations, recognitions, or certifications from states that require those actions, and a verifiable statement that the remaining states of operation, if any, do not require licensure, registration, recognition, or certification to provide worker leasing or PEO services;
(I) Verification of compliance with tax laws from Oregon Employment Department, Oregon Department of Revenue, and the Internal Revenue Service, using Attachments A, B, and C of Form 440-2466, the worker leasing license application;

(m) A record of any present or prior experience of providing workers by contract and for a fee in any state, by the person or any controlling person, and an explanation of that experience;

(n) A record of any bankruptcies, liens, or any actions involving or demonstrating dishonesty or misrepresentation, including but not limited to: fraud, theft, burglary, embezzlement, deception, perjury, forgery, counterfeiting, bribery, extortion, money laundering, or securities, investments, or insurance violations on the part of the person or any controlling person. Records of such actions must include:

(A) Charges, guilty pleas, or pleas of no contest;
(B) Criminal convictions;
(C) Lawsuits;
(D) Judgments; or
(E) Discharges or permitted resignations based on allegations of these actions.

(o) Full details regarding any bankruptcy, liens, or action under subsection (n) of this section, including:

(A) The nature and dates of the action(s);
(B) Outcomes, sentences, and conditions imposed;
(C) Name and location of the court or jurisdiction in which any proceedings were held or are pending, and the dates of the proceedings; and

(D) The designation and license number for any actions against a license;

(p) Full details of any administrative actions against the person by a regulatory agency of any state regarding matters listed in subsection (2)(n) or worker leasing activities;

(q) A plan of operation that demonstrates how the worker leasing company will meet the requirements of ORS chapter 654, The Oregon Safe Employment Act;

(r) A plan of operation that demonstrates how the worker leasing company will collect and report the information necessary to establish each client’s separate experience rating to the insurer providing workers’ compensation coverage for each client, or to the National Council on Compensation Insurance for a self-insured worker leasing company and

(s) A notarized signature of an authorized representative of the applicant.

(3) The director may request additional information to further clarify the information and documentation submitted with the application. Under ORS 656.850(2), no person may perform services as a worker leasing company in Oregon without first being licensed to do so.

(4) The director will review complete applications, and may conduct a background investigation of the person applying for a license, an owner, or any controlling person. Information learned through a background investigation, or other information submitted during the application process, may be the basis for the director to refuse to issue or renew a license, or to disqualify the person from making further application.

(5) If the application is approved, the director will issue a license. Each license issued under these rules will automatically expire two years after the date of issuance unless renewed by the licensee. To renew a license, the worker leasing company must submit a renewal application to the director at least 90 days before the expiration of the current worker leasing license. Any supplemental material, whether requested by the director or submitted by the worker leasing company to establish a complete application, must be received by the director at least 45 days before expiration of the current license.

(6) The director may refuse to issue or renew a license or may disqualify a person, controlling person, or worker leasing company from applying for a license in the future for misrepresentation, failure to meet any of the requirements of ORS 656.850, 656.855, or these rules, or for reasons including, but not limited to:

(a) Denial of a previous application for, or prior suspension or revocation of, a worker leasing license by the director;

(b) Denial, suspension, or revocation of a license, registration, or certification, or other discipline by any governmental agency or entity;

(c) Having exercised authority, control, or decision-making responsibility concerning any worker leasing company at the time that company had its authorization to provide worker leasing services denied, suspended, revoked, or restricted;

(d) Having been the subject of an order, adverse to the person, controlling person, or worker leasing company, by any governmental agency or entity in connection with any worker leasing activity;

(e) Having been found by any governmental agency or entity to have made a false or misleading statement, material misrepresentation, or material omission, or to have failed to disclose material facts;

(f) Violations of worker leasing statutes or regulations;

(g) Failure to establish minimum experience, training, or education that demonstrates competency in providing worker leasing services;

(h) Having been the subject of a complaint, investigation, or proceeding related to an action in subsection (2)(n) of this rule;

(i) Having been charged with, convicted of, or pleaded guilty or no contest to any felony or misdemeanor specified in subsection (2)(n) of this rule; or

(j) Having failed to provide documents the director has requested.

(7) “Disqualification,” as used in this rule, means a person or a prospective worker leasing company may reapply no sooner than two years from the disqualification date.
(8) A disqualification may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person, owner, or controlling person.

(9) A person may appeal the director’s refusal to approve issue or renew a license, or a disqualification, under this rule as provided in OAR 436-050-0008 and OAR 436-001.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0450 Recordkeeping and Reporting Requirements

(1) Every licensed worker leasing company must give notice to the director of one Oregon location where Oregon leasing records are kept and made available for review by the director. The notice must include the physical address, mailing address, telephone number, and any other contact information in this state.

(2) Every licensed worker leasing company must have at least one representative of the worker leasing company at the Oregon location authorized to respond to inquiries and make records available by the date specified in the director’s request or demand for information regarding leasing arrangements and client contracts.

(3) The following records must be kept and made available for review at the Oregon location:

(a) Copies of signed worker leasing notices for the most recent three years;

(b) Copies of signed notices of termination of leasing arrangements for the most recent three years;

(c) Copies of signed contracts between the worker leasing company and clients for the most recent three years; and

(d) Payroll records for the most recent seven years for all workers that identify leased workers subject to coverage by the worker leasing company; leased workers not subject to coverage by the worker leasing company; and, written records for all regular and temporary employees of the worker leasing company.

(4) The worker leasing company must notify the director within 30 days of the effective date of a change in any items listed in OAR 436-050-0440(2).

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0455 Reporting Requirements of a Self-Insured Worker Leasing Company

(1) A self-insured worker leasing company must maintain and report to the National Council on Compensation Insurance separate statistical data for each client whose coverage is provided by the self-insured employer. Reporting must be according to the uniform statistical plan prescribed by the director according to ORS 737.225(4).

(2) Records relating to the client statistical data for self-insured worker leasing companies must be made available for review by the National Council on Compensation Insurance upon request.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855
Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0460 Suspension or Revocation of License

(1) Reasons for suspension or revocation of a worker leasing license include, but are not limited to:

(a) Insolvency, whether the worker leasing company’s liabilities exceed their assets or the worker leasing company cannot meet its financial obligations;

(b) Judgments against or convictions, within the last ten years, of any worker leasing company or controlling person for the reasons identified in OAR 436-050-0440(2)(n);

(c) Administrative actions involving worker leasing activities resulting from failure to comply with the requirements of any state;

(d) Nonpayment of taxes, fees, assessments, or any other monies due the State of Oregon;

(e) If the worker leasing company or controlling person has failed to comply with any provisions of ORS chapters 654, 656, 659, 659A, 731 or 737; or any provisions of these rules; or

(f) If the worker leasing company or controlling person is permanently or temporarily enjoined by a court from engaging in or continuing any conduct or practice involving any aspect of the worker leasing business.

(2) For the purposes of this rule:

(a) “Suspension” means a stopping by the director of the worker leasing company’s or controlling person’s authority to provide leased workers to clients for a specified period of time. A suspension may be in effect for a period of up to two years. When the suspension expires, the worker leasing company or controlling person may petition the director to resume its worker leasing company activities.

(b) “Revocation” means a permanent stopping by the director of the worker leasing company’s or controlling person’s authority to provide leased workers to clients. After a revocation has been in effect for five years or longer, the worker leasing company or controlling person may reapply for license.

(c) “Show-cause hearing” means an informal meeting with the director in which the worker leasing company will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a worker leasing company’s authority to provide leased workers to clients.

(3) The director may revoke a license upon discovery of a misrepresentation in the information submitted in the worker leasing application.
(4) Suspension or revocation under this rule will not be made until the worker leasing company has been given notice and the opportunity to be heard through a show-cause hearing before the director and “show cause” why it should be permitted to continue to be licensed as a worker leasing company.

(5) A show-cause hearing may be held at any time the director finds that a worker leasing company has failed to comply with its obligations under a leasing contract or that it failed to comply with the rules or orders of the director.

(6) Appeal of proposed and final orders of suspension or revocation issued under this rule may be made as provided in OAR 436-050-0008 and OAR 436-001.

(7) Notwithstanding section (4) of this rule, the director may immediately suspend or refuse to renew a license by issuing an "emergency suspension order" if the worker leasing company fails to maintain workers’ compensation coverage; or if the director finds there is a serious danger to public health or safety.

(8) A suspension or revocation may apply to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855; Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0470 Monitoring/Auditing

(1) The division will monitor and conduct periodic audits of employers as necessary to ensure compliance with the worker leasing company licensing and performance requirements.

(2) All pertinent records of the worker leasing company required by these rules must be disclosed upon request of the director.

(3) Under ORS 656.726 and 656.758, the director may inspect the books, records and payrolls of employers pertinent to the administration of these rules. Employers must provide the director with all pertinent books, records and payrolls upon request.

(4) For the purposes of this rule, both the worker leasing company and its clients will be considered employers.

Stat Auth: ORS 656.704, 656.726(4), 656.850 and 656.855; Stats. Implemented: ORS 656.850 and 656.855
Hist: Amended 11/1/07 as WCD Admin. Order 07-063, eff. 11/28/07
Amended 10/4/12 as WCD Admin. Order 12-056, eff. 1/1/13

436-050-0480 Assessment of Civil Penalties

(1) Failure to provide timely notice to the director for proof of coverage and cancellation of workers’ compensation insurance policies under ORS 656.419 or OAR 436-162, or failure to provide timely worker leasing notice to the director under ORS 656.850(5) and OAR 436-050-0410, may result in civil penalties under ORS 656.745.

(2) The director may assess a civil penalty under ORS 656.745 against an employer who fails to respond to requests for information or fails to meet the requirements of 436-050-
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 105
EMPLOYER-AT-INJURY PROGRAM

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436-105-0001 Authority for Rules
The director has adopted OAR Chapter 436, Division 105 under the authority of ORS 656.622 and 656.726.
Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Adopted 8/14/01 as WCD Admin. Order 01-057, eff. 10/1/01

436-105-0002 Purpose of Rules
(1) The Employer-at-Injury Program encourages the early return to work of injured workers by providing incentives to employers.
(2) The Employer-at-Injury Program is activated by the employer and administered by the insurer.
(3) The program consists of Wage Subsidy, Worksite Modification, and Employer-at-Injury Program Purchases.
(4) These rules explain:
(a) The assistance and reimbursements available from the Employer-at-Injury Program;
(b) Who is qualified for the assistance and reimbursement; and
(c) How to receive assistance and reimbursements.
Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-065, eff. 12/1/07

436-105-0003 Applicability of Rules
(1) These rules apply to:
(a) All individual Employer-at-Injury Programs begun on or after the effective date of these rules; and
(b) All reimbursement requests made to the division in accordance with OAR 436-105-0540(4) on or after the effective date of these rules regardless of the date an Employer-at-Injury Program began, unless the insurer requests that reimbursement be based on the rules in effect on the date an individual Employer-at-Injury Program began.
(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.
Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010 Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012

436-105-0005 Definitions
For the purpose of these rules, unless the context requires otherwise:
(1) "Administrator" means the Administrator of the Workers' Compensation Division, or the administrator's delegate for the matter.
(2) "Client" means a person to whom workers are provided under contract and for a fee on a temporary or leased basis.
(3) "Consumables" means purchases required to support the functioning of tools or equipment utilized during transitional work.
(4) "Director" means the Director of the Department of Consumer and Business Services, or the director's delegate for the matter.
(5) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.
(6) "Employer-at-Injury" means the organization that employed the worker when the worker:
(a) Sustained the injury or occupational disease;
(b) Made the claim for aggravation; or
(c) Requested an Own Motion opening under ORS 656.278.
(7) "Fund" means the Workers' Benefit Fund.
(8) "Insurer" means the insurance company or self-insured employer responsible for the workers' compensation claim.
(9) "Premium" means the insurance company or self-insured employer responsible for the workers' compensation claim.
(10) "Regular employment" means the employment the worker held at the time of:
(a) Injury;
(b) The claim for aggravation; or
(c) Own Motion opening under ORS 656.278.
(11) "Reimbursable wages" means the worker's gross wages for the Wage Subsidy period.
(12) "Skills building" means a class or course of instruction taken by the worker for the purpose of enhancing an existing skill or developing a new skill. When skills building is the transitional work, the worker must agree in writing to take the class or course of instruction.
(13) "Transitional Work" means temporary work with the employer-at-injury which is not the worker's full duty regular work and is assigned because the worker cannot perform full duty regular work. Transitional work must be within the worker's injury-caused limitations and may be created through modification of the worker's regular work, job restructuring, assistive devices, worksite modification(s), reduced hours, or reassignment to another job. Transitional work must be within the employer's course and scope of trade or profession, unless the work is "skills building."

(14) "Worker Leasing Company" means the person which provides workers, by contract and for a fee, as prescribed in ORS 656.850.

(15) "Work site" means a primary work area available for a worker to use to perform the required job duties. The work site may be the employer’s, client’s, or worker's premises, property, and equipment used to conduct business under the employer’s or client’s direction and control. A work site may include a worker's personal property or vehicle if required to perform the job.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010

436-105-0006 Administration of Rules

(1) Orders issued by the division to enforce ORS 656.622 or these rules are orders of the director.

(2) The department maintains the financial integrity of the fund and all reimbursement is subject to the availability of funds. If the funds are too low for all reimbursements, the director has the final authority to determine how the funds will be disbursed.

(3) The director may use monies from the fund for activities to provide information about and encourage the reemployment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:

(a) Advertisements and promotion of reemployment assistance programs and associated production costs; and

(b) Public reemployment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Adopted 8/14/01 as WCD Admin. Order 01-057, eff. 10/1/01

436-105-0008 Reconsideration/Appeal to the Director

(1) The division will deny any reimbursement for Employer-at-Injury Program assistance it finds in violation of these rules. The division has the discretion to deny any reimbursement of Employer-at-Injury Program assistance it determines is not reasonable, practical, or feasible, or considers an abuse of the program.

(2) Parties directly affected by a division Employer-at-Injury Program decision may request a reconsideration by sending a written request for reconsideration to the administrator no later than 60 days after the date the decision is issued. Facsimiles that are legible and complete are acceptable and will be processed the same as originals. Reconsideration must precede a director’s review.

(3) The request for reconsideration must specify the reasons why the decision is appealed and may include additional documentation. No reconsideration will be granted unless the request meets the requirements of this rule.

(4) The division will reconsider the decision and notify all directly affected parties of its decision in writing. The affected parties may request a director’s review by sending a written request no later than 60 days after the date the reconsideration was issued. The request must specify the reasons why the decision is appealed and may include additional documentation.

(5) The director may require any affected party to provide information or to participate in the director’s review. If the party requesting the director’s review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.

(6) The director’s review decision will be issued in writing and all directly affected parties will be notified. The director’s review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-065, eff. 12/1/07

436-105-0500 Insurer Participation in the Employer-At-Injury Program

(1) An insurer must be an active participant in providing reemployment assistance with the employer’s consent. Participation includes issuing notices of the available assistance and administering the Employer-At-Injury Program as specified in these rules.

(2) The insurer will notify the worker and employer-at-injury in writing of the assistance available from the Employer-At-Injury Program. A notice must be issued:

(a) Upon acceptance or reopening of a claim; and

(b) Within five days of a worker’s first release for work after claim opening unless the release is for regular work.

(3) The notices of Employer-at-Injury Program assistance must contain the following language:

(a) The notice to the worker must appear in bold type as follows:

The Reemployment Assistance Program provides Oregon’s qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through the Employer-At-Injury Program while your claim is open. Your employer may contact [insurer name and phone number].

(b) The notice to the employer-at-injury must appear in bold type as follows:

Because of your worker’s injury, you may be eligible for assistance through the Employer-At-Injury Program to return the worker to transitional work while the worker's
claim is open. To learn more about the assistance available from the program, please call [insurer name and phone number].

(4) The insurer will administer the Employer-at-Injury Program according to these rules. The insurer must assist an employer to:

(a) Obtain a qualifying medical release, pursuant to section (5) of this rule, from the medical service provider;
(b) Identify a transitional work position;
(c) Process employer wage subsidy requests as specified in OAR 436-105-0520(1);
(d) Make worksite modification purchases as specified in OAR 436-105-0520(2);
(e) Make Employer-at-Injury Program purchases as specified in OAR 436-105-0520(3); and
(f) Request Employer-at-Injury Program reimbursement from the division as specified in OAR 436-105-0540.

(5) For purposes of the Employer-at-Injury Program, medical releases must meet the following criteria:

(a) All medical releases must be dated and related to the accepted or deferred conditions of the claim. The date the medical release is issued by the worker’s medical service provider is considered the effective date if an effective date is not otherwise specified;
(b) Two types of medical release qualify under these rules:
   (A) A medical release that states the worker’s specific current or projected restrictions; or
   (B) A statement by the medical service provider that indicates the worker is not released to regular employment accompanied by an approval of a job description which includes the job duties and physical demands required for the transitional work.
(c) A medical release must cover any period of time for which benefits are requested.

(6) For the purposes of the Employer-at-Injury Program, a medical release, and any restrictions it contains, remains in effect until another medical release is issued by the worker’s medical service provider. An employer or insurer may get clarification about a medical release from the medical service provider who issued the release any time prior to submitting the reimbursement request.

(7) The insurer must maintain all records of the Employer-at-Injury Program for a period of three years from the date of the last Employer-at-Injury Program reimbursement request. The insurer will maintain the following information at the authorized claim processing location(s):

(a) The worker’s claim file;
(b) Documentation from the worker’s medical service provider that the worker is unable to perform regular employment due to the injury and dated copies of all work releases from the worker’s medical service provider;
(c) A legible copy of the worker’s payroll records for the wage subsidy period as follows:

(A) Payroll records must state the payroll period, wage rate(s), and the worker’s gross wages for the wage subsidy period. The payroll record must also include the dates and hours worked each day if the worker has hourly restrictions;
(B) Insurers and employers may supplement payroll records with documentation of how the worker’s earnings were calculated for the wage subsidy. Supplemental documentation may be used to determine a worker’s work schedule, wages earned on a particular day, dates of paid leave, or to clarify any other necessary information not fully explained by the payroll record;
(C) If neither the payroll record(s) nor supplemental documentation show the amount of wages earned by the worker for reimbursable partial payroll periods, the allowable reimbursement amount may be calculated as follows:
   (i) Divide the gross wages by the number of days in the payroll period for the daily rate; and
   (ii) Multiply the daily rate by the number of eligible days; and
(D) If a partial day's reimbursement is requested after a worker is released for transitional work, or prior to returning from a medical appointment with a regular work release, documentation of the time of the medical appointment and hours and wages of transitional work must be provided for those days.
   (d) A legible copy of proof of purchase, providing proof the item was ordered during the Employer-at-Injury Program period and proof of payment of the item(s) for worksite modification purchases and Employer-at-Injury Program purchases;
   (e) Written documentation of the insurer’s decision to approve worksite modifications;
   (f) Documentation of the transitional work, which must include the start date, wage and hours, and a description of the job duties;
   (g) Documentation that payments for a home care worker were made to the Oregon Department of Human Services/Oregon Health Authority, if applicable;
   (h) The written acceptance by the worker when skills building is the transitional work; and
   (i) Documentation, including course title and curriculum for a class or course of instruction when Employer-at Injury Program purchases are requested.

Stats. Implemented: ORS 656.340, 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010
Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012

436-105-0510 Eligibility and End of Eligibility for the Employer-at-Injury Program

(1) The employer must maintain Oregon workers' compensation insurance coverage.

(2) The employer must be the employer at injury as defined in OAR 436-105-0005.

(3) The employer must be employing an eligible worker.
436-105-0511 Worker Eligibility

(1) The worker must have an Oregon workers’ compensation injury or occupational disease claim at the time of the Employer-at-Injury Program.

(2) The worker must not be covered by the Injured Inmate Law.

436-105-0512 End of Eligibility

The Employer-at-Injury Program will end:

(1) When the worker or employer no longer meets the eligibility provisions stated in OAR 436-105-0510 and OAR 436-105-0511;

(2) When the worker’s claim is closed or denied;

(3) When sanctions under OAR 436-105-0560 preclude eligibility;

(4) When the insurer ends the Employer-at-Injury Program at any time while the worker’s claim is open; or

(5) Two years after the original date of acceptance of a non-disabling claim.

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

The Employer-at-Injury Program may be used only once per worker per claim opening, for a non-disabling claim or a disabling claim. If a non-disabling 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. Assistance available includes:

(1) Wage subsidy, which provides 50 percent reimbursement 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 must be limited up to the maximum number of hours of the worker’s hourly restrictions. Paid leave exceeding the worker’s hourly restrictions is not subject to reimbursement;
   (d) Any day during which the worker exceeds his or her injury-caused limitations will not be reimbursed. If, however, an employer uses a time clock, a reasonable time not to exceed 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.

(2) Worksite modification, which means altering a work site by renting, purchasing, modifying, or supplementing equipment to enable a worker to perform the transitional work within the worker’s limitations that resulted in the worker’s EAIP eligibility, or to prevent a worsening of the worker’s conditions. Worksite modification assistance is subject to the following conditions:
   (a) The insurer determines the appropriate worksite modification(s) for the worker;
   (b) The insurer documents its reason(s) for approving the modification(s);
   (c) The worksite modification(s) must be ordered during the Employer-at-Injury Program; and
   (d) Worksite modification items become the employer’s property upon the end of the Employer-at-Injury Program. (3) Employer-at-Injury Program purchases, which are limited to:
   (a) Tuition, books, fees, and materials required for a class or course of instruction to enhance an existing skill or develop a new skill when skills building is used as transitional work or when required 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 determines the instruction will help the worker enhance an existing skill or develop a new skill, and documents its decision; and
      (B) Costs for tuition, books, fees, and required materials may be fully reimbursed if the worker began participation in the class or course 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.
   (4) Employer-at-Injury Program purchases of tools and equipment, including consumables, must be required for the worker to perform transitional work. These purchases will be the employer’s property.
   (5) Worksite modification and purchases of tools and equipment are limited to a combined maximum reimbursement of $5,000.
   (6) 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.

436-105-0530 Employer-at-Injury Program Procedures for Concurrent Injuries

(1) A worker is eligible for only one Employer-At-Injury Program at a time.
(2) When a worker in an Employer-at-Injury Program incurs a new compensable injury, transitional work for the first Employer-At-Injury is considered regular work for the second Employer-at-Injury Program.

(3) If the new injury makes the first Employer-at-Injury Program unsuitable, the worker may be eligible for a second Employer-at-Injury Program under the new injury.

(4) When the worker is no longer eligible for the second Employer-At-Injury Program, the first Employer-At-Injury Program may be resumed if the employer and worker still meet eligibility criteria under that claim.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 5/16/03 as WCD Admin. Order 03-057 eff. 6/6/03

436-105-0540 Employer-at-Injury Program Reimbursement Procedures

(1) Reimbursements may include wage subsidy, Employer-at-Injury Program purchases, and worksite modification.

(2) The insurer is entitled to a program administrative cost of $120.00 for the first reimbursement request of an Employer-at-Injury Program. A subsequent request for reimbursement for the same Employer-at-Injury Program is not entitled to an additional program administrative cost.

(3) The insurer must receive all required documentation for reimbursement within one year from the end of the Employer-at-Injury Program in order to qualify for reimbursement. The insurer must date stamp each reimbursement request document with the receipt date.

(4) The insurer must submit the request for reimbursement (Form 2360) to the division within one year and 30 days from the end of the Employer-at-Injury Program.

(5) The employer-at-injury reimbursement request must be a minimum of $100. The associated administrative costs will also be eligible for reimbursement.

(6) Subsequent requests less than $100 will be eligible for reimbursement. However, the requests will not be eligible for reimbursement of a subsequent administrative cost.

(7) If the original request was less than $100, but the amended request is at least $100, the request and the associated administrative costs will be eligible for reimbursement.

(8) When the division finds the insurer has submitted an Employer-at-Injury Program reimbursement request that is incomplete or contains an error, the division may return the form to the insurer for correction. The insurer has 60 days from the date the insurer receives the reimbursement request, or one year and 30 days from the end of Employer-at-Injury Program eligibility, whichever is greater, to make the corrections and return the corrected form to the division.

(9) The insurer may send an Employer-at-Injury Program reimbursement request to the division when a claim was initially denied and was subsequently accepted after the Employer-at-Injury Program eligibility ended and more than one year and 30 days have passed. In that case, the insurer must send a completed Employer-at-Injury Program reimbursement request to the division within 60 days of the first order or stipulation and order accepting the claim. A copy of the order accepting the claim, or stipulation and order accepting the claim must be attached.

(10) The insurer may request reimbursement for a qualifying Employer-at-Injury Program that took place prior to claim denial even if the claim is denied at the time the reimbursement request is sent to the division.

(11) Amended reimbursement requests must be sent to the division within one year and 30 days from the end of the Employer-at-Injury Program eligibility except as provided in section (6) of this rule. The insurer may not request additional administrative cost reimbursement for filing an amended reimbursement request.

(12) An amended reimbursement request must clearly state that it is an amendment and cite the corrected information.

(13) The insurer will not use Employer-at-Injury Program costs subject to reimbursement for rate making, individual employer rating, dividend calculations, or in any manner that would affect the employer’s insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that Employer-at-Injury Program costs do not affect the employer's rates or dividend.

(14) If a preferred worker employed by an eligible employer with active premium exemption incurs a new injury, the claim is subject to claim cost reimbursement under OAR 436-110. If the worker subsequently enters an Employer-at-Injury Program, program costs are to be separated from claim costs and will not be reimbursed as claim costs.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010
Amended 10-3-2012 as Admin. Order 12-057, eff. 11-1-2012

436-105-0550 Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the division. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements must be repaid to the department.

(2) The audit may include but not be limited to a review of the records required in OAR 436-105-0500(7).

(3) When conflicting documentation exists, the division will utilize a preponderance of evidence standard to decide eligibility for reimbursement and if there is no clear preponderance, reimbursement will be allowed.

(4) The division reserves the right to visit the work site to determine compliance with these rules.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4), 731.475
Stats. Implemented: ORS 656.455, 656.622, 656.726, 731.475
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-059, eff. 1-1-2010

436-105-0560 Sanctions

(1) Any person who knowingly makes a false statement or misrepresentation to the director or an employee of the director for the purpose of obtaining any benefits or reimbursement from the Employer-at-Injury Program or who knowingly
misrepresents the amount of a payroll, or knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for the director to sanction an insurer, self-insured employer, employer or their representative include, but are not limited to:

(a) Misrepresenting information in order to receive Employer-at-Injury Program assistance;

(b) Making a serious error or omission which resulted in the division approving reimbursement in error;

(c) Failing to respond to employer requests for assistance or failing to administer Employer-at-Injury Program assistance; or

(d) Failure to comply with any condition of these rules.

(3) Sanctions by the director may include one or more of the following:

(a) Ordering the person to take corrective action within a specific period of time;

(b) Ordering the person being sanctioned to repay the department all, or part, of the monies reimbursed, with or without interest at a rate set by the department. The order may include the department's legal costs;

(c) Ending the employer’s eligibility to use the Employer-at-Injury Program for a specific period of time; and

(d) Pursuing civil penalties under ORS 656.745 or criminal action against the party.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622, 656.745, 656.990
Hist.: Adopted 8/14/01 as WCD Admin. Order 01-057, eff. 10/1/01
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 110
PREFERRED WORKER PROGRAM

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436-110-0001 Authority for Rules
The director has adopted OAR Chapter 436, Division 110 under authority of ORS 656.622 and 656.726.
Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 8/14/01 as WCD Admin. Order 01-056, eff. 10/1/01

436-110-0002 Purpose of Rules
(1) These rules explain what assistance and reimbursements are available from the Preferred Worker Program, who is qualified, and how to receive assistance and reimbursements.
(2) The Preferred Worker Program encourages the reemployment of workers whose on-the-job injuries result in disability which may be a substantial obstacle to employment by providing assistance from the Workers’ Benefit Fund to eligible injured workers and to the employers who employ them.
(3) The Preferred Worker Program is a worker and employer-at-injury -activated program.
Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 12/5/05 as WCD Admin. Order 05-079, eff. 1/1/06

436-110-0003 Applicability of Rules
(1) These rules apply to all requests for Preferred Worker Program reemployment assistance received by the division on or after the effective date of these rules.
(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.
Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012

436-110-0005 Definitions
For the purpose of these rules, unless the context requires otherwise:
(1) “Administrator” means the Administrator of the Workers’ Compensation Division, or the administrator’s delegate for the matter.
(2) “Client” means a person to whom workers are provided contract and for a fee on a temporary or leased basis.
(3) “Date of eligibility” means the date the division determines a worker is a preferred worker.
(4) “Date of hire” means the date the worker starts work as a preferred worker.
(5) “Director” means the Director of the Department of Consumer and Business Services, or the director’s delegate for the matter.
(6) “Disability” means permanent physical or mental restriction(s) or limitation(s) caused by an accepted disabling Oregon workers’ compensation claim that limits the worker from performing one or more of the worker’s regular job duties.
(7) “Division” means the Workers’ Compensation Division of the Department of Consumer and Business Services.
(8) “Division approval” means a preferred worker agreement signed by an authorized division representative.
(9) “Employer at injury” means the organization in whose employ the worker sustained the injury or occupational disease.
(10) “Exceptional disability” means a disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury that results in impairment equal to or greater than a Class III as defined in OAR 436-035. The division will determine whether a worker has an exceptional disability based upon the combined effects of all of the worker’s Oregon compensable injuries resulting in permanent disability.
(11) “Fund” means the Workers’ Benefit Fund.

436-110-0001 Authority for Rules
436-110-0002 Purpose of Rules
436-110-0003 Applicability of Rules
436-110-0005 Definitions
(12) “Insurer” means the insurance company or self-insured employer responsible for the workers’ compensation claim.
(13) “Premium” means the monies paid to an insurer for the purpose of purchasing workers’ compensation insurance.
(14) “Regular employment” means the job the worker held at the time of the injury, claim for aggravation, or own motion opening.
(15) “Reimbursable wages” means the worker’s gross wages for the wage subsidy period.
(16) “Worksites” 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, worker’s, or worker leasing company’s client’s premises, property, and 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.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012

436-110-0006 Administration of Rules

(1) Orders issued by the division to enforce ORS 656.622 or these rules are orders of the director.
(2) The department maintains the financial integrity of the fund and all reimbursements is subject to the availability of funds. If the funds are too low for all reimbursements, the director has final authority to determine how the funds will be disbursed.
(3) The director may use moneys from the fund for activities to provide information about and encourage reemployment of injured workers. A maximum of $250,000 may be used in a fiscal year, July 1 to June 30. The director must approve all expenditures. Activities include, but are not limited to:
   (a) Advertisements and promotion of reemployment assistance programs and associated production costs; and
   (b) Public reemployment assistance program conferences and workshops.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 8/14/01 as WCD Admin. Order 01-056, eff. 10/1/01

436-110-0007 Reconsideration/Appeal to the Director

(1) The division will deny any request for Preferred Worker Program assistance if it finds is in violation of these rules. The division has the discretion to deny a request it determines is not reasonable, practical, or feasible, or considers an abuse of the program.
(2) Parties directly affected by a division reemployment assistance decision may request a reconsideration by sending a written request for reconsideration to the administrator no later than 60 days after the date the decision is issued. Facsimiles that are legible and complete are acceptable and will be processed the same as originals. Reconsideration must precede a director’s review.
(3) The request for reconsideration must specify the reasons why the decision is appealed. No reconsideration will be granted unless the request meets the requirements of this subsection.
(4) The division will reconsider the decision prior to a director’s review and will notify all affected parties of its decision upon reconsideration.
(5) If, upon reconsideration, the division upholds the original decision, the director’s review will begin.
(6) The director may require any affected party to provide information or to participate in the director’s review. If the party requesting the director’s review fails to participate without reasonable cause as determined by the director, the director may dismiss the review.
(7) The director’s review decision will be issued in writing. The director’s review decision is final and not subject to further review by any court or other administrative body.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07

436-110-0240 Insurer Participation in the Preferred Worker Program

(1) The insurer of the employer at injury must be an active participant in providing reemployment assistance. Participation includes issuing notices of the assistance available from the preferred worker program.
(2) The insurer must notify the worker and employer at injury in writing of the reemployment assistance available from the fund. A notice must be issued:
   (a) Within 5 days of a worker’s release for work after the worker has been declared medically stationary by the attending physician;
   (b) Upon determination of eligibility or ineligibility of the worker for vocational assistance under OAR 436-120; and
   (c) Upon approval of a claim disposition agreement.
(3) Pursuant to section (2) of this rule, the notice to the worker must appear in bold type and contain the following language:

   The preferred worker program helps Oregon’s injured workers get back to work. To find out whether you qualify, contact the preferred worker program at one of the telephone numbers, fax numbers, mailing addresses, or e-mail address listed below.


   For the Medford office call: 541-776-6032, 1-800-696-7161, or FAX 541-776-6022.

   Or write the preferred worker program at: 350 Winter St NE, P.O. Box 14480, Salem, Oregon 97309-0405. Or write to the preferred worker program at: pwp.oregon@state.or.us
(4) Under section (2) of this rule, the notice to the employer must appear in bold type and contain the following language:

As the employer of an injured worker, you may be eligible for valuable preferred worker program incentives if the worker cannot return to regular work and has permanent limitations caused by the injury.

If the worker’s preferred worker program eligibility has not been determined, you may contact the Workers’ Compensation Division for an eligibility review.

To be eligible for exemption from paying workers’ compensation premiums for this worker for three years, you must:

• Bring back your preferred worker to a new or modified job; and

• Notify us within 90 days of the date the worker is determined eligible or within 90 days of the date you bring the worker back to work, whichever is later.

To request all other preferred worker program benefits, you must contact the Workers’ Compensation Division within 180 days of the worker’s claim closure date.

To find out more about the preferred worker program, contact the program at one of the telephone numbers, fax numbers, or addresses listed below.


For the Medford office call: 541-776-6032, 1-800-696-7161, or FAX 541-776-6022.

Or write the preferred worker program at: 350 Winter St NE, P.O. Box 14480, Salem, Oregon 97309-0405. Or write to the preferred worker program at:
pwp.oregon@state.or.us

(5) The insurer must provide the division with preferred worker information in the form and format the director prescribes in OAR 436-030, upon the following:

(a) Claim closure according to ORS 656.268;

(b) Within 30 calendar days from the insurer’s receipt of the earliest opinion and order of an administrative law judge, order on reconsideration, order on review by the board, decision of the Court of Appeals, or stipulation that grants initial permanent disability after the latest opening of the worker’s claim; and

(c) Approval of a claim disposition agreement according to ORS 656.236 and documented medical evidence indicates permanent disability exists as a result of the injury or disease, and the worker is unable to return to regular employment.

Stats. Implemented: ORS 656.340(1), (2), (3), 656.622, 656.726(4)
Hist.: Amended 6/12/08 as WCD Admin. Order 08-029, eff. 10-20-08
Amended 11/1/07 as WCD Admin. Order 11-008, eff. 11-1-07
Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
Amended 6/1/12 as WCD Admin. Order 12-058, eff. 11-1-2012

436-110-0290 Employer at Injury Use of the Preferred Worker Program

The conditions for the employer at injury to activate the preferred worker program include:

(1) To be eligible for premium exemption the employer at injury must:

(a) Bring back its preferred worker to a new or modified job;

(b) Contact the Workers’ Compensation Division for a preferred worker eligibility review if the worker’s eligibility has not been determined; and

(c) Notify its insurer within 90 days from the date of eligibility or the date of hire, whichever is later.

(2) For all other preferred worker program benefits the employer at injury must request preferred worker program assistance from the division within 180 days of the worker’s claim closure date, with the following exception: When worksite modification are provided, and the modifications are completed and verified by the division more than 150 days after the worker’s claim closure date, the employer at injury will have 30 calendar days from the verification date to request other assistance.

(3) In calculating the 180 day period under this rule, the claim closure date will not be included, and if the 180th day falls on a Saturday, Sunday, or legal holiday, the next business day will be considered the end of the 180 day period.

(4) The worker must agree to accept the new or modified regular job in writing. The job offer must include:

(a) The start date. If the job starts after the modifications are in place, so note;

(b) Wage and hours;

(c) Job site location; and

(d) Description of job duties.

(5) If the employer at injury uses worksite modification assistance and the employer or worker later requests additional modifications for the same job, the employer’s worksite modification benefit will be exhausted before using the worker’s worksite modification benefits.

(6) All other provisions under OAR 436-110 apply unless otherwise indicated.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
Amended 4/15/10 as WCD Admin. Order 10-050, eff. 4/15/10 (temp)
Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10

436-110-0310 Eligibility and End of Eligibility for the Preferred Worker Program

(1) The eligibility requirements for an employer, except as provided in OAR 436-110-0345(1) for Employment Purchases, are:

(a) The employer has and maintains Oregon workers’ compensation insurance coverage;

(b) The employer complies with the Oregon Workers’ Compensation Law;

(c) The employer must offer or provide employment to an eligible Preferred Worker who is a subject Oregon worker according to ORS 656.027;

(d) If the employer is a worker leasing company, it must be licensed with the division; and
(e) The employer is not currently ineligible for Preferred Worker benefits under OAR 436-110-0900.

(2) The eligibility requirements for a worker are:

(a) The worker has an accepted disabling Oregon compensable injury or occupational disease. Injuries covered by the Injured Inmate Law do not qualify;

(b) Medical evidence indicates that, because of injury-caused limitations, the worker will not be able to return to regular employment as defined in OAR 436-110-0005 under the most recent disabling claim or claim opening. If the worker is not eligible under the most recent disabling claim or claim opening, eligibility may be based on the most recent disabling claim closure where injury-caused permanent restrictions prevented the worker from return to regular employment;

(c) Medical documentation indicates permanent disability exists as a result of the injury or disease, whether or not an order has been issued awarding permanent disability; and

(d) The worker is authorized to work in the United States.

(3) A worker may not use Preferred Worker benefits for self-employment unless the injury that gave rise to the worker’s eligibility for the Preferred Worker Program occurred in the course and scope of self-employment. In that case, the worker may use the benefits to return to the same self-employment or for employment other than self-employment.

(4) Reasons for ending Preferred Worker Program eligibility include, but are not limited to, the following:

(a) Misrepresentation or omission of information by a worker or employer to obtain assistance;

(b) Failure of a worker or employer to provide requested information or cooperate;

(c) Falsification or alteration of a Preferred Worker card or a Preferred Worker Program Agreement;

(d) Conviction of fraud in obtaining workers’ compensation benefits;

(e) The worker no longer meets the eligibility requirements under section (2) of this rule;

(f) The worker or employer is sanctioned from receiving reemployment assistance in accordance with OAR 436-110-0900;

(g) The employer does not maintain Oregon workers’ compensation insurance coverage, except as provided in OAR 436-110-0345(1) for Employment Purchases;

(5) The division retains the right to reinstate Preferred Worker Program eligibility if eligibility was ended prematurely or in error, or the employer has reinstated or obtained workers’ compensation insurance coverage.

(6) A worker found ineligible because he/she was not authorized to work in the United States may request a redetermination of eligibility after providing the division with documentation that he/she is authorized to work in the United States.

436-110-0320 Preferred Worker Cards

(1) The division issues a Preferred Worker Identification card to eligible workers. The card identifies the worker as being eligible to offer an employer Preferred Worker Program assistance. If a Preferred Worker loses the card, the division will issue a replacement card.

(2) The division issues this card as follows:

(a) Automatically at the time of claim closure based upon insurer submission of Preferred Worker information as specified in OAR 436-110-0240(5);

(b) When the worker or their representative request a card, and the worker is eligible; or

(c) Any other time the division finds a worker eligible.

(3) The division may inactivate a Preferred Worker card if:

(a) The Preferred Worker card was issued in error; or

(b) Any reason for ending Preferred Worker Program eligibility as specified in OAR 436-110-0310(4) applies.

436-110-0325 Premium Exemption General Provisions

(1) The purpose of premium exemption is to provide an incentive to employers to hire preferred workers.

(2) Premium exemption releases an employer from paying workers’ compensation insurance premiums and premium assessments on a preferred worker for three years from the date premium exemption started. While using premium exemption, the employer does not report, and the insurer cannot use, the preferred worker’s payroll for the calculation of insurance premiums or premium assessments. However, the employer must report and pay workers’ compensation employer assessments and withhold employee contributions as required by OAR 436-070. The employer must start paying insurance premiums and premium assessments when premium exemption ends.

(3) Premium exemption cannot be used for regular employment unless the job is modified to accommodate the worker’s injury-caused limitations.

(4) To qualify for premium exemption the employer at injury or aggravation must bring back its preferred worker to a new or modified job and notify its insurer within 90 days from the date of eligibility or the date of hire, whichever is later. Premium exemption starts on the date of hire or the date of eligibility, whichever is later.

(5) If a worker’s preferred worker eligibility has not been determined as of the date of hire, the worker or the employer at injury or aggravation may request a preferred worker eligibility review. If the worker is eligible, the Workers’ Compensation Division will issue a Preferred Worker Identification Card to the worker. The employer must notify its insurer of the worker’s preferred worker status within 90 days of the eligibility date on the preferred worker identification card. Premium exemption starts on the date of hire or the date of eligibility, whichever is later.
(6) If the employer is not the employer-at-injury or aggravation, the worker discloses preferred worker status to that employer, and the employer notifies the insurer within 90 days from the date of hire that they have hired a preferred worker, premium exemption starts on the date of hire.

(7) If a worker covered under premium exemption incurs a compensable injury or occupational disease during the premium exemption period, the employer must notify its insurer of the injury and the worker’s preferred worker status. The claim costs for the injury are reimbursed under OAR 436-110-0330.

(8) If a business changes its name, is sold, merged, or otherwise changes its ownership during a premium exemption period, the premium exemption period is three years from the date the exemption was initiated by the original business. There will not be an additional three-year premium exemption period allowed due to the change(s) in the business.

(9) If an employer changes the job duties of a preferred worker during the premium exemption period, there is no change in the three-year premium exemption period. There will not be an additional three-year premium exemption period allowed due to changes in the preferred worker’s job duties with the same employer.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012

436-110-0330 Claim Cost Reimbursement

(1) Claim Cost Reimbursement provides reimbursement to the insurer for claim costs when a Preferred Worker files a claim for injury or occupational disease while employed under Premium Exemption as follows:

(a) Reimbursements will be made for the life of the claim;
(b) Reimbursable claim costs include disability benefits, medical benefits, vocational costs in accordance with OAR 436-120-0720, Claim Disposition Agreements in accordance with ORS 656.236, Disputed Claim Settlements in accordance with ORS 656.289, stipulations, as well as attorney fees awarded the worker or the worker’s beneficiaries, and administrative costs;
(c) Reimbursable claim costs for denied claims include costs incurred up to the date of denial, but are limited to the benefits the insurer is obligated to pay under ORS 656 and diagnostic tests, including independent medical examinations necessary to determine compensability of the claim;
(d) The administrative cost factor to be applied to claim costs will be as published in Bulletin 316; and
(e) The claim must not be used for ratemaking, individual employer rating, dividend calculations, or in any manner that would affect the employer’s insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that claim data will not affect the employer’s rates or dividend.

(2) The insurer must request Claim Cost Reimbursement as follows:

(a) Requests for reimbursement must be made within one year of the end of the quarter within which payment was made;
(b) Quarterly reimbursement requests must be in the format the director prescribes by bulletin; and
(c) Reimbursement documentation must include, but is not limited to:
(A) Net amounts paid. “Net amounts” means the total compensation paid less any recoveries including, but not limited to, third party recovery or reimbursement from the Retroactive Program, Reopened Claims Program, or the fund;
(B) Payment certification statement; and
(C) Any other information the division deems necessary.

(3) Requests for reimbursement must not include:

(a) Claim costs for any injury that did not occur while the worker was employed with Premium Exemption;
(b) Costs incurred for conditions completely unrelated to the compensable claim;
(c) Costs incurred due to inaccurate, untimely, unreasonable, or improper processing of the claim;
(d) Penalties, fines or filing fees;
(e) Disposition amounts in accordance with ORS 656.236 (CDA) and 656.289 (DCS) not previously approved by the division;
(f) Costs reimbursed or outstanding requests for reimbursement from the Reopened Claims Program, Retroactive Program, or the fund; or
(g) Reimbursable Employer-at-Injury Program costs.

(4) Periodically, the division will audit the physical file of the insurer to validate the amount reimbursed. Reimbursed amounts must be refunded to the division and, as applicable, future reimbursements will be denied if, upon audit, any of the following is found to apply:

(a) Reimbursement has been made for any of the items specified in section (3) of this rule;
(b) If claim acceptance as a new injury rather than an aggravation is questionable and the rationale for acceptance has not been reasonably documented;
(c) The separate payments of compensation have not been documented;
(d) The insurer included claim costs in any dividend or retrospective rating or experience rating calculations;
(e) The insurer is unable to provide applicable records relating to experience rating, retrospective rating, or dividend calculations at the time of audit or within 14 working days thereafter.

(5) If the conditions described in subsections (4)(a) through (e) of this rule are corrected and all other criteria of the rules are met, eligibility for reimbursement may be reinstated. If reimbursement eligibility is reinstated, any moneys previously
reimbursed and then recovered will be reimbursed again according to these rules.

(6) A Claim Disposition Agreement according to ORS 656.236, a Disputed Claim Settlement according to ORS 656.289, or any stipulation or agreement of a claim subject to claim cost reimbursement from the fund must meet the following requirements for reimbursement:

(a) The insurer must obtain prior written approval of the disposition from the division. The proposed disposition must be submitted to the division prior to submitting the disposition to the Workers’ Compensation Board or administrative law judge for approval;

(b) A claim’s future liability and the proposed contribution from the fund must be a reasonable projection, as determined by the division, in order to be approved for reimbursement from the fund; and

(c) A request for approval of the proposed disposition must include:

(A) The original proposed disposition, containing appropriate signatures and appropriate signature lines for division and Workers’ Compensation Board or administrative law judge approval, that specifies the proposed assistance from the fund;

(B) A written explanation of how the calculations for the amount of assistance from the fund were made; and

(C) Other information as required by the division.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010


Wage subsidy provides an employer with partial reimbursement of a worker’s gross wages for a specified period. Wage subsidy benefits are subject to the following conditions:

(1) The effective date of a Wage Subsidy Agreement is mutually agreed to by the division, employer, and worker if applicable;

(2) A wage subsidy is limited to a duration of 183 calendar days and a monthly reimbursement rate of 50 percent, except for a worker with an exceptional disability as defined in OAR 436-110-0005. For a worker with an exceptional disability, the wage subsidy duration is limited to 365 calendar days and a monthly reimbursement rate of 75 percent;

(3) A Wage Subsidy Agreement may be interrupted once for reasonable cause and extended to complete the Wage Subsidy Agreement on a whole workday basis. Reasonable cause includes, but is not limited to, personal or family illness, death in the worker’s family, pregnancy of the worker or worker’s spouse, a compensable injury to the worker, participation in an employer-at-injury program, or layoff. A layoff must be a minimum of 10 consecutive work days. A period of time during which the employer is without workers’ compensation insurance coverage is not “reasonable cause,” and no extension will be granted;

(4) A preferred worker’s pay structure must be the same as the pay structure for other workers employed in similar jobs by the employer;

(5) Wages subject to reimbursement must be within the prevailing wage range for that occupation. The prevailing wage range is determined by the following method:

(a) First, examine the wages paid by the employer for other workers doing the same job;

(b) If no other workers are doing the same job, a labor market survey of the local labor market may be conducted; and

(c) If the labor market survey does not support the wage rate requested, the division will determine the wage subject to reimbursement;

(6) Preferred worker program wage subsidies may not be combined with a wage subsidy for a training plan under OAR 436-120;

(7) A worker-activated and employer at injury-activated wage subsidy can not be used for the same job with the employer at injury;

(8) If the worker’s employer changes during the Wage Subsidy Agreement period due to a sale of the business, incorporation, or merger, the agreement can be transferred to the new employer by an addendum to the agreement approved by the division as long as the worker’s job remains the same and the new employer is eligible under OAR 436-110-0310(1);

(9) A completed and signed Wage Subsidy Reimbursement Request form must be submitted to the division with a copy of the worker’s payroll records. The payroll record must state the dates (daily or weekly), hours, wage rate, and the worker’s gross wage. Payroll records must be a legible copy and compiled in accordance with generally accepted accounting procedures; and

(10) All requests for reimbursement must be made within one year of the Wage Subsidy Agreement end date.

(11) Wage subsidy cannot be used for “regular employment” as defined in OAR 436-110-0005 unless the job has been modified to overcome the worker’s injury-caused permanent restrictions.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10

436-110-0336 Wage Subsidy – Employer at Injury Activated

Wage subsidy may be activated by the employer at injury as follows:

(1) The job must be within the worker’s injury-caused restrictions. If a worksite modification is necessary to meet this requirement, wage subsidy will be deferred until:

(a) The worksite modification is complete, or

(b) The employer accommodates the worker’s injury-caused restrictions while waiting for the worksite modification to be complete.
(2) The employer must complete and sign a wage subsidy agreement, and send it to the division in the timeframes allowed in OAR 436-110-0290.

(3) The completed and signed job offer must accompany the request as required in OAR 436-110-0290(4), unless it was already submitted with another request.

(4) The employer at injury may use wage subsidy once during an eligibility period.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10
Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012

436-110-0337 Wage Subsidy – Worker Activated

A Wage Subsidy may be requested by a worker as follows:

(1) The worker and employer must complete and sign a Wage Subsidy Agreement and submit the agreement to the division within three years of the date of hire.

(2) A Preferred Worker may use Wage Subsidy twice, once each for two different jobs. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(3) If the employer at injury uses Wage Subsidy for a job, the worker cannot use Wage Subsidy for the same job.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010


(1) An employment purchase is assistance necessary for a worker to find, accept, or retain employment in Oregon. These purchases may be provided for a job with a non-subject employer in Oregon, as long as that employer complies with the appropriate workers’ compensation law. Employment purchases cannot be used for “regular employment” as defined in OAR 436-110-0005 unless the job has been modified to overcome the worker’s injury-caused permanent restrictions. Except as provided in subsection (2)(h) of this rule, all purchases become the worker’s property.

(2) Employment purchases are limited to:

(a) Tuition, books, and fees for instruction provided by an educational entity accredited or licensed by an appropriate body in order to update existing skills or to meet the requirements of an obtained job. Maximum expenditure per use is $1,000;

(b) Temporary lodging, meals, and mileage to attend instruction when overnight travel is required. The cost of meals, lodging, public transportation, and use of a personal vehicle will be reimbursed at the rate of reimbursement for State of Oregon classified employees as published in Bulletin 112. Lodging, meals, and mileage are limited to a combined period of one month, and the total maximum expenditure per use is $500;

(c) Tools and equipment mandatory for employment. Purchases must not include items the worker possesses, duplicate Worksite Modification items, vehicles, or items needed for worksite creation. Maximum expenditure per use is $2,500;

(d) Clothing required for the job. Maximum expenditure per use is $400;

(e) Moving expenses for a job if the new worksite is in Oregon and more than 50 miles from the worker’s primary residence. When the worker’s permanent disability from the injury precludes the worker from commuting the required distance, moving expenses may be provided to move within 50 miles of the worker’s primary residence or within the distance the worker commuted for work at claim opening. Moving expenses are limited to one use. Expenditure is limited to:

(A) The cost of moving household goods weighing not more than 10,000 pounds and reasonable costs of meals and lodging for the worker. The cost of meals, lodging, public transportation, and use of a personal vehicle will be paid at the rate of reimbursement for State of Oregon classified employees as published in Bulletin 112. Lodging and meals are limited to a maximum period of two weeks. Mileage for one personal vehicle is limited to a single one-way trip; and

(B) Rental allowance for the worker’s primary residence limited to first month’s rent as specified in the rental agreement, non-refundable deposit in an amount not to exceed the first month’s rent, and a required credit check for that residence;

(f) Initiation fees, or back dues and one month’s current dues, required by a labor union;

(g) Occupational certification, licenses, and related testing costs, drug screen testing, physical examinations, or membership fees required for the job. Maximum expenditure is $500;

(h) Worksite creation costs that are limited to equipment, furnishings or other things the employer needs to create a new job for the worker. All items purchased are the property of the employer. Maximum expenditure per use is $5,000;

(i) Placement assistance requested by a preferred worker and provided by a certified vocational counselor or any public or private agency that provides placement services, that resulted in employment that the preferred worker retained for at least 90 days. This category can be used as often as necessary up to a maximum expenditure of $2000. Placement assistance may not be combined with vocational assistance under OAR 436-120; and

(j) Miscellaneous purchases that do not fit into subsections (a) through (i) of this section, subject to approval by the director. This category does not include a vehicle purchase. This category can be used as often as necessary up to a maximum of $2,500.

(3) The person or entity that purchased the item(s) may request reimbursement by submitting to the division a legible copy of an invoice or receipt showing payment has been made for the item(s) purchased. Reimbursement will be made for only those items and costs approved and paid.
(4) Costs of employment purchases will be paid by reimbursement, by an Authorization for Payment, or by other instrument of payment approved by the director.

(5) The division will not purchase directly or otherwise assume responsibility for employment purchases.

(6) Reimbursed costs will not be charged by the insurer to the employer as claim costs or by any other means.

(7) All requests for reimbursement must be made within one year of the Employment Purchase Agreement end date.

**Stat. Auth.: ORS 656.726(4), 656.622**

**Stats. Implemented: ORS 656.622**

**Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010**

**Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10**

**436-110-0346 Employment Purchases – Employer at Injury Activated**

Conditions for use of Employment Purchases by the employer at injury are as follows:

1. The employer must submit a completed Employment Purchase Agreement listing item(s) that are required of the worker to perform the job for which the worker is employed.

2. The employer at injury may use each Employment Purchase category once.

**Stat. Auth.: ORS 656.726(4), 656.622**

**Stats. Implemented: ORS 656.622**

**Hist.: Amended 11-1-07 as WCD Admin. Order 07-066, eff. 12/1/07**

**436-110-0347 Employment Purchases – Worker Activated**

Conditions for use of employment purchases by a worker are as follows:

1. Except for moving expenses, placement assistance, and miscellaneous purchases needed to find a job, the worker and employer must submit a completed employment purchase agreement listing item(s) that are required of the worker to obtain or perform the job.

2. If employment purchases are to be used with a non-subject employer in Oregon, Premium Exemption is not activated.

3. Except as otherwise provided in these rules, a preferred worker may use each employment purchase category twice, once each for two different jobs. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

4. A preferred worker may request employment purchases as follows:

   a) The worker must contact the division directly for assistance in receiving employment purchases. The worker may make the request prior to employment, but not more than three years after the date of hire.

   b) The employment purchase agreement form must be completed and signed by the worker and employer and submitted to the division. If the request is for moving expenses, placement assistance, or the miscellaneous category, only the worker’s signature is required.

Stat. Auth.: ORS 656.726(4), 656.622

Stats. Implemented: ORS 656.622

Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010

Amended 10-3-2012 as Admin. Order 12-058, eff. 11-1-2012

**436-110-0350 Worksite Modification – General Provisions**

1. Worksite modification means altering a worksite in Oregon, or available for inspection and modification in Oregon, by purchasing, modifying, or supplementing equipment, or changing the work process, to enable a worker to work within the limitations imposed by compensable injuries or occupational diseases. Worksite modification may also include the means to protect modifications purchased by the preferred worker program in an amount not to exceed $2,500.

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

   a) Modifications will be provided to allow the worker to perform the job duties within the worker’s injury-caused permanent limitations. In order to determine appropriate worksite modifications, the reemployment assistance 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 limitations. The job analysis may be submitted to the attending physician for approval before the modification is performed;

   c) Modifications are limited to a maximum of $25,000 for one job. A modification over $25,000 may be provided if the worker has an exceptional disability as defined in OAR 436-110-0005;

   d) Modifications not to exceed $1,000 may be provided that would reasonably be expected to prevent further injury or exacerbation of the worker’s accepted condition. A reemployment assistance consultant will determine the appropriateness of this type of modification based upon his or her 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 modification(s) 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 or other similar on-the-job training programs when the trainer is not the employer at injury. A modification will not be approved for any other type of training;

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

(i) Modifications must be reasonable, practical, and feasible, as determined by the division;

(j) When the division determines the appropriate form of modification and the worker or employer requests a form of modification equally appropriate but with a greater cost, upon division approval, funds equal to the cost of the form of modification identified by the division 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 division approval and are limited to a cost of up to $3,500 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 worker leasing company’s client on the “end date” of a Worksight Modification Agreement or when the worker’s employment ends, whichever occurs first. The division will determine ownership of worksite modification equipment prior to approving an agreement and has the final authority to assign property;

(n) The division may request a physical capacities evaluation, work tolerance screening, or review of a job analysis to quantify the worker’s injury-caused permanent limitations. 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 of reimbursement for State of Oregon classified employees as published in Bulletin 112. The cost of the services described in this subsection does not apply toward the total cost of a worksite modification;

(o) If the property provided for the modification is damaged, in need of repair, or lost, the division 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 prior to the end of the agreement without division 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 prior to the end of the agreement without division approval. Failure to repair or replace the property, or inappropriate disposal of the property, may result in sanctions under OAR 436-110-0900.

(3) A worker, employer or their representative may request worksite modification assistance.

(4) The person or entity that purchased the item(s) 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; and

(5) Costs of approved worksite modifications are paid by reimbursement, an Authorization for Payment, or by other instrument of payment approved by the director.

(6) The division will not purchase directly or otherwise assume responsibility for worksite modifications.

(7) Reimbursed costs will not be charged by the insurer to the employer as claims costs or by any other means.

(8) A division worksite modification consultant will determine if competitive quotes are required.

(9) All requests for reimbursement must be made within one year of the Worksight Modification Agreement end date.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
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436-110-0351 Worksight Modification – Employer at Injury Activated

Conditions for use of worksite modifications by the employer at injury are as follows:

(1) The employer at injury may use worksite modification assistance once for a job provided for their injured worker, or a second time if the worker changes to another job with the employer at injury within the timeframes allowed in OAR 436-110-0290(2).

(2) Modifications are limited to a maximum of $25,000 on the claim which qualified the worker for assistance. A modification over $25,000 may be provided if the worker has an exceptional disability as defined in OAR 436-110-0005.

(3) The division must approve, by authorized signature, a completed and signed Worksight Modification Agreement prior to any reimbursement or Authorization for Payment.

(4) Modifications may be provided for requests received within 180 days from the worker’s claim closure date. Additional modifications may be provided under an approved agreement by addendum for requests received within three years from the date the worker started work for the employer in employment for which the worksite modification request was made.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
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Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10

436-110-0352 Worksight Modification – Worker Activated

Conditions for use of worksite modification assistance by the worker are as follows:
(1) The division must approve, by authorized signature, a completed and signed Worksite Modification Agreement form, prior to any reimbursement or Authorization for Payment.

(2) Modifications may be provided for requests received within three years from the date of hire.

(3) A worker may use worksite modification assistance once with one employer and once with a second employer, or twice with the same employer if there is a job change. The number of allowable uses will be restored if there is a subsequent claim closure, and the worker is unable to return to regular employment.

(4) Modifications after June 30, 1990, are limited to a maximum of $25,000 on the claim which qualified the worker for assistance. A modification over $25,000 may be provided for a worker with an exceptional disability as defined in OAR 436-110-0005. This maximum is not reduced by the use of worksite modifications by the employer at injury.

Stat. Auth.: ORS 656.726(4), 656.622
Stats. Implemented: ORS 656.622
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07
Amended 9-15-10 as WCD Admin. Order 10-055, eff. 10-12-10

436-110-0850 Audits

(1) Insurers and employers are subject to periodic program and fiscal audits by the division. All reimbursements are subject to subsequent audits, and may be disallowed on any of the grounds set forth in these rules. Disallowed reimbursements may be recovered by the division directly or from future reimbursements by way of offset. If the division finds upon audit that procedures which led to disallowed reimbursements are still being used, the division may withhold further reimbursements until corrections satisfactory to the division are made.

(2) An insurer or employer must maintain claim records, notices, worker payroll records, reports, receipts, and documentation of payment supporting reemployment assistance costs for which reimbursement has been requested or expenditure by Authorization for Payment has been made. These records must be maintained for a period of three years after the last reimbursement request or expenditure by Authorization for Payment.

(3) The division reserves the right to visit the worksite to determine compliance with the agreement under which reemployment assistance has been provided.

Stat. Auth.: ORS 656.455, 656.622, 656.726(4), 731.475
Stats. Implemented: ORS 656.455, 656.622, 731.475
Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07

436-110-0900 Sanctions

(1) Any person who knowingly makes any false statement or representation to the director or an employee of the director for the purpose of obtaining any benefit or payment from the Preferred Worker Program, or who knowingly misrepresents the amount of a payroll, or who knowingly submits a false payroll report, is subject to penalties under ORS 656.990.

(2) Reasons for the director to sanction an individual certified under OAR 436-120, a vocational assistance provider authorized under OAR 436-120, an agency of the State of Oregon, an insurer, an employer, or a Preferred Worker include, but are not limited to, the following:

(a) Misrepresenting information in order to obtain reemployment assistance. Two examples of misrepresentation are:

(A) Changing a job description or job title in order to obtain benefits where there are not corresponding job duty changes; and

(B) Obtaining a worker’s signature on incomplete, incorrect, or blank agreements or reimbursement requests;

(b) Making a serious error or omission that resulted in the division approving a Preferred Worker Program Agreement, issuing a Preferred Worker card, or reimbursing claim costs in error;

(c) Failing to abide by the terms and conditions of a Preferred Worker Program Agreement;

(d) Failing to abide by the provisions of these rules or ORS 656.990;

(e) Failing to return required receipts or invoices;

(f) Submitting false reimbursement requests or job analyses;

(g) Altering an Authorization for Payment form or purchasing unauthorized items; or

(h) Failing to return a Preferred Worker card if requested by the division.

(3) Sanctions by the director may include one or more of the following:

(a) Ordering the person being sanctioned to repay the department for reemployment assistance costs incurred, including the department’s legal costs;

(b) Prohibiting the person being sanctioned from negotiating or arranging reemployment assistance for such period of time as the director deems appropriate;

(c) Decertifying an individual or vocational assistance provider under the authority of OAR 436-120;

(d) Ordering an employer or worker ineligible for reemployment assistance for a specific period of time; and

(e) Pursuing civil or criminal action against the party.

Stat. Auth.: ORS 656.622, 656.726(4)
Stats. Implemented: ORS 656.622, 656.990
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-060, eff. 1-1-2010
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120
VOCATIONAL ASSISTANCE TO INJURED WORKERS

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436-120-0001 Authority for Rules
The director has adopted OAR 436-120 by the director's authority under ORS 656.340 and 656.726(4).

436-120-0002 Purpose of Rules
The purpose of these rules is to prescribe uniform standards for determining eligibility, delivery and payment for vocational services to injured workers, procedures for resolving disputes, and to establish standards for the certification of vocational counselors and providers.

436-120-0003 Applicability of Rules
(1) These rules govern vocational assistance under the workers' compensation law on or after the effective date of these rules except as OAR 436-120 otherwise provides.

(2) The director's decisions under OAR 436-120-0008 regarding eligibility will be based on the rules in effect on the date the insurer issued the notice. The director's decisions regarding the nature and extent of assistance will be based on the rules in effect at the time the assistance was provided. If the director orders future assistance, such assistance must be provided in accordance with the rules in effect at the time assistance is provided.
(3) Under these rules a claim for aggravation or reopening a claim to process a newly accepted condition will be considered a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules.

(4) Under ORS 656.206, when a worker receiving permanent total disability incurs a new compensable injury, the worker is not entitled to vocational assistance.

(5) The requirement for the director's advance approval of services eligible for claims cost reimbursement pursuant to OAR 436-120-0720(7) will apply to any actions taken after the effective date of these rules.

(6) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(7) Timeliness of any document required by these rules to be filed or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or e-mailed, it must be received by the division by 11:59 p.m. Pacific time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(8) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

(9) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, or a self-insured employer. A vocational assistance provider acting as the insurer's delegate may provide notices and warnings required by OAR 436-120.

(10) “Likely eligible” means the worker will be unable to return to regular or other suitable work with the employer-at-injury or aggravation or is unable to perform all of the duties of the regular or suitable work and it is reasonable to believe that the barriers are caused by the accepted conditions.

(11) “Mailed” means postmarked to the last known address.

(12) "Permanent employment" is a job with no projected end date or a job that had no projected end date at time of hire. Permanent employment may be year-round or seasonal.

(13) “Physical demand characteristics of work” strength rating: The physical demands strength rating reflects the estimated overall strength requirements of the job, which are considered to be important for average, successful work performance. The following definitions are used: “occasionally” is an activity or condition that exists up to 1/3 of the time; “frequently” is an activity or condition that exists from 1/3 to 2/3 of the time; “constantly” is an activity or condition that exists 2/3 or more of the time.

(a) Sedentary work (S): Exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

(b) Light work (L): Exerting up to 20 pounds of force occasionally, or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; (2) when it requires sitting most of the time but entails pushing or pulling of arm or leg controls; or (3) when the job requires working at a production rate pace entailing the constant pushing or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and
strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

(c) Medium work (M): Exerting 20 to 50 pounds of force occasionally, or 10 to 25 pounds of force frequently, or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

(d) Heavy work (H): Exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

(e) Very heavy (VH): Exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently, or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

(14) “Reasonable cause” may include, but is not limited to, a medically documented limitation in a worker’s activities due to illness or medical condition of the worker or the worker’s family, financial hardship, incarceration for less than six months, or circumstances beyond the reasonable control of the worker. “Reasonable cause” for failure to provide information or participate in activities related to vocational assistance will be determined based upon individual circumstances of the case.

(15) “Reasonable labor market”: An occupation can be said to have reasonable employment opportunities if competitively qualified workers can expect to find equivalent jobs in the occupation within a reasonable period of time. A reasonable period of time, for workers in the majority of occupations, would be the six months that they could collect regular unemployment insurance benefits, if they were entitled to them.

(16) “Regular employment” means the employment the worker held at the time of the injury or at the time of the claim for aggravation, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of aggravation, the employment the worker held on the last day of work prior to the aggravation claim. If the basis for potential eligibility is a reopening to process a newly accepted condition, "regular employment" is the employment the worker held at the time of the injury; when the condition arose after claim closure, "regular employment" is determined as if it were an aggravation claim.

(17) "Substantial handicap to employment," as determined under OAR 436-120-0340, means the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment. "Knowledge," "skills," and "abilities" have meanings as follows:

(a) "Knowledge" means an organized body of factual or procedural information derived from the worker's education, training, and experience.

(b) "Skills" means the demonstrated mental and physical proficiency to apply knowledge.

(c) "Abilities" means the cognitive, psychological, and physical capability to apply the worker's knowledge and skills.

(18) "Suitable employment" or "suitable job" means employment or a job:

(a) For which the worker has the necessary physical capacities, knowledge, skills and abilities;

(b) Located where the worker customarily worked, or within reasonable commuting distance of the worker's residence. A reasonable commuting distance is no more than 50 miles one-way modified by other factors including, but not limited to:

(A) Wage of the job. A low wage may justify a shorter commute;

(B) The pre-injury commute;

(C) The worker's physical capacities, if they restrict the worker's ability to sit or drive for 50 miles;

(D) Commuting practices of other workers who live in the same geographic area; and

(E) The distance from the worker's residence to the nearest cities or towns that offer employment opportunities;

(c) That pays or would average on a year-round basis a suitable wage as defined in section (19) of this rule;

(d) That is permanent. Temporary work is suitable if the worker's job at injury was temporary; and the worker has transferable skills to earn, on a year-round basis, a suitable wage as defined in section (19) of this rule;

(e) For which a reasonable labor market as described under OAR 436-120-0340 is documented to exist; and

(f) That is modified or new employment resulting from an employer at injury activated use of the Preferred Worker Program, under OAR 436-110:

(A) Nine months from the effective date of the premium exemption if there are no worksite modifications, or

(B) Twelve months from the date the department determines the worksite modification is complete, or

(C) If the worker is terminated for cause, or

(D) If the worker voluntarily resigns for a reason unrelated to the work injury.

(19) "Suitable wage" means:

(a) For the purpose of determining eligibility for vocational assistance, a wage at least 80 percent of the adjusted weekly wage as defined in OAR 436-120-0007.

(b) For the purpose of providing or ending vocational assistance, a wage as close as possible to 100 percent of the adjusted weekly wage. This wage may be considered suitable if less than 80 percent of the adjusted weekly wage, if the wage is as close as possible to the adjusted weekly wage.

(20) “Training” means a vocational rehabilitation service provided to a worker who is enrolled and actively engaged in an approved “Return-to-Work Plan; Training” as documented on Form 1081.
(21) "Transferable skills" means the knowledge and skills demonstrated in past training or employment that make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

(22) "Vocational assistance" means any of the services, goods, allowances, and temporary disability compensation under these rules to assist an eligible worker return to work. This does not include activities for determining a worker's eligibility for vocational assistance.

(23) "Vocational assistance provider" means an insurer or other public or private organization, registered under these rules to provide vocational assistance to injured workers.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0006 Administration of Rules

(1) At any time, the director may order the insurer to determine eligibility or provide specified vocational assistance to achieve compliance with ORS chapter 656 and these rules. The order may be appealed as provided by statute.

(2) Orders issued by the division in carrying out the director's authority to administer and to enforce ORS chapter 656 and these rules are considered orders of the director.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Hist.: Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0007 Establishing the Adjusted Weekly Wage to Determine Suitable Wage

To determine a suitable wage as defined in OAR 436-120-0005 the insurer must first establish the adjusted weekly wage as described in this rule. The insurer must calculate the "adjusted weekly wage" whenever determining or redetermining a worker's eligibility.

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

(a) "Adjusted weekly wage" is the wage currently paid as calculated under this rule.

(b) "Cost-of-living adjustments" or "collective bargaining adjustments" are increases or decreases in the wages of all workers performing the same or similar jobs for a specific employer. These adjustments are not variations in wages based on skills, merit, seniority, length of employment, or number of hours worked.

(c) "Earned income" means gross wages, salary, tips, commissions, incentive pay, bonuses, and the reasonable value of other consideration (housing, utilities, food, etc.) received from all employers for services performed from all jobs held at the time of injury or aggravation. Earned income also means gross earnings from self-employment after deductions of business expenses excluding depreciation. Earned income does not include fringe benefits such as medical, life or disability insurance, employer contributions to pension plans, or reimbursement of the worker's employment expenses such as mileage or equipment rental.

(d) "Job at aggravation" means the job or jobs the worker held on the date of the aggravation claim; or, for a worker not employed at time of aggravation, the last job or concurrent jobs held prior to the aggravation. Volunteer work does not constitute a job for purposes of this subsection.

(e) "Job at injury" is the job on which the worker originally sustained the compensable injury. For an occupational disease, the job at injury is the job the worker held at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease.

(f) "Permanent, year-round employment" is permanent employment in which the worker worked or was scheduled or projected to work in 48 or more calendar weeks a year. Paid leave is counted as work time. Permanent year-round employment includes trial service. It does not include employment with an annual salary set by contract or self-employment.

(g) "Temporary disability" means wage loss replacement for the job at injury.

(h) "Trial service" is employment designed to lead automatically to permanent, year-round employment subject only to the employee's satisfactory performance during the trial service period.

(2) The insurer must determine the nature of the job at injury or the job or jobs at aggravation by contacting the employer or employers to verify the worker's employment status. All figures used in determining a weekly wage by this method must be supported by verifiable documentation such as the worker's state or federal tax returns, payroll records, or reports of earnings or unemployment insurance payments from the Employment Department. The insurer must calculate the worker's adjusted weekly wage as described by this rule.

(3) When the job at injury or the job at aggravation was temporary or seasonal, calculate the worker's average weekly wage as follows, then convert to the adjusted weekly wage as described in section (6) of this rule:

(a) When the worker's regular employment is the job at injury and the worker did not hold more than one job at the time of injury, and did not receive unemployment insurance benefits during the 52 weeks prior to the injury, the worker's average weekly wage is the same as the wage upon which temporary disability is based.

(b) When the worker's regular employment is the job at aggravation and the worker did not hold more than one job at the time of aggravation, and did not receive unemployment insurance benefits during the 52 weeks prior to the aggravation, the worker's average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025.

(c) If the worker held more than one job at the time of the injury or aggravation, and did not receive unemployment insurance payments during the 52 weeks prior to the date of...
the injury or aggravation, divide the worker’s earned income by the number of weeks the worker worked during the 52 weeks prior to the date of injury or aggravation.

(d) If the worker held one or more jobs at the time of the injury or aggravation, and received unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation, combine the earned income with the unemployment insurance payments and divide the total by the number of weeks the worker worked and received unemployment insurance payments during the 52 weeks prior to the date of the injury or aggravation.

(4) When the job at injury was other than as described in section (3) of this rule, use the weekly wage upon which temporary disability was based, and then convert the weekly wage to the adjusted weekly wage as described in section (6) of this rule.

(5) When the job at aggravation was other than as described in section (3) of this rule, the worker’s average weekly wage is calculated using the same methods used to calculate temporary disability as described in OAR 436-060-0025, and then converting the adjusted weekly wage as described in section (6) of this rule.

(6) Adjusted weekly wage: After arriving at the weekly wage under this rule, establish the adjusted weekly wage by determining the percentage increase or decrease from the date of injury or aggravation, to the date of calculation, as follows:

(a) Contact the employer at injury regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. Adjust the worker’s weekly wage by any percentage increase or decrease;

(b) If the employer at injury is no longer in business and the worker’s job was covered by a union contract, contact the applicable union for any cost-of-living or collective bargaining adjustments. Adjust the worker’s weekly wage by the percentage increase or decrease;

(c) If the employer at injury is no longer in business or does not currently employ workers in the same job category, adjust the worker’s weekly wage by the appropriate factor from the cost-of-living matrix;

(d) If the worker’s regular employment was the employment the worker held at the time of aggravation, adjust the worker’s weekly wage by the appropriate factor from the cost-of-living matrix.

Stat. Auth.: ORS 656.340(9), ORS 656.726(4)
Stat. Imptd.: ORS 656.340(5) and (6)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0008 Administrative Review and Contested Cases

(1) Administrative review of vocational assistance matters: Under ORS 656.340(16), a worker wanting review of any vocational assistance matter must apply to the director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0185(1) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer must apply to the director for administrative review. Because effective vocational assistance is best realized in a nonadversarial environment, the first objective of the administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director will close the record and issue a Director’s Review and Order as described in subsections (f) and (g) of this section. A worker need not be represented to request or to participate in the administrative review process, which is as follows:

(a) The worker’s request for review must be mailed or otherwise communicated to the department no later than the 60th day after the date the worker received written notice of the insurer’s action; or, if the worker was represented at the time of the notice, within 60 days of the date the worker’s representative received actual notice. Issues raised by the worker where written notice was not provided may be reviewed at the director’s discretion.

(b) The worker, insurer, employer at injury, and vocational assistance provider must supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director. Upon the director’s request, any party to the dispute must provide available information within 14 days of the request. The insurer must promptly schedule, pay for, and submit to the director any medical or vocational tests, consultations, or reports required by the director. The worker, insurer, employer at injury, or vocational assistance provider must simultaneously send copies to the other parties to the dispute when sending material to the director. If necessary, the director will assist an unrepresented worker in sending copies to the appropriate parties. Failure to comply with this subsection may result in the following:

(A) If the worker fails to comply without reasonable cause, the director may dismiss the administrative review as described in subsection (d); or, the director may decide the issue on the basis of available information.

(B) If the insurer, vocational assistance provider, or employer at injury fails to comply without reasonable cause, the director may decide the issue on the basis of available information.

(c) At the director’s discretion, the director may issue an order of deferral to temporarily suspend administrative review. The order of deferral will specify the conditions under which the review will be resumed.

(d) The director may issue an order of dismissal under appropriate conditions.

(e) The director will issue a letter of agreement when the parties resolve a dispute within the scope of these rules. Any agreement may include an agreement on attorney fees, if any, to be paid to the worker’s attorney. The agreement will become effective on the 10th day after the letter of agreement...
is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may reconsider approval of the agreement upon the director's own motion or upon a motion by a party. The director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) One or both parties fail to honor the agreement;
(B) The agreement was based on misrepresentation;
(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or
(D) All parties request revision or reinstatement of the review.

(f) After the parties have had the opportunity to present evidence, and any meetings or conferences deemed necessary by the director have been held, the director will issue a final order. The parties have 60 days from the date the order is issued to request a hearing. An order is issued on the date it is mailed.

(g) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the proposed and final order is issued.

(h) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(i) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(j) A request for reconsideration does not stay the 60-day time period within which the parties may request a hearing.

(2) Attorney fees will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 to 436-001-0440.

(3) Hearings before an administrative law judge:

(a) Under ORS 656.340(16) and 656.704(2), any party that disagrees with an order issued under subsection (1)(f) of this rule or a dismissal issued under subsection (1)(d) of this rule may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days after the party received the dismissal or written denial.

(b) Under ORS 656.704(2), any party that disagrees with an order of dismissal based on lack of jurisdiction under subsection (1)(d) of this rule or department denial of reimbursement for vocational assistance costs may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days after the party received the dismissal or written denial.

(c) Under ORS 656.704(2), an insurer sanctioned under OAR 436-120-0900, a vocational assistance provider or certified individual sanctioned under ORS 656.340(9) and OAR 436-120-0915, a vocational assistance provider denied registration under ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification under ORS 656.340(9)(a) and OAR 436-120-0810 may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 no later than 60 days after the party received notification of the action.

(d) OAR 436-001 applies to the hearing.

(4) Contested case hearings of civil penalties: Under ORS 656.740 an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty under ORS 656.745 and OAR 436-120-0900 as follows:

(a) The insurer or employer must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must file the request with the division within 60 days after the mailing date of the notice of the proposed order or assessment.

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

(d) The Hearings Division will conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10

436-120-0012 General Requirements For Notices and Warnings

(1) All notices and warnings to the worker issued under OAR 436-120 must:

(a) Be in writing, signed, and dated.

(b) State the basis for the decision.

(c) Include the effective date of each action in the heading.

(d) Cite the relevant rule(s).

(e) Include the worker's appeal rights. All notices and warnings except those notifying a worker of entitlement to training or deferral of vocational assistance eligibility must contain the worker's appeal rights in bold type, as follows:

“If you disagree with this decision, you should contact (insert the person's name and the insurer name) within five days of receiving this letter to discuss your concerns. If you are still dissatisfied, you must contact the Workers’ Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: Employment Services Team,
436-120-0014 Notification of Employment and Reinstatement Rights and Responsibilities

(1) The insurer must inform a worker with a compensable injury of the employment reinstatement rights and responsibilities under ORS chapter 659A and this rule:
   (a) When the claim is accepted under ORS 656.262(6);
   (b) When the insurer contacts the worker under OAR 436-120-0115 about the need for vocational assistance under ORS 656.340(2); and
   (c) Within five days of receiving notification that the attending physician has released the worker to go back to work, under ORS 656.340(3).

(2) The insurer must inform the employer about the worker’s reemployment rights within five days of receiving notification of the attending physician’s release of the worker to return to work, under ORS 656.340(3).

436-120-0016 Warning Letters

(1) A warning letter can be issued at any time during the vocational eligibility evaluation or vocational assistance process.

   (2) Warning letters do not require specific language in the headings but must include a heading clearly indicating the purpose of the warning.

   (3) A warning letter must state what the worker must do, and by when, to avoid ineligibility or the ending of eligibility or training.

   (4) A warning letter must include the worker’s appeal rights under OAR 436-120-0012(1)(e).

436-120-0017 Types of Notices

When the insurer takes any of the actions listed below, it must issue the corresponding notices, using the headings listed in this rule. If a notice is used for more than one purpose, it must include all the headings that apply:

   (1) The NOTICE OF ELIGIBILITY must:
      (a) Include the date the worker became eligible.
      (b) Inform the worker which category of vocational assistance the insurer will provide:
         (A) NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE and NOTICE OF ENTITLEMENT TO TRAINING, or
         (B) NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE and NOTICE OF ENTITLEMENT TO DIRECT EMPLOYMENT SERVICES.
      (c) Include the worker’s rights and responsibilities;
      (d) 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 entitled to a training plan, or within 45 days of determining you 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 plan developer, 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 rehabilitation 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; 503-947-7816 or 1-800-452-0288 ext. 1719.”
      (e) Include the current list of vocational assistance providers (published with Bulletin 151), and explain that the worker and the insurer must agree on the selection of a vocational assistance provider.
      
      (f) 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 ext. 1719.”
      (g) Include information about the Preferred Worker Program.
      (h) Explain what the worker can do if he or she disagrees with something the insurer does.
      (i) 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.
   (2) The NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE must:
(a) Include information about services which may be available at no cost from the Employment Department or the Office of Vocational Rehabilitation Services.

(b) Include 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.

(c) Include a list of suitable occupations the worker can perform without being retrained, if the notice is based on a finding of “no substantial handicap.”

(3) The NOTICE OF DEFERRAL OF VOCATIONAL ASSISTANCE ELIGIBILITY DETERMINATION must:

(a) Inform the worker the insurer deferred the vocational eligibility process because the employer at injury has activated preferred worker benefits.

(b) Inform the worker that, if the job with the employer at injury does not begin on the hire date listed in the job offer letter, the worker can ask the insurer, within 30 days, to determine vocational eligibility.

(c) Include the following language in bold type:

“If you have questions about the deferral of the vocational eligibility 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 ext. 1719.”

(4) The NOTICE OF DENIAL OF VOCATIONAL ASSISTANCE BENEFITS must:

(a) Identify what vocational assistance benefits the insurer denies and explain why. This notice is not to be used for finding a worker ineligible or ending a worker’s eligibility for vocational assistance.

(b) Explain why the insurer denies the proposed return-to-work plan, if the notice is used for that purpose.

(5) The NOTICE OF END OF TRAINING:

(a) Must include the date the training plan ended. The effective date is the worker’s last date of attendance.

(b) Must state whether the worker is entitled to further training.

(c) Does not have to be submitted to the division.

(6) The NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE:

(a) Must include the date when eligibility ended. The effective date is the worker’s last date of eligibility.

(b) Must include the reason the worker’s eligibility for vocational assistance is ending. However, this notice is not required if the insurer is ending the worker’s eligibility because the worker has given up his or her vocational assistance rights through a claims disposition agreement.

(c) Does not have to be submitted to the division.

(7) The NOTICE OF SELECTION OF VOCATIONAL ASSISTANCE PROVIDER, must be issued when a vocational assistance provider is agreed upon by the worker and the insurer.

(8) The NOTICE OF CHANGE OF VOCATIONAL ASSISTANCE PROVIDER, must be issued anytime there is a change in vocational assistance provider.

(9) The return-to-work plan and amendments must:

(a) Be reported using Form 1081, Return-to-Work Plan, Training, or Form 1083 Return-to-Work Plan, Direct Employment.

(b) Indicate what the changes are and why they are necessary, if the insurer amends the proposed plan.

(10) The Vocational Closure Report (Form 2800) must:

(a) Include the effective date for the end of eligibility.

(b) Include the reason for the end of eligibility.

(c) Include return-to-work and vocational assistance provider information.

(d) Be issued for each eligible worker within 30 days after eligibility ends.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Hist.: Amended and renumbered from OAR 436-120-0004, 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0018 Postponement Notices

A letter informing the worker that the eligibility evaluation has been postponed does not require specific language in the headings but must include a heading clearly indicating the purpose of the letter and must:

(1) Explain the reason the worker’s eligibility evaluation is postponed.

(2) Explain to the worker in writing what information is necessary if the insurer cannot complete the vocational eligibility process because it needs more information. In that case, the insurer must state when it expects to determine eligibility or make a decision.

(3) Explain, if the worker has accepted a job offer from the employer at injury, that if the job does not begin on the hire date listed in the job offer letter, the worker can ask the insurer within 30 days to determine vocational eligibility.

(4) Be mailed to the worker within 14 days of the insurer receiving notification that the worker is likely eligible for vocational assistance.

(5) Include the following language in bold type:

“If you have questions about the postponement of the vocational eligibility 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 ext. 1719.”
436-120-0115  Conditions Requiring Completion of a Vocational Eligibility Evaluation

(1) If the worker has an accepted disabling claim, the insurer is required to begin an eligibility evaluation within five days of any of the following conditions:

(a) The insurer receives information that indicates 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.

(c) The worker enters into a claim disposition agreement, retains vocational assistance rights, and is likely eligible for vocational assistance; or

(d) Eligibility was previously determined under the current opening of the claim and the insurer has accepted new condition(s).

(2) Even if conditions in (1) are met, the insurer is not required to do an eligibility evaluation if the worker is deceased, the worker has a permanent total disability award, or the worker’s claim is reopened under a board’s own motion.

(3) Nothing in these rules prevents an insurer from finding a worker eligible and providing vocational assistance at any time.

(4) If the insurer receives a request for vocational assistance from the worker and the insurer is not required to determine eligibility, the insurer must notify the worker in writing, within 14 days of the request. The notice must include at least:

(a) The reason(s) an eligibility determination is not required;  
(b) The circumstances that, if present, would trigger a requirement to determine eligibility; and
(c) Instructions to contact the division at 503-947-7816 or 1-800-452-0288 ext. 1719 with questions about vocational assistance eligibility requirements and procedures.

(5) The insurer must determine eligibility if the worker’s claim was initially denied and is later accepted as disabling and all appeals of the denial have been exhausted.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stat. Implt.: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0320 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0125  Conditions for Postponement of the Vocational Eligibility Evaluation

(1) If the worker requested an eligibility evaluation but the insurer does not know the worker’s permanent limitations, the insurer may postpone the evaluation until the worker’s permanent restrictions are known or can be projected. In that case, within 14 days of receiving the worker’s request the insurer must contact the attending physician to ask if permanent limitations are known or can be projected. The insurer must also notify the worker in writing that the determination will be postponed until permanent restrictions are known or can be projected.

(2) If the claim qualifies for closure under ORS 656.268(1)(b) or (c), the insurer may postpone the determination until the worker is medically stationary or until permanent restrictions are known or can be projected, whichever occurs first.

(3) If the insurer is unable to determine eligibility or make a decision regarding a particular vocational service because of insufficient data, the insurer must explain to the worker in writing what information is necessary and when it expects to determine eligibility or make a decision. This explanation must be mailed to the worker within 14 days of the insurer receiving notification that the worker is likely eligible for vocational assistance.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0320 as WCD Admin. Order 09-061, eff. 1-1-2010

436-120-0135  General Requirements and Timeframes for Vocational Eligibility Evaluations

(1) When an eligibility evaluation is required, the insurer must contact the worker to start the eligibility determination process within 5 days of the date the insurer received knowledge of likely eligibility.

(2) A certified vocational counselor must determine vocational eligibility and the insurer must provide the vocational counselor with all existing relevant medical information.

(3) At the insurer’s request, the worker must provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(4) The insurer must complete the eligibility determination within 30 days of the date the insurer initiated contact with the worker under subsection (1) of this rule, unless postponed under OAR 436-120-0125.

(5) If the eligibility determination is postponed, the eligibility evaluation must be completed within 30 days of the insurer’s receipt of requested relevant information.

(6) Either the insurer or certified vocational counselor may issue the notice with the results of the eligibility evaluation to the worker.

(7) Vocational assistance will only be provided for one claim at a time, unless the parties agree otherwise. 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.
Vocational Assistance Eligibility Criteria

(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 the following conditions are met:

(a) The worker is authorized to work in the United States.

(b) The worker is available for vocational assistance in Oregon or within commuting distance of Oregon.

(A) If the worker is not available in Oregon or within commuting distance of Oregon, the insurer must consider the worker available in Oregon if the worker states in writing that within 30 days of being determined eligible for vocational assistance the worker will move back to Oregon, or to within commuting distance of Oregon, at the worker’s own expense.

(B) The requirement that the worker be available in Oregon or within commuting distance of Oregon for vocational assistance does not apply if the Oregon subject worker did not work and live in Oregon at the time of the injury.

(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. Prior to 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 non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(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 prior to ending the worker’s eligibility. If the reason was for incarceration, this reason must be cited 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.

(g) The worker did not refuse or otherwise relinquish his or her rights to vocational assistance in writing.

(3) 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.

Deferral and Completion of an Eligibility Evaluation When the Employer Activates Preferred Worker Program Benefits:

(1) The insurer must defer the determination of vocational assistance eligibility when the employer at injury activates preferred worker benefits under OAR 436-110 and the worker agrees in writing to accept the new or modified regular job. All of the following conditions must exist:

(a) The employer must make a written job offer to the worker that includes the following information:

(A) The start date;

(B) Wage and hours;

(C) Job site location;

(D) Description of job duties; and

(E) A statement that the job does not begin until the modifications are in place.

(b) The insurer must send the worker a Notice of Deferral of Vocational Assistance Eligibility Determination within 14 days of the date the worker signed the job offer letter indicating acceptance of the job.

(2) The insurer must complete the eligibility evaluation within 30 days of a determination that preferred worker benefits will not be provided or if the agreement is terminated.

End of Eligibility for Vocational Assistance

A worker’s eligibility ends when any of the following conditions apply:

(1) 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.

(2) The worker has been employed in suitable employment as described in OAR 436-120-0005(18) for at least 60 days after the date of injury or date of aggravation, and any necessary worksite modification is in place.

(3) The worker, prior to beginning an authorized return-to-work plan, refused an offer of suitable employment. If the employer-at-injury offers employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(4) The worker, prior to 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.
(5) The worker, prior to 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. Prior to 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 non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(6) The worker, after completing an authorized training plan, refused an offer of suitable employment.

(7) The worker declined or became unavailable for vocational assistance. The insurer must determine if the reasons are for reasonable or unreasonable cause prior to ending the worker’s eligibility. If the reason was for incarceration, this reason must be cited 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.

(8) The worker refused a suitable training site after the vocational counselor and worker agreed in writing upon a return-to-work goal.

(9) 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 vocational counselor or the insurer by the close of next business day.

(10) 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.

(11) The worker misrepresented information relevant to providing vocational assistance.

(12) 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.

(13) 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.

(14) After written warning the worker continues to harass any participant to the vocational process. This section does not apply if such behavior is the result of a documented medical or mental condition.

(15) The worker entered into a claim disposition agreement and disposed of vocational rights. The parties may agree in writing to suspend vocational services pending approval by the Workers’ Compensation Board. The insurer must end eligibility when the Worker’s Compensation Board approves the claims disposition agreement that disposes of vocational assistance rights. No notice regarding the end of eligibility is required.

(16) The worker received maximum direct employment services and is not entitled to other categories of vocational assistance.

Stat. Auth.: ORS 656.340, ORS 656.726(4)
Stat. Implt.: ORS 656.340
Hist.: Amended and renumbered 12-1-2009 from OAR 436-120-0350 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0175 Redetermining Eligibility for Vocational Assistance

If a worker was previously determined ineligible or the worker’s eligibility ended, the insurer must redetermine eligibility within 35 days of notification of a change 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 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 ineligible 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) The worker, who returned to work prior to becoming medically stationary, informs the insurer that he or she is likely eligible for vocational assistance and requests a determination within 60 days of the mailing date of the Notice of Closure.
(7) Prior to claim closure, a worker's limitations due to the injury became more restrictive.

(8) Prior to claim closure, the insurer accepts a new condition that was not considered in the original determination of the worker's eligibility.

(9) The worker's average weekly wage is redetermined and increased.

(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). 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 prior to the injury.

(3) When determining the worker's eligibility for vocational assistance, the insurer may include 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 own expense after the date of injury or aggravation.

(436-120-0185) Choosing a Vocational Assistance Provider

(1) Once the worker is found eligible, the insurer and worker must agree on a vocational assistance provider. Within 20 days of an eligibility finding, the insurer must notify the worker of the selection of vocational assistance provider. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer must notify the director and the director will select a provider.

(2) If the worker or insurer requests a change in vocational assistance provider, the insurer and worker must agree on a vocational assistance provider. If they are unable to agree, the insurer must refer the dispute to the director.

(436-120-0320) Determining Eligibility for Vocational Assistance and Selection of Vocational Assistance Provider

(1) The insurer must select one of the following categories of vocational assistance before referring a worker to a vocational assistance provider:

(a) Direct employment services, if the worker has the necessary transferable skills to obtain suitable new employment.

(b) Training, if the worker needs training in order to return to employment which pays a wage significantly closer to 100 percent of the adjusted weekly wage. "Significantly closer" may vary depending on several factors, including, but not limited to, the worker's wage at injury, adaptability, skills, geographic location, limitations and the potential for the worker's income to increase with time as the result of training.

(2) The insurer must notify the worker of the category selection and the reason for the selection.

(3) The insurer must reconsider the category of vocational assistance within 30 days of the insurer's knowledge of a change in circumstances including, but not limited to:

(a) A change in the worker's permanent limitations;

(b) A change in the labor market; or

(c) The category of vocational assistance proves to be inappropriate.

(4) The insurer must notify the worker immediately if the reconsideration in section (3) results in a change in the vocational assistance category.

(436-120-0340) Determining Substantial Handicap

(1) A certified vocational counselor must perform a substantial handicap evaluation as part of the eligibility determination when applicable.

(2) To complete the substantial handicap evaluation the vocational counselor must submit a report documenting the following information:

(a) Relevant work history for at least the preceding five years;

(b) Level of education, proficiency in spoken and written English or other languages, where relevant, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage as determined under OAR 436-120-0007 and suitable wage as defined by OAR 436-120-0005;

(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) below;
436-120-0410 Vocational Evaluation
A certified vocational counselor must complete the vocational evaluation. Vocational evaluation may include one or more of the following:

1. **Vocational testing** must be administered by an individual certified to administer the test.

2. A **work evaluation** must be performed by a Certified Vocational Evaluation Specialist (CVE), certified by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists.

3. **On-the-job evaluations** must evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job environment.
   - First, the vocational counselor must perform a job analysis to determine if the job is within the worker's capacities. The insurer must submit the job analysis to the attending physician if there is any question about the appropriateness of the job.
   - The evaluation should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.
   - The evaluation does not establish any employer-employee relationship.
   - A written report must evaluate the worker's performance in the areas originally identified for assessment.

4. **Situational assessment** is a procedure that evaluates a worker's aptitude or work behavior in a particular learning or work setting. It may focus on a worker's overall vocational functioning or answer specific questions about certain types of work behaviors.
   - The situational assessment requires these steps: planning and scheduling observations; observing, describing and recording work behaviors; organizing, analyzing and interpreting data; and synthesizing data including behavioral data from other pertinent sources.
   - The assessment should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

5. **Work adjustment** is work-related activities that assist workers in understanding the meaning, value, and demands of work. It may include the assistance of a job coach.

6. **Job analysis** is a detailed description of the physical and other demands of a job based on direct observation of the job.

7. **Labor market search** is obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.
   - A labor market search is needed when standard labor market reference materials do not have adequate information upon which to base a decision, or there are questions about a worker's specific limitations, training and skills, that must be addressed with employers to determine if a reasonable labor market exists.
   - The person giving the information must have hiring responsibility or direct knowledge of the job's requirements; and the job must exist at the firm contacted.
   - The labor market search report must include, but is not limited to, the date of contact; firm name, address and telephone number; name and title of person contacted; the qualifications of persons recently hired; physical requirements; wages paid; condition of hire (full-time, part-time, seasonal, temporary); date and number of last hire(s); and available and anticipated openings.
   - Specific openings found in the course of a labor market search are not, in themselves, proof a reasonable labor market exists.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010

436-120-0430 Direct Employment

1. If the insurer determines the worker is entitled to direct employment services, the insurer must provide an eligible worker with at least four months of direct employment services.

2. Direct employment services must be provided by a certified vocational counselor.

3. Direct employment services must begin on the date the insurer approves a direct employment plan, or on the completion date of an authorized training plan.

4. Direct employment services may include, but are not limited to:
   - Employment counseling.
   - Job search skills instruction, which teaches workers how to write resumes, research the job market, locate suitable new employment, complete employment applications, interview for employment, and develop other skills related to obtaining suitable new employment.
   - Job development with related return-to-work activities, which helps the worker contact appropriate prospective employers.
   - Job analysis.
   - The insurer must provide return-to-work follow-up for at least 60 days after the worker becomes employed to ensure the work is suitable and to provide any necessary assistance that enables the worker to continue the employment.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07 Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10

436-120-0443 Training

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 certified vocational 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 – Return to Work Plan must be completed, signed by all parties, and submitted to the director.

(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), 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 that does not prevent completion of the training by the planned date.

(12) A worker actively engaged in training must receive temporary disability compensation under ORS 656.268 and ORS 656.340.

(13) Temporary disability compensation is limited to 16 months unless extended to 21 months by the insurer. In no event will 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) An “exceptional disability,” defined as a disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury that results in impairment equal or greater than Class III as defined in OAR 436-035.

(c) An “exceptional loss of earning capacity” exists when no suitable training plan of 16 months or less is likely to eliminate the worker’s substantial handicap to employment. The extension must allow the worker to obtain a wage as close as possible to the worker’s adjusted weekly wage and at least 10 percent 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 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 436-120-0455, including but not limited to payment of expenses for tuition, fees, books, and supplies.

(d) The return-to-work 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.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stat. Impld.: ORS 656.340
Hist.: Amended and renumbered from OAR 436-120-0440, 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10
Amended 10-3-2012 as Admin. Order 12-059, eff. 11-1-2012

436-120-0445 Training Requirements

(1) Basic education is limited to six months unless extended by the insurer.

(2) On-the-job training

(a) Training time is limited to 12 months unless extended by the insurer.

(b) The insurer must reimburse the training employer for a portion of the worker’s wages.

(c) The on-the-job training contract between the training employer, the insurer, and the worker must include, but is not limited to:

(A) The worker’s name;

(B) The employer's legal business name;

(C) The employer’s current workers’ compensation insurance policy number;

(D) The name of the individual providing the training;

(E) The training plan start and end dates;

(F) The job title and duties;

(G) The skills to be taught;

(H) The base wage and the terms of wage reimbursement;
(I) An agreement that the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee; and

(J) An acknowledgement that the training may not prepare the worker for jobs elsewhere, if the training prepares a worker for a job unique to the training site.

(d) The insurer must pay temporary disability compensation as provided in ORS 656.268.

(e) Absent a need to accommodate the worker’s documented medical condition or class schedule, the worker’s schedule must be the same as for a regular full-time employee.

(3) Occupational skills training

(a) Training is limited to 12 months unless extended by the insurer.

(b) The training is primarily for the worker’s benefit. The worker does not receive wages.

(c) Training does not establish any employer-employee relationship with the training employer. The training employer makes no guarantee of employing the worker when the training is completed.

(d) The training employer has a sufficient number of employees to accomplish its regular work and the training of the worker, and the worker does not displace an employee.

(e) Absent a need to accommodate the worker’s documented medical condition or class schedule, the worker’s schedule must be the same as for a regular full-time employee.

(4) Formal training

(a) Training time is limited to 16 months unless extended by the insurer.

(b) Course load must be consistent with the worker’s abilities, limitations, and length of time since the worker last attended school.

(c) Courses must relate to the vocational goal.

(5) If the worker begins or completes training between the date of injury and the date of the eligibility determination, and then the insurer finds the worker eligible for vocational assistance and finds the worker’s training suitable, the insurer must reimburse the worker for costs required by that training and verified by the insurer or the director, including temporary disability compensation as required under ORS 656.268 and ORS 656.340.

(a) A change occurs in the worker’s limitations that may render the training inappropriate.

(b) In an academic program:

(A) The worker fails to maintain at least a 2.00 grade point average for two grading periods, or

(B) The worker fails to complete the minimum credit hours required under the training plan.

(2) In an academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker may:

(a) Fail to maintain a 2.00 grade point average for two consecutive grading periods, or

(b) Fail to complete the minimum credit hours in the training plan curriculum.

(3) In a non-academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

(2) In an academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

(3) In a non-academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

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(3) In a non-academic program, the vocational counselor must notify the insurer, and the insurer must give the worker a written warning of the possible end of training, at the first indication that the worker's performance in training is unsatisfactory and may not result in employment in that field.

1. Training ends when:

(a) In an academic program:

(A) The worker fails, after written warning, to maintain at least a 2.00 grade point average for two consecutive grading periods, or

(B) The worker fails, after written warning, to complete the minimum credit hours in the training plan curriculum for two consecutive grading periods.

(b) In a non-academic program, the worker’s performance in training is unsatisfactory and further training is not likely to result in employment in that field. The insurer must give the worker a written warning prior to ending the worker’s training under this rule.

2. A training plan re-evaluation may include a conference with the division, under OAR 436-120-0500(2).

1. Training ends when:

(a) In an academic program:

(A) The worker fails, after written warning, to maintain at least a 2.00 grade point average for two grading periods, or

(B) The worker fails, after written warning, to complete the minimum credit hours in the training plan curriculum for two consecutive grading periods.

(b) In a non-academic program, the worker’s performance in training is unsatisfactory and further training is not likely to result in employment in that field. The insurer must give the worker a written warning prior to ending the worker’s training under this rule.

2. A training plan re-evaluation may include a conference with the division, under OAR 436-120-0500(2).
436-120-0455 Optional Services
(1) Optional services are services provided to an ineligible worker or services provided to an eligible worker in excess of those described in these rules. Such services are at the discretion of an insurer.

(2) The insurer must not use optional services to circumvent the intent of these rules.

Stat. Auth.: ORS 656.283, 656.340, 656.704, 656.726
Stats. Implemented: ORS 656
Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07

436-120-0500 Return-to-Work Plans: Development and Implementation
(1) A return-to-work plan should be a collaborative effort between the vocational counselor and the injured worker, and should include all the rights and responsibilities of the worker, the insurer, and the vocational counselor. Prior to submitting the plan to the insurer, the vocational counselor must review the plan and plan support with the worker. Certain information may be excluded, as allowed by OAR 436-010. The injured worker must be given the opportunity to review the plan with the worker's representative prior to signing it. The vocational assistance provider must confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature. The counselor must submit copies signed by the vocational counselor and the worker to all parties. If the insurer lacks sufficient information to make a decision, the insurer must advise the parties what information is needed and when it expects to make a decision.

(2) If the insurer does not approve a return-to-work plan within 90 days of determining the worker is entitled to a training plan, or within 45 days of determining the worker is entitled to a direct employment plan, the insurer must contact the division within five days to schedule a conference. 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 plan developer, and any other parties involved in the return-to-work process must attend the conference. The conference may be postponed for a period of time agreeable to the parties. The insurer or the worker may request a conference with the division if other delays in the vocational rehabilitation process occur.

(3) If, during development of a return-to-work plan, an employer offers the worker a job, the insurer must perform a job analysis, obtain approval from the attending physician, verify the suitability of the wage, and confirm the offer is for a bona fide, suitable job as defined in OAR 436-120-0005. If the job is suitable, the insurer must help the worker return to work with the employer. The insurer must provide return-to-work follow-up during the first 60 days after the worker returns to work. If return to work with the employer is unfeasible or, during the 60-day follow-up the job proves unsuitable, the insurer must immediately resume development of the return-to-work plan.

(4) If the vocational goal or category of assistance is later changed, the insurer must amend the plan. All amendments to the plan must be initialed by the insurer, vocational assistance provider, and the worker.

Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07
Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10

436-120-0510 Return-to-Work Plan Support
(1) The worker and vocational counselor must work together to develop a return-to-work plan that includes consideration of the following:

(a) The worker's transferable skills;
(b) The worker's physical and mental capacities and limitations;
(c) The worker's vocational interests;
(d) The worker's educational background and academic skill level;
(e) The worker's pre-injury wage; and
(f) The i worker's place of residence and that labor market.

(2) Return-to-work plan support must contain, but is not limited to, the following:

(a) Specific vocational goal(s) and projected return-to-work wage(s).
(b) A description of the worker’s current medical condition, relating the worker’s permanent limitations to the vocational goals.
(c) A description of the worker’s education and work history, including job durations, wages, Standard Occupational Classification (SOC) codes or other standardized job titles and codes, and specific job duties. The SOC codes can be found on the Oregon Employment Department OLMIS website.
(d) If a direct employment plan, a description of the worker’s transferable skills that relate to the vocational goals and a discussion of why training will not bring the worker a wage significantly closer to 100 percent of the adjusted weekly wage at the time of injury.
(e) If a training plan, a discussion of why direct employment services will not return the worker to suitable employment.
(f) A summary of the results of any evaluations or testing. If the results do not support the goals, the vocational assistance provider must explain why the goals are appropriate.
(g) A summary of current labor market information that shows the labor market supports the vocational goals and documents that the worker has been informed of the condition of the labor market.
(h) A labor market search as prescribed in 436-120-0410(7), if needed.
(i) If the labor market information does not support the goals, the vocational assistance provider must explain why the goals are appropriate. The worker and worker’s representative, if any, must acknowledge in writing an awareness of the poor labor market conditions and a willingness to proceed with the
plan in spite of these conditions. In the case of a training plan, this acknowledgment must include an understanding the insurer will provide no additional training should the worker be unable to find suitable employment because of the labor market.

(j) A job analysis prepared by the vocational assistance provider, signed by the worker and by the attending physician or a qualified facility designated by the attending physician, and based on a visit to a worksite comparable to what the worker could expect after completing training. If the attending physician is unable or unwilling to address the job analysis and does not designate a facility as described above, the insurer may submit the job analysis to a qualified facility of its choice. The insurer must submit the resulting information to the attending physician for concurrence. If the attending physician has not responded within 30 days of the date of request for concurrence, the plan may proceed.

(k) A signed on-the-job training contract, if applicable.

(l) A description of the curriculum, which must be term by term if the curriculum is for formal training.

(m) If material pertinent to a return-to-work plan is contained in a previous eligibility the insurer may attach a copy of the evaluation to the plan.

436-120-0520 Return-to-Work Plan: Responsibilities of the Eligible Worker and the Vocational Assistance Provider

(1) The worker must participate and maintain contact with the vocational counselor throughout plan development and as required in the plan, and must inform the vocational counselor of anything which might affect the worker’s participation or complete the plan. If the worker stops attending training for any reason, the worker must notify the vocational counselor by the close of the next working day.

(2) Vocational counselors are responsible for the following:

(a) During plan development, the vocational counselor must provide resource materials about jobs, training programs (if appropriate), labor markets and other pertinent information to help the worker select a vocational goal; direct information gathering; and otherwise help the worker analyze and evaluate options.

(b) The vocational counselor must help the worker plan the curriculum and help the worker enroll. The vocational assistance provider must contact the worker, trainers and training facility counselors to the extent necessary to assure the worker’s participation and progress.

436-120-0530 Return-to-Work Plan Review

The director may review return-to-work plans and supporting information. If the director finds a return-to-work plan or its supporting information does not conform to these rules:

(1) The director must notify the insurer and vocational assistance provider in writing of the preliminary finding of nonconformance. The notification must inform the insurer of changes or information required to bring the plan into conformance.

(2) The insurer must, within 30 days of notification, make appropriate changes, supply additional information requested by the division, or explain why no change(s) should be made.

(3) If the insurer does not respond timely or is unable to bring the plan into conformance, the director will return the plan to the parties with notification that the plan does not conform to OAR 436-120 and may order the insurer to develop a plan that conforms to the rules.

436-120-0700 Direct Worker Purchases

(1) The insurer must provide direct worker purchases as necessary for an eligible worker’s participation in vocational assistance and to meet the requirements of a suitable job. A worker is no longer eligible for these purchases once eligibility ends unless the purchases are necessary to complete a plan. Direct worker purchases include partial purchase, lease, rental and payment.

(2) Direct worker purchases will not include purchases of real property; payment of fines or other penalties; or payment of additional driver’s license costs, increased insurance costs or any other costs attributable to problems with the worker’s driving record.

(3) In making its decision regarding a direct worker purchase, the insurer may choose the least expensive, adequate alternative. If the worker wants a direct worker purchase which is more expensive than that authorized by the insurer, the worker may select that alternative, and the worker shall pay the difference in cost.

(4) Within 14 days of its receipt of a request for a direct worker purchase, the insurer must approve the purchase or notify the worker of its denial.

(5) The insurer must pay for approved direct worker purchases in time to prevent delay in the provision of services.

(6) The worker may pay for mileage, child or senior care, or for purchases such as clothing, books and supplies or the worker may request an advance of any of these costs based on documentation of need.

(a) The insurer must reimburse costs within 28 days of receiving the written request from the worker and any required supporting documentation.

(b) The insurer must return denied requests for reimbursement to the worker within 28 days of the insurer’s receipt with an explanation of the reason for nonpayment.
(7) The insurer must assign to the worker right and title to the nonexpendable direct worker purchases paid by the insurer as follows:

(a) The insurer must make such assignment no later than the 60th day of continuous employment unless the worker remains eligible and the suitability of the employment in question.

(b) The insurer may repossess nonexpendable property if the worker no longer requires the property for training or employment.

(c) The insurer may require repayment of advancements or reimbursements if the worker misrepresented information material to the purchase decision or if the worker used the funds for something other than the approved purchase.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 11/1/07 as WCD Admin. Order 07-067, eff. 12/1/07

436-120-0710 Direct Worker Purchases: Kinds

The insurer must provide the direct worker purchases described in sections (1) through (12) of this rule without regard to the worker's pre- or post-injury income. The insurer may not require the worker to submit a financial statement in order to qualify for direct worker purchases listed in sections (1) through (12). In determining the necessity of direct worker purchases described in sections (13) through (18), the insurer must consider, among all factors, the worker's pre-injury net income as compared with the worker's post-injury net income. Permanent partial disability award payments will not be considered as income. For the insurer to find the purchase necessary, the worker's pre-injury net income, as adjusted by the cost-of-living matrix, must be greater than the worker's post-injury net income, unless the worker can establish financial hardship. The insurer may require the worker to provide information about expenditures or family income when the worker claims a financial hardship.

(1) Tuition, fees, books, and supplies for training or studies. Payment is limited to those items identified as mandatory for the training or initial employment, such as starter sets. Purchases will not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker possesses.

(2) Wage reimbursement for on-the-job training. The amount must be stipulated in a contract between the training employer and the insurer.

(3) Travel expenses for transportation, meals, and lodging required for participation in vocational assistance. For the purposes of this section, "participation in vocational assistance" includes, but is not limited to job search, required meetings with the vocational assistance provider, and meetings with employers or at training sites as required by the plan or plan development. The conditions and rates for payment of travel expenses are as follows:

(a) Transportation. Costs will be paid at public transportation rates when public transportation is available; otherwise, mileage will be paid at the rate published in Bulletin 112. Costs incidental to mileage, such as parking fees, also will be paid. For workers receiving temporary total disability or equivalent income, private car mileage will be paid only for mileage in excess of the miles the worker traveled to and from work at the time of injury. Mileage payment in conjunction with moving expenses will be allowed only for one vehicle and for a single one-way trip. To receive reimbursement for private car mileage, the worker must provide the insurer with a copy of the driver's valid driver's license and proof of insurance coverage.

(b) Meals and lodging, overnight travel. For overnight travel, meal and lodging expense will be reimbursed at the rate published in Bulletin 112.

(c) Special travel costs. Payment will be made in excess of the amounts specified in this section when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds prevailing costs in the travel area are substantially higher than average.

(4) Tools and equipment for training or employment. Payment is limited to items identified as mandatory for the training or initial employment, such as starter sets. Purchases will not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker possesses.

(5) Moving expenses. Payment is limited to workers with employment or training outside reasonable commuting distance. In determining the necessity of paying moving expenses, the insurer may consider the availability of employment or training which does not require moving, or which requires less than the proposed moving distance. Payment is limited to moving household goods weighing not more than 10,000 pounds. If necessary, payment includes reasonable costs of meals and lodging for the worker's family and mileage pursuant to subsection (3)(a) of this rule.

(6) Second residence allowance. The purpose of the second residence is to enable the worker to participate in training outside reasonable commuting distance. The allowance must equal the rental expense reasonably necessary, plus not more than $200 a month toward all other expenses of the second residence, excluding refundable deposits. In order to qualify for second residence allowance, the worker must maintain a permanent residence.

(7) Primary residence allowance. This allowance is applicable when the worker must change residence for training or employment. Payment includes the first month's rent and the last month's rent only if required prior to moving in.

(8) Medical examinations and psychological examinations for conditions not related to the compensable injury when necessary for determining the worker's ability to participate in vocational assistance.

(9) Physical or work capacities evaluations.

(10) Living expense allowance during vocational evaluation. Payment is limited to workers involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not receiving temporary disability
payments. The worker will not be barred from receiving a living expense allowance if the worker is unable to participate five hours daily because of limitations caused by the injury. Payment must be based on the worker’s temporary total disability rate if the worker’s claim were reopened.

(11) Work adjustment, on-the-job evaluation, or situational assessment cost(s).

(12) Membership fees and occupational certifications, licenses, and related testing costs. Payment under this category is limited to $500.

(13) Clothing required for participation in vocational assistance or for employment. Allowable purchases do not include items the trainer or employer would provide or the worker possesses.

(14) Child or disabled adult care services. These services are payable when required to enable the worker to participate in vocational assistance at rates prescribed by the State of Oregon's Department of Human Services. For workers receiving temporary total disability compensation or equivalent income, these costs will be paid only when in excess of what the worker paid for such services at the time of injury, adjusted using the cost-of-living matrix.

(15) Dental work, eyeglasses, hearing aids, and prosthetic devices. These are not related to the compensable injury and enable the worker to obtain suitable employment or participate in training.

(16) Dues and fees of a labor union. Payment will be limited to initiation fees, or back dues and one month's current dues.

(17) Vehicle rental or lease. There is no reasonable alternative enabling the worker to participate in vocational assistance or accept an available job. The worker must provide the insurer with proof of a valid driver's license and insurance coverage. Payment under this category is limited to $1,000.

(18) Any other direct worker purchase the insurer considers necessary for the worker's participation as described in the introductory paragraph of this rule. Payment under this category is limited to $1,000.

 Categories of Vocational Assistance

<table>
<thead>
<tr>
<th>Category</th>
<th>Professional Spending Limits</th>
<th>Direct Worker Purchases Spending Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility determination</td>
<td>54.7%</td>
<td>Not applicable (NA)</td>
</tr>
<tr>
<td>without substantial handicap</td>
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<tr>
<td>analysis</td>
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<tr>
<td>Substantial handicap analysis</td>
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<td>Direct Employment</td>
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<td>368.1%</td>
</tr>
<tr>
<td>Training</td>
<td>1840.4%</td>
<td>2429.3%</td>
</tr>
<tr>
<td>DE/Training Combined</td>
<td>2044.8%</td>
<td>NA</td>
</tr>
<tr>
<td>Dispute Resolution</td>
<td>61.3%</td>
<td>NA</td>
</tr>
</tbody>
</table>

NOTE: *Each limit is shown as a percentage of Oregon's state average weekly wage (SAWW), determined under ORS 656.211. Dollar amounts are published in Bulletin 124 and are adjusted annually, effective July 1, based on changes in the SAWW.

(4) Wage reimbursement for on-the-job training contracts are not covered by the fee schedule.

(5) Services and direct worker purchases provided after eligibility ends to complete a plan or employment is subject to the maximum amounts in effect at the time of closure.

(6) The insurer must pay, within 60 days of receipt, the vocational assistance provider's billing for services provided under the insurer-vocational assistance provider agreement. The insurer must not deny payment on the grounds the worker was not eligible for the assistance if the vocational assistance provider performed the services in good faith without knowledge of the ineligibility.

(7) An insurer entitled to claims cost reimbursement under OAR 436-110 for services provided under OAR 436-120 is subject to the following limitations:

(a) Optional services are not reimbursable.

(b) The insurer must obtain the director's approval in advance for any waiver of the provisions of OAR 436-120.

(8) To receive reimbursement from the Workers' Benefit Fund, the insurer or self-insured employer must provide the division with the following documentation, within one year from the date of the final order:

(1) The director will reimburse the insurer or self-insured employer for costs associated with providing vocational benefits when:

(a) The director issues an order overturning the insurer’s or self-insured employer’s denial of vocational benefits; and

(b) The insurer’s or self-insured employer’s denial is later upheld by a final order.
(a) Injured worker’s name and Workers’ Compensation Division’s claim file number;
(b) Date and order number of the director’s order appealed;
(c) Itemized listing with dates of service for all costs incurred after the date of the director’s order that was reversed. All costs, in order to be reimbursed, must meet all conditions set forth in OAR 436-120, and reimbursement requests must:
   (A) Use terms, “direct employment” or “training” to show the category of vocational assistance provided;
   (B) List vocational provider costs by category of “professional services”;
   (C) List direct worker purchases by the categories in OAR 436-120-0710, to include purchase dates and costs;
   (D) Show temporary total disability paid between the start and end dates of the return to work plan; and
   (E) List any other costs incurred in providing vocational benefits as a result of the order that was appealed.
   (d) Signed certified statement that the requested reimbursement amount was actually paid; and
   (e) The insurer’s or self-insured employer’s name and address where reimbursement is to be sent.

(3) The director may require additional information to clarify and process a reimbursement request.

(4) No reimbursement is allowed for the insurer’s administrative costs.

Stat. Auth.: 656.726(4)
Stats. Implemented: Oregon Laws 2005, chapter 588, sections 4 & 5; ORS 656.313, 656.605
Hist.: Filed 12/5/05 as WCD Admin. Order 05-080 eff. 01/01/06

436-120-0810 Certification of Individuals

Individuals determining workers’ eligibility and providing vocational assistance must be certified by the director and on the staff of a registered vocational assistance provider, insurer, or self-insured employer.

   (1) An applicant for certification must submit an application, as prescribed by the director, demonstrating the qualifications for the specific classification of certification as described in OAR 436-120-0830.

   (2) Department certification is not required to perform work evaluations, but the work evaluator must be certified by the professional organizations described in OAR 436-120-0410(2).

   (3) The director may approve or disapprove an application for certification based on the individual’s application.

      (a) Certification will be granted for five years. A vocational counselor who is nationally certified as described in OAR 436-120-0830(1)(a) will be granted an initial certification period to coincide with their national certification.

      (b) Certified individuals must notify the division within 30 days of any changes in address and telephone number.

      (c) Individuals whose certification is denied under this rule may appeal as described in OAR 436-120-0008.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff.1-1-2010

436-120-0820 Renewal of Certification

(1) A certified individual must renew their certification every five years by submitting the following documentation to the director no later than 30 days prior to the end of their certification period:

      (a) Current certification by the Commission on Rehabilitation Counselor Certification (CRCC) or the Commission for Case Managers Certification (CCMC) or the Certification of Disability Management Specialists Commission (CDMSC) and six hours of training on the Oregon vocational assistance and reemployment assistance rules; or

      (b) Verification of a minimum of 60 hours of continuing education units under this rule within the five years prior to renewal.

      (a) At least eight hours must be for training in ethical practices in rehabilitation counseling.

      (B) At least six hours of training must be on the Oregon vocational assistance and reemployment assistance rules. Individuals already certified on the effective date of these rules will have no less than one year to complete this requirement.

      (2) The department will accept continuing education units for training approved by the CRCC, CCMC or the CDMSC; courses in or related to psychology, sociology, counseling, and
vocational rehabilitation, if given by an accredited institution of higher learning; training presented by the department pertaining to OAR 436-120, 436-105, and 436-110; and any continuing education program certified by the department for vocational rehabilitation providers. Sixty minutes of continuing education will count as one unit, except as noted in section (3) of this rule.

(3) In the case of college course work, the department 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.

(4) Failure to meet the requirements of this section will cause an individual's certification to expire. Such an individual may reapply for certification upon completion of the required 60 hours of continuing education.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010
Amended 9/15/10 as WCD Admin. Order 10-056, eff. 11/15/10

436-120-0830 Classification of Vocational Assistance Staff

Individuals providing vocational assistance will be classified as follows:

(1) Vocational Rehabilitation Counselor certification allows the individual to determine eligibility and provide vocational assistance services. Vocational Rehabilitation Counselor certification requires:

(a) Certification by the following national certifying organizations: Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC);

(b) A master's degree in vocational rehabilitation counseling and at least six months of direct experience;

(c) A master's degree in psychology, counseling, or a field related to vocational rehabilitation, and 12 months of direct experience; or

(d) A bachelor's or higher degree and 24 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree.

(2) Vocational Rehabilitation Intern certification allows an individual who does not meet the requirements for certification as a Vocational Rehabilitation Counselor the opportunity to gain direct experience. Vocational Rehabilitation Intern certification requires a master’s degree in psychology, counseling, or a field related to vocational rehabilitation; or a bachelor's degree and at least six hours of training on the Oregon vocational assistance and reemployment assistance rules. Thirty-six months of direct experience may substitute for a bachelor's degree. The Vocational Rehabilitation Intern certification is subject to the following conditions:

(a) The intern must be supervised by a certified Vocational Rehabilitation Counselor who must co-sign and assume responsibility for all the intern's eligibility determinations, return-to-work plans, vocational and billing reports.

(b) When the intern has met the experience requirements, the intern may apply for certification as a Vocational Rehabilitation Counselor.

(3) Return-to-Work Specialist certification allows the person to provide job search skills instruction, job development, return-to-work follow-up, labor market search, and to determine eligibility for vocational assistance, except where such determination requires a judgment as to whether the worker has a substantial handicap to employment. This certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, education, a human services related field, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-month basis. To conduct only labor market research/job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

(4) To meet the direct experience requirements for Vocational Rehabilitation Counselor, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (A) through (J) of this subsection for the required number of months, with at least six months of the experience in one or more of functions listed in paragraphs (A) through (D) of this subsection. The qualifying job functions are:

(A) Return-to-work plan development and implementation;

(B) Employment counseling;

(C) Job development;

(D) Early return-to-work assistance which must include working directly with workers and their employers;

(E) Vocational testing;

(F) Job search skills instruction;

(G) Job analysis;

(H) Transferable skills assessment or employability evaluations;

(I) Return-to-work plan review and approval; or

(J) Employee recruitment and selection for a wide variety of occupations.

(5) To meet the direct experience requirements for Vocational Rehabilitation Intern or Return-to-Work Specialist, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule for the required number of months.

(6) To receive credit for direct experience, the individual must:
(a) Perform one or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule at least 50 percent of the work time for each month of direct experience credit. Qualifying job functions performed in a job that is less than full time will be prorated. For purposes of this rule, full time will be 40 hours a week. An individual will not receive credit for any function performed less than 160 hours.

(b) Provide any documentation required by the director, including work samples. The director may also require verification by the individual’s past or present employers.

(7) All degrees must be from accredited institutions and documented by a copy of the transcript(s) with the application for certification.

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Stats. Implemented: ORS 656.340
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436-120-0840 Professional Standards for Registered Vocational Assistance Providers and Certified Individuals

(1) Registered vocational assistance providers and certified individuals must:

(a) Determine eligibility and provide assistance in an objective manner not subject to any conditions other than those prescribed in these rules;

(b) Fully inform the worker of the categories and kinds of vocational assistance under OAR 436-120 and reemployment assistance under OAR 436-110;

(c) Document all case activities in legible file notes or reports;

(d) Provide only vocationally relevant information about workers in written and oral reports;

(e) Recommend workers only for suitable employment;

(f) Fully inform the worker of the purpose and results of all testing and evaluations and

(g) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Registered vocational assistance providers and certified individuals must not:

(a) Provide evaluations or assistance if there is a conflict of interest or prejudice concerning the worker;

(b) Enter into any relationship with the worker to promote personal gain, or the gain of a person or organization in which the vocational assistance provider or certified individual has an interest;

(c) Engage in, or tolerate, sexual harassment of a worker. "Sexual harassment" means deliberate or repeated comments, gestures or physical contact of a sexual nature;

(d) Violate any applicable state or federal civil rights law;

(e) Commit fraud, misrepresent, or make a serious error or omission, in connection with an application for registration or certification;

(f) Commit fraud, misrepresent, or make a serious error or omission in connection with a report or return-to-work plan, or

the vocational assistance activities or responsibilities of a vocational assistance provider under OAR chapter 436;

(g) Engage in collusion to withhold information, or submit false or misleading information relevant to the determination of eligibility or provision of vocational assistance;

(h) Engage in collusion to violate these rules or other rules of the department, or any policies, guidelines or procedures issued by the director;

(i) Fail to comply with an order by the director to provide specific vocational assistance, except as provided in ORS 656.313; or

(j) Instruct any individual to make decisions or engage in behavior that is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.313, 656.340
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Audits, Penalties and Sanctions

(1) Insurers and employers at injury must fully participate in any department audit, periodic program review, investigation or review, and provide records and other information as requested.

(2) If the director finds the insurer or employer at injury failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:

(a) Reprimand by the director.

(b) Recovery of reimbursements.

(c) Denial of reimbursement requests.

(d) An insurer or employer may be assessed a civil penalty under ORS 656.745 for any violation of statutes, rules, or orders of the director.

(3) In determining the amount of a civil penalty to be assessed the director may consider:

(a) The degree of harm inflicted on the worker;

(b) Whether there have been previous violations or warnings; and

(c) Other matters as justice may require.

(4) Under ORS 656.447, the director may suspend or revoke an insurer's authority to issue worker’s compensation insurance policies upon determining that the insurer has failed to comply with these rules.

Stat. Auth.: ORS 656.340, 656.726(4)
Stats. Implemented: ORS 656.340, 656.447, 656.745(1) and (2)
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010

Sanctions of Registered Vocational Assistance Providers and Certified Individuals

(1) Vocational assistance providers and certified individuals must fully participate in any department audit, periodic program review, investigation or review, and provide records and other information as requested.

(2) If the director finds any registered vocational assistance provider or certified individual failed to comply with OAR 436-120, the director may impose one or more of the following sanctions:
(a) Reprimand by the director.

(b) Probation, in which the department systematically monitors the vocational assistance provider's or individual's compliance with OAR 436-120 for a specified length of time. Probation may include the requirement an individual receive supervision, or successfully complete specified training, personal counseling or drug or alcohol treatment.

(c) Suspension, which is the termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The vocational assistance provider or individual may reapply for registration or certification at the end of the suspension period. If granted, the vocational assistance provider or individual will be placed on probation as described in subsection (2)(b) of this rule.

(d) Revocation, which is a permanent termination of registration or certification to determine eligibility and provide vocational assistance to Oregon injured workers.

(3) The director will investigate violations of OAR 436-120 and may impose a sanction under these rules. Before issuing a suspension or revocation, the director will send a notice of the proposed action and provide the opportunity for a show-cause hearing. The process is as follows:

(a) The director will send by certified mail a written notice of intended suspension or revocation and the grounds for such action. The notice must advise of the right to participate in a show-cause hearing.

(b) The vocational assistance provider or individual has 10 days from the date of receipt of the notification of proposed action in which to request a show-cause hearing.

(c) If the vocational assistance provider or individual does not request a show-cause hearing, the proposed suspension or revocation will become final.

(d) If the vocational assistance provider or individual requests a show-cause hearing, the director will send a notification of the date, time and place of the hearing.

(e) After the show-cause hearing, the director will issue a final order which may be appealed as described in OAR 436-120-0008(3).

(4) For the purposes of section (3) “show-cause hearing” means an informal meeting with the director in which the vocational assistance provider or certified individual will be provided an opportunity to be heard and present evidence regarding any proposed actions by the director to suspend or revoke a vocational assistance provider or certified individual’s authority to provide vocational assistance services to injured workers.

(5) The director may bar a vocational assistance provider or individual who has received a suspension or revocation under this rule from sponsoring or teaching continuing education programs.

Stat. Auth.: ORS 656.340(9), 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: Amended 12-1-2009 as WCD Admin. Order 09-061, eff. 1-1-2010