

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

**PROPOSED OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120**

VOCATIONAL ASSISTANCE TO INJURED WORKERS

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PROPOSED CHANGES ARE MARKED

[Bracketed text is deleted]; **Bold/underlined text is added**

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services, Workers' Compensation Division		OAR CHAPTER 436	
Agency and Division		Administrative Rules Chapter Number	
Fred Bruyns		(503) 947- 7717 Fax (503) 947-7581	
Rules Coordinator		Telephone	
PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879			
Address			
		Room 260 (2 nd floor), Labor & Industries Building	
January 22, 2004	2:00 p.m..	350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

NOTE: The hearing will convene at 2:00 p.m. and end when all present who have indicated their intention to testify have been called to present testimony. Written testimony will be accepted until 5:00 p.m., January 27, 2004 (must be received by the Workers' Compensation Division).

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

RULEMAKING ACTION

ADOPT: 436-001-0300, 436-030-0023

AMEND: OAR chapter 436, divisions 001, 009, 010, 030, 060, and 120

REPEAL: OAR ~~436-001-0025~~, 436-001-0025, 436-001-0045, 436-001-0055, 436-001-0065, 436-001-0090, 436-001-105, 436-001-120, 436-001-0135, 436-001-0140, 436-001-0171, 436-001-0175, 436-001-0191, 436-001-0195, 436-001-0205, S436-001-0231, 436-001-0255, 436-001-0285, 436-001-0295, 436-010-0350, 436-030-0581, 436-060-0210, 436-120-0920

AMEND AND RENUMBER: OAR 436-030-0045 to 436-060-0018

ORS 656.726(4), 656.704
Stat. Auth.
ORS 183.335; OAR 137-001; OAR 436-001
Other Authority
ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)
Stats. Implemented

RULE SUMMARY

The agency proposes to amend these rules and replace temporary rules issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature:

- Senate Bill 233 changed the time frame for appeal of a proposed order or proposed assessment of civil penalty from 60 days following the party's receipt of notice to 60 days from the date the order is mailed by the department. Related proposed rule changes affect OAR 436-010, 436-030, and 436-120.
- Senate Bill 285 allows an insurer or self-insured employer to contest its Notice of Closure if it disagrees with the findings used to rate impairment, and OAR 436-030 has been revised accordingly.
- Senate Bill 620 requires payment of fees to workers' attorneys when a claimant prevails at the administrative level in certain medical and vocational disputes or when the attorney is instrumental in obtaining a settlement. This fee provision affects OAR 436-001, 436-009, 436-010, and 436-120.
- Senate Bill 914 eliminates the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim, and the director proposes to amend OAR 436-060 to require reporting within 14 days after acceptance or denial of the claim. Senate Bill 914 also clarified the statute regarding the department's obligation both to administer and pay supplemental disability benefits if the

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Notice of Proposed Rulemaking Hearing

insurer or self-insured employer chooses to have the department do so, and related amendments are proposed to OAR 436-060.

- House Bill 2305 addresses how medical records may be released, consistent with the federal Health Insurance Portability and Accountability Act, and related changes are proposed to OAR 436-010 and 436-060.
- House Bill 3669 gives additional authority to nurse practitioners to treat injured workers and authorize temporary disability payments. Amendments are proposed to OAR 436-009, 436-010, 436-030, 436-060, and 436-120 to reflect this change. This bill was a result of legislative action after development of the legislative concepts by nurse practitioners and the Management Labor Advisory Committee.

In addition, these proposed rules:

436-001

- Update the rulemaking notice rule.
- Update the contested case rules to establish consistency with the Attorney General's Model Rules of Procedure applicable to hearings before the Office of Administrative Hearings, OAR 137-003. Because the model rules control, duplicative or inconsistent rules are proposed to be repealed. Remaining supplementary rules are updated. Significant changes include filing of hearing requests; delegation of authority to the ALJ; clarifications regarding scope of review; admissibility of reproductions of originals; attorney fee matrix to implement SB 620 (2003); and a new process for alternative dispute resolution.

436-009

- Adopt updated medical fee schedules.
- Incorporate data reporting requirements currently published in Bulletin 220.
- Add Group number nine to the fee schedule of Medicare ambulatory service center groups.
- Require insurers and self-insured employers to keep track of dates of receipt of medical bills.
- Provide that if a provider's usual and customary fee is excessive compared to similar providers, the director may determine a reasonable fee based on the usual and customary fee of similar providers.
- Increase the dollar amount of each conversion factor by 2.33%, based on the annual increase in the physicians' component of the consumer price index.
- Require electronic billings to include a "zz" modifier.
- Modify the definitions of first and second level physical capacity evaluations and of work capacity evaluation.
- Provide that pharmacy fees shall be paid at 85% of the Average Wholesale Price (AWP) – a reduction from 95% in the current rules -- with a \$10 dispensing fee – an increase from \$6.70 in the current rules.
- Provide that a brand name drug that has a generic equivalent will be reimbursed at the lesser of 85% of the AWP for the brand name or 85% of the average AWP for a generically equivalent drug, plus dispensing fee, unless the prescribing medical provider writes "Do not substitute" or similar phrase on the prescription.
- Provide that reimbursement for Oxycontin, Vioxx, Celebrex and Neurontin is limited to an initial 5-day supply unless the prescriber writes a clinical justification for the drug.

436-010

- Provide that a dispute may be resolved by agreement between the parties, and that the director may then issue a letter of agreement in lieu of an administrative order.
- Allow reimbursement to medical service providers such as physical therapists even if a physician fails to sign the required treatment plan within 30 days of starting treatment.
- Require that, except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are compensable for a maximum supply of 10 days.
- Require insurers to forward requested medical information to new attending physicians or authorized nurse practitioners within 14 days of a request.
- Require that the insurer forward a copy of the insurer medical examination report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt of the report.
- Require that the insurer notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim.

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- Delete the provision that allows an insurer or the director to request an examination to determine the extent of impairment.

436-030

- Prescribe the conditions under which a Notice of Closure may be corrected or rescinded by the insurer or self-insured employer.
- Move rule 0045, “Disabling/Nondisabling Reporting Requirements and Change in Status Determinations” to OAR 436-060.
- Clarify criteria for determination and periodic review of permanent total disability; define “withdrawn from the workforce”; require that preexisting disability be included in redetermination of permanent total disability status.
- Reorganize procedural requirements for reconsideration of the notice of closure.
- Require that medical arbiter panel requests be received within ten working days of the start of the reconsideration.
- Prescribe the conditions for submission of surveillance videotapes.
- Provide for a medical arbiter deselection process; if the claim qualifies for the process, each party may eliminate one physician from the list of arbiters provided by the director.
- Repeal the rule prescribing how the director issues penalty orders.

436-060

- Revise the requirements and limitations for release of medical information by the insurer.
- Adopt rule 0018, “Nondisabling/Disabling Reclassification (amended and renumbered from 436-030-0045); Requires the insurer to reclassify a non-disabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in rule 0018; simplifies related notification requirements.
- Require that if permanent partial disability is paid monthly, it be paid at 4.35 times the weekly temporary disability rate.
- Require the insurer to send a lump-sum application (for payment of a permanent partial disability award) to the worker or his or her attorney within five business days of a request.
- Clarify actions required if the worker cooperates after the insurer has requested suspension of benefits or if the worker documents that the failure to cooperate was reasonable.
- Require that notices of claim acceptance be copied to the worker’s representative and attending physician.
- Require a claim denial notice to include one of three specific statements if the denial was based in whole or in part on an insurer medical examination.
- Require that if the insurer receives medical bills after claim denial, it send a copy of the denial to the medical provider and explain the status of the denial.
- Require the insurer to pay for a worker requested medical examination that the worker fails to attend, but not for a subsequent examination unless the worker failed to attend the first exam for reasons beyond the worker’s control.
- Require that if claim responsibility is at issue, insurers share claim information without charge.
- Provide time frames for monetary adjustments among insurers.
- Provide for civil penalties if an insurer intentionally or repeatedly fails to give notice as required by ORS 656.331 and OAR 436-060-0015.

436-120

- Require the insurer to notify the worker in writing, within 14 days of a request for vocational assistance when the insurer is not required to determine eligibility.
- Refer vocational professionals to the *Oregon Wage Information* (OWI) publication in lieu of the *Oregon Automated Reporting System (OARS) Job Order Wage Report*, both published by the Oregon Employment Department. The OARS publication will no longer provide job/wage data effective 4/1/04. When using the OWI wage information data, the presumed standard shall be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate.
- Eliminate the requirement that vocational counselors sign statements that their eligibility determinations were based on substantial handicap assessments.
- Specify the conditions under which training may be terminated for failure to attend.
- State additional circumstances that require vocational eligibility to be redetermined.

**Oregon Administrative Rules, Chapter 436
Notice of Proposed Rulemaking Hearing**

- Provide that for workers found to have an exceptional disability or exceptional loss of earning capacity, certain fee schedule spending limits are increased by 30%.
- Increase the direct worker purchase training category fee schedule maximum by 10% due to state-wide tuition increases.
- Provide that to conduct only labor market research and/or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

Request for public comment:

The agency requests public comment on whether other options should be considered for achieving the rules' substantive goals while reducing the negative economic impact of the rules on business.

Address questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us Proposed rules are available on the Workers' Compensation Division's Web site: <http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules> or from WCD Publications at 503-947-7627 or fax 503-947-7630.

January 27, 2004
5 p.m.

Last Day for Public Comment

/s/ John L. Shilts December 15, 2003

Authorized Signer and Date

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

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

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

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

OAR CHAPTER 436
Administrative Rules Chapter Number

In the Matter of

The Amendment of:

OAR 436-001, Procedural Rules Governing Rulemaking and Hearings) Statutory Authority,
OAR 436-009, Oregon Medical Fee and Payment Rules) Statutes Implemented,
OAR 436-010, Medical Services) Statement of Need,
OAR 436-030, Claims Evaluation, Determination, and Reconsideration) Principal Documents Relied Upon,
OAR 436-060, Claims Administration) Statement of Fiscal Impact
OAR 436-120, Vocational Assistance to Injured Workers)
)

Statutory Authority: ORS 656.704, 656.726(4)

Other Authority: ORS 183.335; OAR 137-001; OAR 436-001

Statutes Implemented: ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)

Need for the Rule(s):

Rule revisions are needed to make permanent the changes implemented by temporary rules effective 1/1/04. The temporary rules were issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669. In addition, rule revisions are needed to effectively carry out existing workers' compensation laws: These changes were discussed with advisory committees comprised of people and organizations affected by the rules, and a number of the changes were made at the request of these committees, as well as other customers and stakeholders. Specific substantive changes are listed on the Notice of Proposed Rulemaking Hearing. A number of "housekeeping" changes are proposed. In general, substantive revisions are needed to:

- Carry out the director's duties to publish and update medical fee schedules under ORS 656.248.
- Establish time frames for certain actions required by statutes and rules.
- Require more thorough notification of medical providers and the injured worker regarding decisions and actions affecting the claim.
- Provide for a medical arbiter deselection process in reconsideration proceedings.
- Provide an alternative source of labor market information to be used in determining eligibility for vocational assistance.

Documents Relied Upon: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669; fiscal impact statement forms for SB 285, 620, and 914; advisory committee meeting minutes and audio tapes; issues documents, and medical cost analyses. These documents will be available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7810.

Fiscal and Economic Impact:

SB 233 and HB 2305, in so far as they affect these rules, should have no fiscal impact on any party.

SB 285 is expected to increase the number of reconsideration requests by about 4%, based on historical data. Most of these requests will include a medical arbiter examination. However, a downward trend in reconsideration requests means the net effect will be approximately a 1.7% increase, which will be absorbed by existing division resources. The fiscal impact on insurers and self-insured employers cannot be determined at this time, but may be slightly positive, since appeal will generally only be made if a party thinks it is in the party's financial interest to do so.

Oregon Administrative Rules, Chapter 436
Statement of Need and Fiscal Impact

SB 620-related rule changes will have a fiscal impact on insurers and self-insured employers, estimated to be \$500,000 to \$700,000 annually. Currently, the Workers' Compensation Division receives approximately 1,000 disputes (administrative reviews) per year. Workers prevail in nearly 50% of these, for which we estimate a \$1,000 attorney fee per case. There is a potential for fees to slightly increase the number of disputes. These dollars will flow to Oregon attorneys, the majority of whom are self-employed or employed by small businesses. The overall cost increase to the workers' compensation system would be about 0.1 to 0.2%.

SB 914-related rule changes should result in savings for insurers, self-insured employers, and the Workers' Compensation Division. Elimination of the reporting of "deferred" claims will reduce the number of documents that must be completed and filed. However, the extent of savings cannot be quantified at this time.

HB 3669 increased the authority of nurse practitioners to provide medical services and authorize temporary disability. This change should positively impact nurse practitioners. Medical payments to nurse practitioners will therefore not go to medical providers who can be attending physicians under Oregon law. We do not know how many workers will choose to treat with nurse practitioners, but we estimate any impact on other provider types will be small, and there should be no fiscal impact to the workers' compensation system as a whole.

The proposed 2.33% increase to the medical conversion factors would increase overall medical payments by between 1.0 and 1.2%. Based on actuarial analysis, expected reductions in other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates.

The proposed change in the pharmacy reimbursement formula and increased dispensing fee is projected to reduce insurers' and self-insured employers' pharmacy costs by at least 6%. Pharmacies, wholesalers, and manufacturers would therefore have decreased revenues equal to insurers' savings.

The proposed incentive to dispense generic drugs should reduce insurers' and self-insurers' costs slightly. Use of generics is already quite common, so savings for insurers and reduced revenues to brand-name manufacturers is expected to be minor.

The proposal to limit Oxycontin, Vioxx, Celebrex and Neurontin to an initial 5-day supply unless the physician provides a clinical justification is expected to reduce costs for insurers and self-insured employers. While these drugs represent approximately 13% of total prescriptions, they account for about 34% of total prescription payments. We do not know how many physicians will write clinical justifications or prescribe a suitable alternative medication. This change would result in reduced revenues for the manufacturers of these brand-name drugs.

The proposed requirements to notify medical providers of certain actions taken regarding claims would slightly increase insurers' and self-insured employers' administrative costs. However, during advisory meetings, insurer representatives told us that certain notifications are already common practice.

The increase in the direct worker purchase training category fee schedule maximum by 10% is estimated to cost insurers and self-insured employers an additional \$250,000 to \$375,000 annually. The change is proposed because tuition costs have risen sharply, e.g. community college costs rose 12% in the past year. The 30% increase allowed for workers with exceptional disabilities is expected to have a minor effect on costs because very few workers meet the criteria for exceptional disability.

Additional changes to these rules are expected to have no significant fiscal impact on any party.

Administrative Rule Advisory Committee consulted: Yes

October 16, 2003, November 3, 2003, November 17, 2003, November 18, 2003, November 21, 2003

/s/ John L. Shilts

December 15, 2003

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of Oregon Administrative Rules, chapter 436, divisions:)	
001, Procedural Rules Governing Rulemaking and Hearings)	
009, Oregon Medical Fee and Payment Rules)	SUMMARY OF
010, Medical Services)	TESTIMONY AND
030, Claim Closure and Reconsideration)	AGENCY RESPONSES
060, Claims Administration)	
120, Vocational Assistance to Injured Workers)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to provide the Director with a record of the agency conclusions about the major issues raised.

The amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated January 1, 2004. On January 22, 2004 a public rulemaking hearing was held as announced at 2:00 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, Rules Coordinator, acted as presiding officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through 5:00 p.m. January 27, 2004.

The following individuals gave oral testimony on these rules at the public hearing:

Subject Division	Testimony received from:
009	Dave Dery, P.T., Work Injury Management Association of Oregon
009	Mark Healy, O.T., Work Injury Management Association of Oregon
009	Cathy Zarosinski, Oregon Physical Therapy Association
009	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	Colleen Guido, Department of Consumer and Business Services, Workers’ Compensation Division
060	Jennifer Flood, Department of Consumer and Business Services, Workers’ Compensation Division

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

The following written testimony was received:

Subject Division	Exhibit #	Testimony received from:
NA	1	Testimony withdrawn at request of submitter
010	2	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009 & 010	3	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009	4	David Silver, M.D.
030	5	Rodger M. Hepburn, Attorney, Reinisch Mackenzie Healey Wilson & Clark, PC
009	6	Karen Elton-Walz, PT, MA, OCS, COMT, Therapeutic Associates; Central Oregon Physical Therapy
060	7	Jennifer Flood, Department of Consumer and Business Services, Workers' Compensation Division
060	8	Bradford A. Vinson, Attorney, Starr & Vinson, P.C.
009	9	Colleen Guido, Department of Consumer and Business Services, Workers' Compensation Division
009	10	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	11	Dave Dery, P.T., and Mark Healy, O.T., Work Injury Management Association of Oregon
009	12	Michael Casey, M.D.
120	13	Nyla L. Jebousek, Attorney
120	14	Robert J. Malone, CPDM, Vocational Unit Supervisor, Liberty Northwest Insurance
009, 010, 030, 060	15	Linda Jefferson, Oregon Self-Insurers Association
010	16	Nancy Bieber, Department of Consumer and Business Services, Information Management Division

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

009	17	Kevin C. Tribout, PMSI
009	18	Perry Lewis, Third Party Solutions
009	19	Tom Holt, Executive Director, Oregon State Pharmacists Association
001	20	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
030	21	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
060	22	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
120	23	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
009 & 010	24	Linda Olsen, Medical Audit Review Manager, SAIF Corporation
010	25	Morris D. Haney, DPDM, Operations Manager, WMCI Prime Evaluations
009	26	Gene Ogrod, M.D., CEO, Oregon Medical Association

The following is a summary of the testimony received and the agency’s responses to that testimony. If oral and written testimony were submitted by the same party, summarized oral testimony is listed separately only if and to the extent it differs from written testimony.

OAR 436-001-0155(1)

Testimony: Exhibit # 20

The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers’ Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): “. . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law.”

Response: We agree. Under ORS 656.726(4)(a), “Mailing date” determines timeliness.

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

OAR 436-001-0240(8)

Testimony: Exhibit # 20

Section (8) of this rule is superfluous. Although this matches the Workers' Compensation Board's requirements affecting document reproductions, it serves no purpose for the Workers' Compensation Division. At the board, all documents are submitted as a group. At the division, the insurer submits most documents as part of the initial review. This rule would require certification of the few additional documents submitted at hearing, and there is no reason for the distinction.

Response: We agree that this proposed requirement is unnecessary. The Workers' Compensation Division has not experienced problems with document reproductions. Section (8) will not be included in the permanent rule.

OAR 436-001-0265(2)

Testimony: Exhibit # 20

Two additional factors should be considered in determining attorney fees:

- ‘“Attorney time devoted” shall be limited to those hours that a reasonable attorney, well-trained in workers' compensation law, would expend on the matter at issue.’
- ‘Proof of “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.’

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of “extraordinary circumstances” the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of \$10,000.

OAR 436-009-0004

Testimony: (Exhibit #3)

Widely used medical fee schedules take effect January 1st of each year. Medical providers and health insurers generally begin using them for services provided after that date. The Workers' Compensation Division has to adopt fee schedules via rule-making, and updated schedules become effective April 1st, causing a “gap” during which insurers and providers still use the “old” schedules only for injured workers. We propose that rule 0004 be permissive, allowing providers to bill and insurers to pay, using current codes and schedules. This change will not have an effect until January 1, 2004, and any administrative or data collection issues can be addressed prior to that time.

**Oregon Administrative Rules, Chapter 436
Summary of Public Testimony & Agency Responses**

Response: We agree this is a good idea, but believe there are logistical problems that we need to address before this can be done. By making it permissive, there can be disagreement about which codes to use, giving rise potentially to more disputes. In the event of a dispute, which set of standards apply? This is an issue we would like to explore with external advisors at more length prior to the next rule revisions, and leave as is for now.

OAR 436-009-0008

Testimony: (Exhibit #3)

We support the incorporation of the provisions of Senate Bill 620 (Ch. 756, OL2003) and approach for calculating appropriate attorney fees. However, the proposed revisions fail to include attorney fees for represented medical providers who prevail in a medical treatment or fee dispute with an insurer. Section 2 of SB 620 amends ORS 656.385(1) to allow the award of attorney fees to a claimant who prevails, not just a worker. If the Legislature had intended to limit attorney fees to a worker's attorney, it would use the word "worker," as it did elsewhere in the bill. The injured worker benefits if a represented medical provider prevails in a medical dispute; e.g. if a medical provider doesn't challenge an insurer's denial of palliative care (even though it is appropriate and the provider would prevail in a dispute), OAR 436-009-0015(1)(c) allows the provider to bill the worker.

Response: ORS 656.385, as revised by SB 620 refers solely to attorney fees paid to the claimant or the claimant's attorney. We believe the reference uses "claimant" to mean the injured worker. We do not believe the intent was to provide insurer-paid attorney fees to medical providers.

OAR 436-009-0008(1)(b), (2)(a), (2)(b), & (5)

Testimony: Exhibit # 24

All language regarding attorney fees associated with medical billing disputes must be stricken from the Division 009 rules. Senate Bill 620 does not provide authority to award attorney fees when medical fees are the subject in dispute. Division 009 is promulgated under the authority of ORS 656.248, and SB 620 does not refer to ORS 656.248, but only to ORS 656.245, 260, 327, and .340.

Response: We agree and will delete all references to attorney fees from this rule.

OAR 436-009-0008(2)(a)

Testimony: Exhibit #24

Proposed subsection (2)(a) states: "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." We do not send fee disputes to MCOs even if they have a dispute resolution process in place. It is our understanding that MCOs do not want to become involved in fee disputes. Providers and workers are already informed of their appeal rights with the director through the explanation of benefits they receive with payment. The proposed language should be deleted as it adds a layer of bureaucracy to a process that already works well.

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Response: This concept is not new, but moved from (1)(c) of this rule and simplified. The purpose of the rule is to clarify the process that is current practice. While in general the rules require a party to first go through the MCO process, that is not a reasonable requirement if there is no MCO process. Other timelines and procedures then apply. If an insurer is notifying parties with the bill of their entitlement to appeal to the director, that already complies with the new rule, and does not add a layer of bureaucracy.

OAR 436-009-0008(4)(c)(A), (B), & (C)

Testimony: Exhibit #24

We appreciate the department's acknowledgement of the need to allow medical providers and insurers to resolve disputes without going through the formal dispute process. However, the rule states the director may revise the final agreement or reinstate the review under certain conditions. All issues should be addressed before the agreement becomes final. If the department's concern is that workers may not truly understand the process, limit the use of agreements to include insurers, providers, and workers who are represented. A final agreement is just that, final.

Response: We believe that the short list of conditions listed would require a reinstatement of the review except the provision that allows reinstatement if all parties agree. We believe that if all parties agree, the director should allow it. The others allow reinstatement if one or both parties fails to honor the agreement, the agreement becomes infeasible or it was based on a misrepresentation.

OAR 436-009-0010(3)(a)

Testimony: Exhibit #10

The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend this subsection accordingly. Also, delete the language that requests the provider's social security number and instead refer to the option of providing a federal tax reporting identification number.

Response: We will make this change.

OAR 436-009-0010(7)

Testimony: Exhibit #24

We recommend deletion of the second sentence of this section, that states in part that mere submission of the bill by the provider shall serve as warrant that the fee submitted is the provider's usual fee for the services provided. Inconsistent billing patterns may indicate unintentional mistakes or possibly fraud. The language of this rule would make a lack of knowledge defense by the provider difficult to make, when that may in fact be the case. If the department is concerned that insurers will not pay bills because they believe they don't represent the provider's usual fees, there is already a dispute process in place to address that concern. If the department is concerned insurers may misuse this rule, again, there is a process in place that can also result in penalties to insurers.

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Response: We believe it is appropriate to expect medical providers to “warrant” that their bill is their usual and customary fee, and have had no complaints from medical providers that this is a potential problem for them.

OAR 436-009-0020(3)(b)(C) & (3)(j)

Testimony: Exhibit #24

This rule requires payment in full to out of state hospitals, and the wording of the rule even inhibits an insurer’s ability to reimburse at the rate of that state. Out of state providers will not negotiate a lower fee when they know they must be reimbursed in full by the insurer. The rule should either be eliminated entirely or revised to say services will be paid as negotiated. If the concern is that the worker should not be billed for balances not paid by Oregon insurers, the rule should require a clause in the agreement stating that the worker will not be billed for the remaining balance for compensable services related to the workers’ compensation claim.

Response: We are concerned about workers being burdened with balance billing if insurers are able to negotiate a lower price with the hospital, but also are concerned about making it difficult for insurers to control costs. This is a complex issue, and we will keep it on the issues document for the next rule revision process.

OAR 436-009-0030 Appendix A language:

Testimony: Exhibit #10

The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend the Appendix accordingly. Delete references to the provider’s social security number and instead refer to the federal tax reporting identification number. See the testimony regarding OAR 436-009-0010(3)(a) for this exhibit number.

Response: We will make this change.

OAR 436-009-0030(9)(b)(B)

Testimony: Exhibit #24

The last sentence should end “ICD-9-CM diagnostic code” rather than procedure code.

Response: We will make this change.

OAR 436-009-0030(9)(d)

Testimony: Exhibit #10

Revise the following sentence as shown: ~~Only~~ Insurers transmitting data for more than one insurer may batch multiple insurer data files in one file transmission. . . “

Response: We will make this change.

OAR 436-009-0040(3)

Testimony: (Exhibit #3)

We support the revision to allow an insurer to dispute (under OAR 436-009-0008) a provider's "usual and customary" fee as being unreasonably high; however, if the provider prevails, he or she should be able to recover reasonable attorney fees.

Response: Based on past experience, we believe there will be few cases where the provider's usual and customary fee is found to be unreasonably high. Most fees are governed by the fee schedule, and this only applies for the relatively rare cases of "pay as billed," and the insurer believes the provider's charges are unreasonable compared to the industry as a whole. We do not believe the current statute has a provision for an award of attorney fees to medical providers.

OAR 436-009-0040(4)

Testimony: Exhibit #24

We are still concerned about the impact of much higher workers' compensation conversion factors, when compared to healthcare factors, on employer medical and insurance costs. The consumer price index (CPI) relates to what consumers pay, not to what it costs to provide services. It appears you want to automatically apply the medical component of the CPI to the fee schedule each year. The statute requires more rigorous review prior to adjusting fees than to merely apply the CPI automatically without hearing or due process. Consider alternatives to the CPI; at least it should not be the sole determinant to changing the fee schedule each year.

The annualized average rate of increase in the CPI over the last 56 years is 5.3%. Since 1990 it is 3.9%. In only four of the last 56 years has the increase been less than the current 2.3%. Between 65% and 72% of medical dollars paid are subject to the conversion factors. We estimate the 2.3% increase will increase our medical costs by \$1.6 million dollars. If over the next four years the rate increase is at the average since 1990 (3.9%), at the end of 5 years, just due to the increase in the conversion factors, we will have an increase of \$13.45 per year.

The department's fiscal impact statement said other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates. Our calculations don't come close to offsetting payment of an additional \$1.6 million. The 6%+ savings projected based on proposed pharmacy changes appear to be based on the assumption that we reimburse pharmacies at the current rate of AWP minus 5% plus a \$6.70 dispensing fee. The assumption is incorrect. SAIF and the other major workers' compensation carrier in Oregon use a Pharmacy Benefits Manager (PBM), and the rates we have negotiated with our pharmacies through the PBM are much more in line with the proposed reimbursement rates than the current rates.

Response: By this current rule revision, we are simply increasing the conversion factor for this year only, for the first time in several years. Each year we will consider an adjustment based on an array of relevant factors. We do believe the increase will be offset by other cost drivers.

OAR 436-009-0040(4)

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Testimony: (Exhibit #3)

We support the 2.33% increase in the conversion factors.

Response: We will include this provision in the permanent rules.

OAR 436-009-0070(2) & (3)

Testimony: Exhibit #9

“. . . by the attending physician” and “attending physician’s” were inadvertently deleted in the proposed rules. The deleted wording should be reinserted, as well as “or authorized nurse practitioner,” and thus make the wording match the temporary rule.

Response: We agree and will make the appropriate revisions.

OAR 436-009-0070(4) and (12)

Testimony: Exhibit # 6

See amended testimony submitted as Exhibit #11.

Response: NA

OAR 436-009-0070(4)(a) & (b)

Testimony: Exhibit #24

This rule should make it clear that additional time components should be billed only when multiple or additional body parts are reviewed. Some providers are confused on this issue.

Response: We agree, but believe the proposed language makes this clear.

OAR 436-009-0070(4)(a)

Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] **“This [first level PCE] is a limited evaluation to measure the musculoskeletal components of a specific body part as required for claim closure which are: AROM, motor power using 5/5, and 2 point discrimination.”**

Response: The proposed rules incorporate these recommended changes, and the changes will be included in the permanent rules.

OAR 436-009-0070(4)(b)

Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski

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The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “Additional 15 minute increments (~~per additional body part~~) may be necessary to establish endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion) **may be necessary to measure additional body parts, and/or establish endurance, and/or to project tolerances.**”

Response: This change was incorporated in the proposed rule and will be incorporated in the permanent rule.

OAR 436-009-0070(4)(c) & (d)

Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “**This [work capacity evaluation] is a PCE . . . with special emphasis on 1) the ability to perform essential physical function of the job, based on a specific job analysis as related to the accepted condition, 2) the ability to sustain activity over time and 3) the reliability of the evaluation findings. Other general evaluation information . . . may be included in accordance with requirements for claim closure. This level requires not less than 4 hours of actual claimant contact** [current rule wording requires not less than 6 hours]. **A record review is required before the evaluation begins.**”

Delete subsection (4)(d).

Response: Most of the concepts in this suggestion were incorporated in the proposed rules and will be incorporated in the permanent rules.

OAR 436-009-0070(12)

Testimony: Exhibit #9

The division inadvertently deleted “attending physician” from the table in this section (next to N0001/brief narrative). The deleted wording should be reinserted, as well as “or authorized nurse practitioner.” To be consistent, add to “complex narrative” (Code N0002), “by the attending physician or authorized nurse practitioner.”

Response: We will make the change.

OAR 436-009-0070(12)

Testimony: Exhibit #11

We propose a price increase for physical capacity evaluations (PCEs). Clinics routinely have labor expenses above and beyond the identified evaluation contact time: 10 to 30 minutes authorization process, 15 minutes clerical support, 15-30 minutes of record review by therapist(s), 15-30 minutes of report time by therapist(s), and 15-30 minutes for clerical support to transcribe and mail the report. Under the current fee schedule, therapists perform PCEs for

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less money than a standard procedure when breaking it down into 15-minute billable units. We request the following fee increases:

Code 99196	First Level PCE	Increase Relative Value to 2.77
Code 99197	Second Level PCE	Increase Relative Value to 5.54
Code 99193	Additional 15 minutes	Increase Relative Value to 0.94

Response: The relative value units for these services were developed by a broad group of stakeholders, and reimbursement for these procedures will be increased by the across-the-board increase in the conversion factors. Any specific change to the relative value units or a particular conversion factor would need to be developed through a thorough interchange between various stakeholders.

OAR 436-009-0090

Testimony: Exhibit #4

Regarding the proposal to limit reimbursement for four drugs – Oxycontin, Vioxx, Celebrex, and Neurontin – to an initial 5-day supply unless the physician writes a clinical justification, this will create more paperwork for providers – in contrast to the goals of the Paperwork Reduction Taskforce, which was formed by the Workers’ Compensation Division a few years ago, in recognition of providers’ paperwork burdens.

“Clinical justification” is not defined. Who reviews it, the claims examiner? IMEs or file reviews about whether a patient should take a prescribed drug or a less expensive drug will result in more paperwork and expense to “justify the justification.”

Only changes in U.S. law can slow the increases in drug prices – pressuring providers to use less desirable drugs is not the answer. The four drugs listed represent improvements over alternatives in many situations. Before Neurontin was available, physicians prescribed carbamazepine, which can cause bone marrow failure, and now use of carbamazepine requires a complete baseline blood screening test and follow-up white blood counts. Celebrex and Vioxx are superior to alternatives in pre-operative patients, as they do not interfere with the effect of platelets on blood clotting. If we keep the list, Bextra, another cox-inhibitor, should be added to the list or it will likely be prescribed in place of Vioxx and Celebrex at no savings to the system (from addendum to Exhibit 4). The cost of Oxycontin is exorbitant. Its value is that it need only be taken twice per day. Some alternatives are less easily controlled, such as methadone, though long acting forms of morphine may be less expensive. It would be useful to provide cost information to providers.

I recommend that the Department consider creating a program that would address the problem of drug costs that relies on clinical studies of comparative effectiveness of drugs and the education of practitioners. I suggest a Pharmacy Review Program, in which the cost and usage information from insurers is shared with a group of physicians, pharmacists, and workers. Publish cost summaries of frequently prescribed medications, along with the costs and suggested dose schedules for alternatives. I respectfully request that this rule not be enacted, and that a program which shares information about drug costs and alternatives be created.

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See response to testimony below.

Testimony: Exhibit #12

The division does have an obligation to be concerned about the cost of medications. However, the proposed rule making reimbursement for (more than a five-day supply of) Oxycontin, Vioxx, Celebrex, and Neurontin contingent on the physician's clinical justification, implies that, unless there is a watchdog, physicians routinely prescribe medications that are not "clinically indicated." The only thing these drugs have in common is their cost. It would be more honest to use the term "unless economically indicated."

See response to testimony below.

Testimony: Exhibit #15

The proposed rule does not reflect the consensus of the Pharmacy Fee Advisory Task Force. The minutes from the final meeting show the group favored a dispensing fee somewhere between \$6.70 and \$8.70. Also, the meeting summary noted general support for limiting certain brand name, cost-driver medications to a three business day supply on the initial prescription, unless clinical justification is provided. We recommend in section (1): an \$8.70 dispensing fee; in section (2), a limit of a three-day supply of the named drugs (or a clinical justification) with the qualification "on the initial prescription," and, also in section (2), insertion of the word "generic" as follows: ". . . clinical justification for prescribing that drug [Oxycontin, Vioxx, Celebrex, or Neurontin] rather than a less costly generic drug with a similar therapeutic effect.

See response to testimony below.

Testimony: Exhibit #17

We oppose the reduction in the pharmacy reimbursement rate. We feel that the division did not examine the financial impact on the pharmacy provider who may be forced to fill prescriptions at a reimbursement rate below the provider's cost, or the cost savings role proper pharmacy care can provide, in the form of early return to work and fewer surgeries. Finally, we feel the division failed to fully examine the most detrimental impact, reduced worker access to quality pharmacy care, because workers' compensation pharmacy is purely voluntary for the pharmacy provider.

Workers' compensation pharmacy claims require more of a pharmacist's professional time and carry far greater risks than State Medicaid or Group Health prescriptions. In fact, most states today provide a higher reimbursement rate for workers' compensation prescriptions than are paid through Medicaid or Group Health.

Our data shows that once a drug or drug ingredient exceeds \$33, the pharmacy begins to lose money on each prescription. Regardless of the proposed increase in the dispensing fee, the reduced reimbursement for the drug ingredient cost will cause pharmacists to lose money on many workers' compensation prescriptions. Pharmacy providers will be unwilling to lose money on high priced prescriptions and begin to withdraw from serving injured workers. California provides an example for Oregon. Effective 1/1/04, reimbursement for workers' compensation prescriptions was reduced to the MediCal rate (AWP – 10%). Several large pharmacy chains have stated that they no longer fill workers' compensation prescriptions. A recent study by the

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California Pharmacy Association Educational Foundation found that 65 percent of its members said that they would no longer fill workers' compensation prescriptions at the MediCal rate. Oregon has proposed an even more drastic cut that would cause greater access issues for Oregon. An NCCI October 2003 study found reducing fee schedule reimbursements to dangerously low levels would cause pharmacy access issues for injured workers.

Oregon already has one of the lowest reimbursement rates to pharmacists. Reducing reimbursement to the pharmacy does not control the underlying problem: the rising costs of prescription drugs. We suggest that the division look to other health care models and engage in practices that will help control the root problem of rising drug prices by: 1. Creating tighter controls on physician prescribing patterns, 2. Utilizing step therapy programs at the physician and pharmacist level, and 3. Creating non-restrictive formularies or preauthorization controls.

Our data show that nearly 57% of Oregon workers' compensation pharmacy transactions are already generic. This number is very close to what Group Health or State Medicaid programs can achieve with generic mandates, so the intent of the proposed rule to drive more generic utilization will not reduce system costs. Further, our data shows that 83% of brand drug fills have no generic substitute. Pharmacy providers will lose money on nearly all of these transactions because the proposed reimbursement level is below pharmacies' cost of doing business.

We request that the division rescind the proposed rule and that the division postpone any final decision on the proposed rule until more testimony and input from pharmacy providers and other stakeholders can be provided.

See response to testimony below.

Testimony: Exhibit #18

Within our program, generics average around 60% or above of prescriptions dispensed. We expect little increase in generic volume, as the percentages are already relatively high. If proposed rates are implemented, brand fills with no generic available will be dispensed at under cost. We recommend either leaving current reimbursement levels for brand drugs as is, or if need be AWP minus 10% + \$10.00. Consider payment for generics at a higher level to support their use. We suggest an AWP plus option: AWP + 5% plus \$8.50.

Regarding limitations affecting Oxycontin, Vioxx, Celebrex, and Neurontin, the rules need to address if the justification covers just the initial fill or multiple refills. If repeat justifications are needed, who is responsible to obtain or provide them, the patient, pharmacist, doctor? Any delay in obtaining pain medication needs to be avoided if at all possible.

Within current rules payment will be based upon the lower of either the provider's usual and customary charge or the fee established by this rule. This provision gives the director authority to determine if a submitted U&C is excessive when compared to other providers. This provision is ambiguous and provides interpretation on a case-by-case basis as to what is reasonable for payment if not paid at established rates. In many states disputes have arisen over what constitutes usual & customary. We recommend deletion of the reference to usual & customary and make the

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rule reflect a true fee based system. Proposed amended language: “Payment will be ~~the lower of either the provider’s usual and customary charge or the~~ **fee established by this rule.**”

See response to testimony below.

Testimony: Exhibit #19

We participated in the Workers’ Compensation Pharmacy Fee Advisory Task force, and the proposed rule appears to be consistent with the recommendations of the Task Force. By increasing the dispensing fee to a level that more appropriately reflects pharmacy dispensing costs, lowering the AWP rate, and requiring clinical justification for the use of certain drugs, the proposed rule provides appropriate incentives for pharmacists and pharmacies to encourage use of *cost-effective* drug therapies. We recommend you clarify the clinical justification process such that once submitted, the justification carries over to any refills authorized the prescribing practitioner.

See response to testimony below.

OAR 436-009-0090(1)

Testimony: Exhibit #24

The Pharmacy Fee Advisory Taskforce made its final recommendation to the Department of Consumer and Business Services to modify the rules as follows: 1) If a brand medication has a generic equivalent, the pharmacist will dispense the generic; 2) If a brand drug has a therapeutic equivalent, the pharmacist would contact the physician to see if the therapeutic substitution could be made, and that a higher dispensing fee -- \$10.00 – would be appropriate in these instances, but not across the board; all other fills and refills of the therapeutic equivalent should remain at \$6.70; and 3) See OAR 436-010-0230(6) for Exhibit #24.

See response to testimony below.

OAR 436-009-0090

Testimony: Exhibit #26

Regarding the proposal to limit reimbursement of OxyContin, Vioxx, Celebrex, and Neurontin to an initial five-day supply unless the medical provider writes a “clinical justification” for the drug: The Oregon Medical Association (OMA) recently polled a sample of its members who treat workers’ compensation patients. The results suggest that adoption of the proposed rule would discourage physicians from seeing workers’ compensation patients and that it would affect patients’ access to timely care.

“Clinical justification” is not defined in the proposed rules, and the absence of clear definition will erect paperwork barriers, adding unnecessary costs and jeopardizing timely access to care. What criteria will be used to determine what is clinically justified and what is not? Will a physician need to repeat the justification every time he or she writes a script for the same patient?

These drugs are not first line drugs, so other drugs will have been tried first. What is the need for requiring additional documentation? The prescription itself should stand as “clinical

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justification” by the prescribing physician. The OMA would be interested in exploring other possibilities, such as the Pharmacy Review Program, which was recommended by Dr. David Silver. We request that the proposed rules not be implemented and that other alternatives be discussed.

Response: Revamping the pharmacy fee schedule has indeed required a careful balance between many competing forces. Last year, WCD convened a Pharmacy Fee Advisory Task Force which met four times over several months to review concerns and make recommendations about pharmacy fees. The recommendations were then reviewed by the medical rules External Advisory Committee and the Medical Advisory Committee. Finally, we received a great deal of public comment, much of it directly in contrast to other comment. Some comments have contended the dispensing fee is higher than recommended by the Pharmacy Task Force. Others have expressed concern that the reduction in the percentage of AWP will drive many pharmacies from participation in workers’ compensation. We note that the Oregon system already tended to have a lower percentage of AWP than other states’ workers’ compensation schedules, but also higher dispensing fees. We believe this combination favors and encourages dispensing lower cost alternatives wherever allowable. We have made some adjustments to the rule based on the public comment. We have increased the percentage of AWP from 85% to 88%, while decreasing the dispensing fee from \$10 per prescription filled to \$8.70 per prescription filled. This will create a somewhat smaller impact on payment to pharmacies. For the less expensive drugs, the new payment will be a little lower than proposed. For example, a drug with an AWP of \$20.00 will be paid at \$26.30 instead of \$27.00. Under the current schedule, it would be paid at \$25.70. Higher cost drugs will be cut less than under the proposed rules. For example, a drug with an AWP of \$100 will be paid at \$96.70 instead of \$95.00. Under current rules, it would be paid at \$101.70. These changes will still provide incentive to dispense lower cost drugs over higher cost drugs.

Another change made as the result of the testimony received was to eliminate Neurontin from the list of drugs requiring clinical justification. Unlike the other drugs on the list, this drug was not part of the studies completed by the Oregon Health Plan, and is not covered by the Oregon Health Plan drug formularies. We added Bextra to the list because it is another cox inhibitor like Celebrex and Vioxx which are on the list. We are also sensitive to the concerns raised by the OMA and medical providers. We not only clarified the language to make it clear that the clinical justification need only be a simple statement explaining why the prescribed drug is the best drug for this patient, but also that the justification is not subject to review and approval by the insurer. The intent, as expressed by the Pharmacy Fee Task Force, is to create a “pause” to let the doctor consider if a therapeutically similar, less expensive drug might be as effective in treating the patient. Oxycontin alone accounts for over 10% of every dollar spent for drugs in Oregon’s workers’ compensation system, and over 1/5th of every dollar is spent on Oxycontin and the cox inhibitors. It was suggested that rather than create this paperwork “hassle,” WCD appoint an advisory council to advise medical providers on the options to prescribing the identified “cost-driver” drugs. We will look into that as an alternative with the OMA and the workers’ compensation Medical Advisory Committee during the upcoming year.

OAR 436-010-0008

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Testimony: Exhibit #3

See recommendations regarding OAR 436-009-0008 for Exhibit #3.

OAR 436-010-0008(13)

Testimony: Exhibit #24

“Professional Hours Devoted” should contain the statement about the hours that a reasonable attorney, well trained in workers’ compensation law, would expend on the matter at issue. The rule should also provide that “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix. The attorney fee provisions in Senate Bill 620 do not include ORS 656.247 or 656.248 and therefore do not apply to medical fee disputes.

Response: It was the intent in creating and adopting a matrix system to keep the attorney fee procedure as simple and non-contentious as possible. We believe that qualifiers such as these suggestions will complicate rather than simplify the process and give rise to more disputes.

OAR 436-010-0210(7)

Testimony: Exhibit #24

Nurse practitioners should be required to complete a self-test on the key elements of workers’ compensation law and their responsibilities to treat Oregon injured workers, a concept supported at a recent Nurse Practitioner sub-committee meeting.

Response: A voluntary self-test is included in the packet of materials provided to the nurse practitioners. We do not believe the statute supports a rule requiring it.

OAR 436-010-0220(3)(f)

Testimony: Exhibit #24

Should the referral to an attending physician for completion of the closing examination count as a worker choice? The language in subsection (f) does not cover this scenario.

Response: We agree this referral does not count as a choice and have revised the language.

OAR 436-010-0230(4)(a)

Testimony: (Exhibits #2 and #3)

We support the intent of the proposed change. The current rule provides a basis for insurer denial of payment to a physical therapist if the attending physician fails to sign the treatment plan within 30 days of the beginning of treatment. The attending physician’s timeliness is outside the control of the physical therapist, yet it is the therapist who has suffered the financial consequences of the current rule – not the worker or the physician.

However, the rule remains ambiguous. The third sentence in subsection 0230(4)(a) still requires the physician to sign within 30 days. Some insurers will likely deny payment and the therapist will be required to go through a fee dispute resolution process. We propose the alternative of

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making reimbursement contingent on having the ancillary care provider send the treatment plan to the physician and to the insurer within seven days of beginning treatment. This gives the physician and the insurer an early opportunity to review the plan and raise any concerns or questions. We also propose requiring the physician to sign a copy of the treatment plan within 30 days after treatment begins and send the plan to the insurer.

Response: We have revised the language to add clarity about what is due, when it is due, and what the appropriate consequences are.

OAR 436-010-0230(4)(a)

Testimony: Exhibit #24

The requirement for a signed treatment plan by the attending physician should not be deleted. The current requirement that an attending physician sign the plan within 30 days of the start of ancillary services allows for checks and balances between the ancillary provider and the attending physician. Without a signed plan and a connection to payment for the ancillary services, treatment could continue indefinitely – even if the worker stops treating with his or her attending physician.

Response: The requirement for the attending physician is not deleted, but the rule is changed to make it clear that the attending physician, not the ancillary care provider, is held accountable.

OAR 436-010-0230(6)

Testimony: Exhibit #15

The Pharmacy Fee Advisory Task Force also addressed dispensing of drugs by a physician's office. We believe the group's intent was to limit the amount dispensed to a five-day supply. We recommend this section be revised to include a five-day limit.

Response: There was a lot of discussion about this issue, and 10 days was selected because of the need to dispense an adequate amount of antibiotics to complete a course of therapy.

OAR 436-010-0230(6)

Testimony: Exhibit #24

This section should not be modified but remain as is allowing for medications to be dispensed from physician offices only in the case of an emergency. The Pharmacy Fee Advisory Taskforce unanimously, and all but two members of the Division 009 & 010 Advisory Committee, recommended that this rule not be changed (current wording: "Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable."). The proposed rule allows for a maximum supply of 10 days. If the rule was intended to allow patients access to first script medications, the rule doesn't limit fills to first scripts. The rule may promote additional office visits for additional medication, increasing costs for both office visits and dispensing fees. If the physician provides an initial supply and writes a prescription for the longer term, the insurer will pay two dispensing fees instead of one..

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Response: The rule allowing a 10-day supply is a compromise between competing interests on this issue. We agree with the physicians who support this concept that there are times when it is medically in the best interests of the patient to assure the patient receives the prescribed drugs. We also understand the concerns about quality control expressed by others. A 10-day supply will allow the doctor to dispense a reasonable starter course of medication or a complete course of antibiotics (in most cases.)

OAR 436-010-0240(12)

Testimony: Exhibit #16

I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

Response: We agree and have modified the language to clarify this requirement.

OAR 436-010-0240(12)

Testimony: Exhibit #24

This rule requires a nurse practitioner to refer a worker to an attending physician for a closing examination, and does not limit the requirement to disabling claims. If closing examinations are required on non-disabling claims, this will add a cost to the system that is unwarranted and unnecessary. In addition, if the nurse practitioner believes the worker has no permanent impairment, the nurse practitioner should be able to state this and not refer to an attending physician. For each referral, the insurer will have to pay a new patient level office visit fee in addition to a closing examination fee.

Response: As noted above, we have clarified that this rule applies only to disabling claims. The provision that exempts certain claims from the requirement to complete a closing exam when an attending physician finds “no impairment” cannot be applied to claims managed by an authorized nurse practitioner because “no” or “zero” impairment are findings of impairment and cannot legally be made by the nurse practitioner.

OAR 436-010-0240(18)(b)&(c)

Testimony: Exhibit #15

For clarity and consistency, we recommend the following wording change to these subsections: “For the purpose of this rule, ‘protected health information in the medical record’ means any oral or written information . . . (c) . . . Upon request, the entire health information record, including any protected health information, in the possession of the medical provider . . .

Response: We have modified the rule to add clarity.

OAR 436-010-0250(13)

Testimony: Exhibit #24

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Regarding elective surgery notifications, we would like the opportunity to state that more information is needed before deciding if a second surgical opinion is warranted. The current form doesn't allow for any objection, other than to notify the physician a second surgical opinion is being obtained. Also, insurers should have 14 rather than 7 days to respond to an elective surgery request, as seven days does not allow sufficient time to assess the need for a second surgical opinion.

Response: We believe this recommendation is a significant departure from the current process and should be reviewed by a broader group of external advisors. We can include a review of the elective surgery procedure during the next revision of these rules if external parties wish to do so.

OAR 436-010-0265(11)

Testimony: Exhibit #24

We object to the proposed requirement that the insurer send a copy of the insurer medical examination (IME) report to the attending physician within 72 hours of receipt. IME providers can forward the report to the attending physician sooner; by transferring the responsibility to the insurer, the rule adds unnecessary delay to delivery of the report. We also propose the language about the IME should refer to "examining physician or IME company" to more accurately describe whose responsibility it is to send the report to the attending physician.

Response: We revised this requirement in the proposed rules because it is an administrative requirement more properly imposed on the insurer managing the claim than on a doctor providing an examination. The change is in response to considerable evidence that examining physicians are not fulfilling this requirement, which then interferes with a workers' ability to obtain a Worker Requested Medical Examination. We have modified the language to add "(s)" to physicians to clarify that the responsibility to send a report to the insurer is a collective responsibility of physicians completing the examination and report.

OAR 436-010-0265(11)

Testimony: Exhibit #25

Regarding the proposed requirement that the insurer forward a copy of the insurer medical examination (IME) report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt: I am not opposed to the rule, but note that this rule section already requires the IME physician to send a copy of the report to the attending physician within seven days. Is it really necessary for the treating physician to receive a copy from two sources? This duplicates effort and expense. The insurer usually includes a concurrence request along with the report, whereas the IME physician provides no explanation as to why it has been sent. I propose that the responsibility for sending a copy of the IME report to the treating physician be with the insurer and that OAR 436-010-0265(11) be removed from the medical rules.

Response: We have deleted the requirement for the IME doctor to submit a copy to the attending physician.

OAR 435-010-0270(3)

Testimony: Exhibit #3

This issue was presented to the Medical Advisory Committee as Primary Issue #8 under Division 010. The stated option was to “require the insurer to provide simultaneous notice to the medical providers [Emphasis added] on denials, partial denials or changes in status, whether or not a denial is on appeal.” The proposed section only requires notice to the attending physician or authorized nurse practitioner, and not any other medical service providers, such as a physical therapist, who may be the only provider actively treating the worker. Therapists suffer financial losses when they are not informed that a claim has been denied. If notified, the therapist can contact the worker’s private health insurer, if any, or discuss payment terms with the worker if treatment is to continue. The insurer should contact any medical service provider known to the insurer when it denies or partially denies a previously accepted claim.

Response: In the Oregon workers’ compensation system, the attending physician has a gate-keeper function that makes it imperative for the attending physician to know what the status of the claim is. The AP makes referrals to other providers and has oversight responsibility for care provided. The insurer may not even be aware of everyone who might be providing care until it receives bills for payment. This provision is a compromise to assure the gate-keeper has adequate information to make decisions about a workers’ care, while maintaining a reasonable administrative burden on the insurer.

OAR 436-010-0270(4)

Testimony: Exhibit #24

Regarding the addition of a time frame for insurer responses to requests for prior medical records, the rule section should specify that the request be in writing, so insurers can comply with the specific needs of requesters.

Response: To require the request be in writing is not necessary and may be overly prescriptive.

OAR 436-010-0270(7)(a)

Testimony: Exhibit #24

We object to the specificity of this proposed language. Nurse practitioners are probably not as prevalent as other medical practitioners that would also qualify as suitable attending physicians in certain geographic areas. We anticipate this would add additional mileage expense to the claim. We propose you change the language in the first sentence to “Reimbursement . . . for transportation costs . . . may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician or nurse practitioner who is in a geographically closer medical community in relationship to the worker’s home.”

Response: The intent of SB 3669 was to allow workers access to nurse practitioners in all cases, but was not intended to require a worker to select a nurse practitioner instead of a physician only because the nurse practitioner was closer geographically to the worker. We needed to make this distinction clear in the rule that a worker is entitled to full reimbursement for transportation costs so long as they are receiving care from the closest type of practitioner of their choice.

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OAR 436-010-0280(1)

Testimony: Exhibit #16

I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

Response: We have made this clarification.

OAR 436-030-0165(3)(c)

Testimony: Exhibit #5

The three-day response time for the deselection process is not long enough. A longer period, perhaps ten days, would seem more appropriate. In order to respond, the file must be pulled and reviewed to see what conditions are at issue, and arbiter options must be discussed with the client. In the rare occasion where the parties may want to stipulate on an arbiter, there is insufficient time to contact the opposing counsel and come to an agreement.

Response: The medical arbiter deselection process represents a way whereby the parties retain some control over the selection of the arbiter physician. But in implementing this process, a price has been paid, that being in terms of timeliness. The new timelines associated with deselection can be challenging. However, over the past year most attorneys have adjusted to the demands of this new process by restructuring their intake process for referrals from their clients.

Historically, the department did look at various aspects of the deselection process, including timeliness, during the pilot study of 2001. An eleven member advisory committee from the workers' compensation industry provided input at that time, followed by in-depth questioning of the actual participants in the pilot (claims handlers, attorneys, etc.). By consensus, it was decided that a three-day turn around for response to the deselection notification letter was adequate.

Part of the consensus process was the fact that the statute allows the department a period of 60 days within which to process, schedule and obtain a medical arbiter evaluation. While this may seem generous, the reality is that the Appellate Review Unit needs all the time it can garner to ensure the medical arbiter's report is received and they secure any clarification of arbiter findings that may be required in time to be used in the order on reconsideration. The medical arbiter scheduling process diminishes the time rapidly because of numerous steps involved, plus the department's obligation to schedule the exam at least two weeks out from the date of the medical arbiter appointment letter, which is triggered only after the deselection response period has expired. This coupled with the time lag often associated with obtaining the arbiter's written report, makes it impractical to lengthen the period of response as suggested by this testimony.

The rule will remain as proposed.

OAR 436-030-0055(1)(h)

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Testimony: Exhibit #15

The proposed definition for “withdrawn from the workforce” needs additional clarification of what constitutes a withdrawal from the workforce by adding “Such withdrawal is considered to be complete and permanent.”

Response: Adding the suggested language would not be accurate unless it was applicable to the period in question, which is already addressed in OAR 436-030-0055(3)(d) and (4)(a). The proposed rule will be modified but based on Exhibit #21 testimony.

OAR 436-030-0003(3)(a)

Testimony: Exhibit #21

A verb is required in the second sentence of this rule.

Response: Agreed. The rule will be modified to include a verb.

OAR 436-030-0007(1)(b)

Testimony: Exhibit #21

The proposed change could be construed to give the director authority to abate or amend an Order on Reconsideration at any time even after the case has gone to the Board for a hearing. There is no reason for the director to maintain jurisdiction once a hearing has been requested. We suggest that the current language remain.

Response: The intent of the rule change is to clarify that the director does have and has had the authority to withdraw an order on reconsideration up to the time the order becomes final. The director has been given by the Legislature the plenary authority to decide matters committed to DCBS, unless clearly limited by statute. There is no legislatively imposed limitation on the director’s authority to withdraw an order on reconsideration prior to that order becoming final. The rule will remain as proposed.

OAR 436-030-0007(3)(a)

Testimony: Exhibit #21

This rule illustrates the inconsistency in appeal procedures that will exist if all of the rule divisions are adopted as proposed. In other divisions, it is proposed that appeals are timely if received by the due date, rather than mailed by that date. This is a different standard than contained in this rule and a different standard than that used by the Worker’s Compensation Board. Stakeholders are best served by a consistent regulatory standard. All rules should use the mailing date, for reasons expressed in Division 001 testimony.

Division 001 (OAR 436-001-0155(1), testimony stated that under the existing rule the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. Recent weather-related problems caused many Oregon Post Offices to suspend service and to

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add a Sunday delivery to clear a backlog. The new rule would cause filings to be deemed untimely for reasons beyond the control of the party making the filing.

The division 001 proposed rule would create different standards for WCD and WCB. The Board uses mailing date, not date of receipt. DCBS should use consistent procedures, so that it is easier for the public to do business with the department.

Furthermore, ORS 656.726(4)(a) requires that “documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law”. The proposed rule is an impermissible deviation from statute.

Response: We agree. Under ORS 656.726(4)(a), “Mailing date” determines timeliness.

OAR 436-030-0023

Testimony: Exhibit #21

“Rescinding Notice of Closure” is a title understood by regular system participants, but its legalese is likely to confuse an unrepresented worker who receives such a document through the mail. “Withdrawal of Notice of Closure” would be a better title.

Response: The word “rescinding” in the form “Rescinding Notice of Closure” does appear to be legalese but once the worker reads further down the form the intent becomes very clear. The first sentence states, “This is to advise you that your workers’ compensation claim closure has been reversed and your claim returned to open status.” In addition, the insurer has an area on the form to specifically explain why the worker’s closure has been withdrawn and the claim has been reopened. Together, these statements clearly inform the worker what has happened with their claim.

Additionally, the department does not have any evidence that would suggest that “withdrawal” would be a better understood word to use than “rescind”. What is known is that the word “rescind” is the common term within workers’ compensation and what is used on forms and in brochures. To change these terms would require additional costs and time, which cannot be justified and spent without significant supporting evidence. The rule will remain as proposed.

OAR 436-030-0023(3)

Testimony: Exhibit #21

The term “current date” as used in this rule is confusing. We suggest “the date of the correction or withdrawal.”

Response: The director agrees, but with the more general perspective that some modifications are needed to clarify that the “current date” must be the date the document is mailed.

OAR 436-030-0034(1)

Testimony: Exhibit #21

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The rule should not require claim closure if there has been no treatment for 30 days. There may be extenuating circumstances, when the best interests of the parties would be served by allowing the claim to remain open. Insurers should have the discretion to make the best judgment in the individual case. We request that the word “may” be left in this rule.

Response: The testimony presents a reasonable argument, but the change in wording from “may” to “must” is required because “may” is in direct conflict with OAR 436-030-0020(1) and ORS 656.268(1). The rule will remain as proposed.

OAR 436-030-0034(6)

Testimony: Exhibit #21

Copies are routinely sent to medical providers. In the infrequent case where the notice is not sent, this should not be grounds to nullify a closure. We suggest adding the following sentence:

“Failure to send a notice required by this rule may subject an insurer to civil penalties, but will not invalidate the closure”.

Response: The attending physician’s and/or nurse practitioner’s input on their patient’s claim closure has been and will continue to be a critical part of the workers’ compensation system. If the medical providers are not sent the required copies, then the claim closure may be rescinded. How critical the information (on the notification and denial letters) is to claim closure will determine if the closure will be rescinded or not. This is not a new procedure, nor is this a new rule. The rule has just been moved, and nurse practitioner has been added as mandated by House Bill 3669.

The recommendation is not an effective remedy when considering the importance of the medical provider’s participation in the claim closure process. Rather than rewrite the rule, review or revision of internal procedures may be necessary to ensure that all necessary documentation is copied to the medical provider. The rule will remain as proposed.

OAR 436-030-0055(1)(h)

Testimony: Exhibit #21

The last sentence of this rule is redundant, but if the rule is to be retained, “retirement” should be defined. Otherwise, it could be interpreted to mean collecting Social Security, collecting a company pension, collecting IRA or 401(k) distributions, ceasing employment without intent to seek new employment, etc.

Response: The director agrees that the term “retirement” is not clearly defined. The intent of the proposed language was to (1) establish the fact that a worker who is receiving retirement benefits (e.g. Social Security, company pension payments, etc.) is not necessarily withdrawn from the workforce, and (2) require an insurer or self-insured employer to use more than the fact a worker is receiving ‘retirement benefits’ to establish that the worker has withdrawn from the workforce. There are numerous examples of workers who receive such benefits and still are working in the workforce. Individuals may retire from the military, state, or federal government and then get

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another job in the private sector or return to government work. Individuals may receive Social Security but continue to work. Employees may collect company pensions and return to the workforce to supplement that income. The proposed language will be modified to better reflect such circumstances.

OAR 436-030-0065(1)

Testimony: Exhibit #21

Two changes in the proposed rule seriously undermine the management of Permanent Total Disability claims.

First, the revised rule suggests that an insurer can only re-examine a PTD claim at two-year intervals, despite intervening events that may make the worker employable. The insurer is responsible for monitoring the worker's condition and, if the insurer determines that the worker's physical condition has improved or the vocational situation has changed, should be able to act on the information as soon as it has been developed, and not wait for an arbitrary schedule of reviews.

Second, the revised rule appears to remove the incentive for a worker to cooperate with any reexamination of a PTD award. Currently, a worker who refuses to attend a medical examination may be subject to benefit suspension. The new rule would allow the worker to ignore a reexamination with impunity. As medical evidence is an essential component in any PTD reexamination, this proposed rule would effectively prevent reversal of PTD awards. This rule violates ORS 656.325(1)(a) which clearly states that benefits will be suspended for failure to submit to an examination. The proposed changes also appear to conflict with ORS 656.325(3), which requires the worker to cooperate in the reduction of disability.

Implementation of these rules would not only affect the system cost to employers and insurers, but would also increase cost to the Worker Benefit Fund. Retroactive Reserve payments are the largest single draw on that Fund.

Response: The director agrees with the first position that the insurer is responsible for monitoring their PTD claims and should be able to act on any information that will change the PTD status as soon as possible. It was not the director's intent to limit the insurer in this respect and the changes that have been proposed have not done so. Statute and rule do not prohibit the insurer from reviewing a PTD claim more frequently than every two years. The purpose of removing this language was to eliminate duplication and reduce rules. Since it appears to have created confusion, the director will modify the language to clarify the insurer's existing right to review a PTD claim more frequently than every two years.

The director does not agree with the second position that the deletion of the suspension rule will remove the incentive for the worker to cooperate with any reexamination of a PTD award. The statutes cited in the testimony have given the insurer the right to suspend a worker who does not cooperate with a reexamination. That right cannot be taken away by rule.

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The director's intent was not to eliminate the insurer's right to suspend a worker who has not cooperated with the reexamination, but to eliminate redundancy of rule and statute. The reason that the suspension part of this rule was taken out is because it is addressed in OAR 436-060-0095, OAR 436-030-0055, and statute. But to ensure clarity, the deleted suspension portion will be restored and a reference to OAR 436-060-0095 will be inserted.

OAR 436-030-0135(6)

Testimony: Exhibit #21

The word "accepted" as used in this rule is undefined and ambiguous. It would be more appropriate to use "requested and received."

Response: The director agrees, but with the suggestion for some modifications to clarify that the fiscal instrument not only has to be received, but also negotiated by the worker. The reason for this terminology is because a worker may receive the money from the insurer but return it after deciding to request reconsideration. The language has been modified to more clearly reflect the intent of the change.

OAR 436-030-0155(3)

Testimony: Exhibit #21

The proposed rule needs to be restructured to more clearly convey the intent. The proposed rule appears to require that the attending physician has viewed the recordings, but the insurer cannot know with certainty whether anything sent to a physician has actually been reviewed. Written reports are routinely sent, but the insurer has no way of knowing whether they have been read. Surveillance material should be treated the same way as any other information. Suggested language:

"The insurer must submit to the director for arbiter review all surveillance documentation (including any materials supplied by the insurer to the physician(s), such as videotape, investigator field notes, summary or narrative reports regarding the worker's observed activities, cover letters or other forms of recorded documentation) of the injured worker's activities, that were obtained prior to the closure and that were submitted to the attending physician. Surveillance tapes, compact discs or other forms of electronic storage that reflect the worker's activities will be accompanied by documentation indicating the dates the information was obtained and the total time of the recording. This information will be supplied to the arbiter to view and consider in conjunction with the arbiter's medical assessment of the worker's accepted condition and level of disability."

Response: The director agrees that the proposed language does need to be clarified because the insurer cannot be sure if material sent to a medical provider has been reviewed by that provider. The director's intent is to require that the insurer submit to the director any surveillance videotape both obtained prior to claim closure and submitted to any physician(s) involved in the treatment of the injured worker. The proposed language will be modified to clarify the intent.

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OAR 436-060-0008(3)(a)

Testimony: Exhibit #22

The proposed change may be more convenient for the Division, but works to the disadvantage of the stakeholders. Under the existing rule, the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. The proposed rule would create different standards for WCD and the Workers' Compensation Board. DCBS should use consistent procedures, so that it is easier for the public to do business with the Department. ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law." The proposed rule is an impermissible deviation from statute.

Response: The Department of Justice has advised the division that ORS 656.726 controls. The current language will be retained.

OAR 436-060-0010(3)

Testimony: Exhibit #15

The proposed language is extremely vague and too subjective to make it a standard for notice or knowledge of a claim. The worker must retain the responsibility of filing the claim. Suggest modifying the sentence to read, "The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a **worker's intent to file a claim, either through written communication from the worker, the worker's representative, or the worker's attending physician.** [or of when enough facts exist to lead a reasonable employer to conclude that workers' compensation liability is a possibility.] (Emphasis in original)

Response: This language is not new. It has been moved from 436-060-0010(10) to (3) in connection with the change from reporting claims to the division within 21 days of the employer's knowledge date to 14 days from the decision to accept or deny the claim. When read in conjunction with 436-060-0010(4), it is clear that the worker retains the responsibility of filing a claim. ORS 656.262(3)(a) reads, in relevant part, "Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer." Emphasis added. The possibility exists that a worker would choose not to file a claim for an accident that may result in a compensable injury claim, but according to the statute the employer should still report the incident to the insurer. However, as a result of this testimony we will add clarification to the rule that it is the employer who must know the facts.

OAR 436-060-0010(12) and (13)

Testimony: Exhibit #7

Senate Bill 914 eliminated the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim. Proposed OAR 436-060-0010(10) clearly indicates that all disabling claims shall now be reported within 14 days of the insurer's decision to either accept or deny the claim.

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To be consistent, it is recommended that the reporting timeframe in OAR 436-060-0010(12) & (13) be changed from 21 days to 14 days. This will eliminate any confusion as to how many days an insurer has to file a form 1502.

Response: Consistency is a valid reason to change all 21-day reporting timeframes to 14 days. In addition to the cites referenced in this testimony, there are also 21 day reporting timeframes in OAR 436-060-0010(14), (15), (16), and 436-060-0018(1). Also, it is not clear in 436-060-0018(1) that this applies only to accepted claims. The language in the proposed rules will be changed to require reporting to the director within 14-days of the action and the language in 436-060-0018(1) will be clarified to apply only to accepted claims.

OAR 436-060-0018(11)

Testimony: Exhibit #22

The rule should be prefaced with the phrase: “Subject to the provisions of subsection (12),...” Exhibit 22. In a follow-up call regarding this testimony, the author stated that (11) implies an insurer can change the classification of the claim anytime. It should be limited to the one year mentioned in (12).

Response: This testimony caused us to look closely at the proposed language and recognize there could be better direction for claim processing in these situations. There have been instances when a claim has been classified as disabling, then closed with a Notice of Closure. When the claim is reopened on aggravation or a new or omitted condition is accepted, the claim status remains disabling even though the aggravation or the new or omitted condition may be non-disabling. We recognize there are times when the original decision to classify the claim as disabling was incorrect because the criteria were never met. Case law (*DeGrauw v. Columbia Knit*) does not clearly establish a process for such circumstances other than the requirement that the worker have access to recourse if they are dissatisfied. The proposed language will be modified.

OAR 436-060-0035(8)

Testimony: Exhibit #22

The proposed revision to this rule is incorrect. The current version of (8) correctly states that TPD for supplemental temporary disability must be calculated on the combined pre- and post-injury earnings, not calculated independently. The proposed rule does not work whenever maximum or minimum TTD rates are involved. You cannot calculate primary and secondary benefits separately to get the correct amount to pay the worker. The benefit has to be figured based on combined earnings. You figure the benefits from the primary job and the difference is the secondary benefit that is reimbursable from WBF.

Response: This change was made to limit the required involvement of insurers who elect not to process and pay supplemental disability. However, this testimony has pointed out the problems this change would create. With some modification to incorporate the assigned processing agent, the previous language will be restored.

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OAR 436-060-0035(18)

Testimony: Exhibit #22

Disputes concerning the rate of disability should be raised before the first closure of the claim. Allowing them “at any time” means that the issue could be raised many years after the initial rate calculation, when evidence of earnings may no longer be available.

Response: There is no statutory limitation on when an injured worker can raise a wage dispute. Similarly, OAR 436-060-0025 does not limit when a wage dispute may be raised. Regardless of when the wage dispute is raised, it is the worker who must supply the wage records for secondary employment. The proposed language will be retained.

OAR 436-060-0060(2)

Testimony: Exhibit 22

We agree that an insurer should respond promptly to a lump sum request. However, we believe the insurer should be allowed ten business days. This would allow the request to be processed within the regular two-week file review cycle. This would allow an average turnaround of five business days, without disrupting the normal review schedule.

Response: When this issue was discussed in the Internal and External Advisory Committees there was general consensus to add a “reasonable timeframe” to the rules. However, what is reasonable was not specifically discussed. Requiring the insurer to send the form within 10 days to coincide with the regular two-week file review cycle seems reasonable. The rule will be modified accordingly.

OAR 436-060-0095

Testimony: Exhibit #22

A proposed revision of OAR 436-030-0065(1) appears to remove the ability to suspend compensation when a worker with a PTD award refuses to attend a medical examination. For the reasons stated in our Division 030 testimony, we oppose that change. It would be logical to move that rule to Division 060, where all other benefit suspension issues are covered.

Response: Suspension of benefits for any worker who refuses to attend a reasonable requested medical examination is currently contained in OAR 436-060-0095. However, the last sentence of OAR 436-030-0065(1) will be added back with a cross-reference to OAR 436-060-0095. This will make it clear that if a worker with a PTD award refuses to attend a medical examination, the process for requesting suspension is under OAR 436-060-0095.

OAR 436-060-0140(9)

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Testimony: Exhibit #22

Since claims that have been resolved by a claim disposition agreement are not subject to reopening under any circumstances, the rule should be prefaced with the phrase: “Except for claims resolved by claim disposition agreement under ORS 656.236,…”

Response: Claims that have been resolved by a claim disposition agreement are subject to reopening if a new or omitted condition is later accepted. The rule will remain as proposed.

OAR 436-060-0155(2)

Testimony: Exhibit 8

The right to the penalty is in ORS 656.262(11). The rule terminates claimant’s rights after 180 days of the alleged violation. The rule is in direct conflict with ORS 656.319(6), which provides claimant a right to a hearing on this issue for a period of two years after the alleged action or inaction. There is adequate case law that explains when the two-year period begins and ends. There is also adequate case law to support the position that the Director cannot promulgate a rule that takes away a right or limits a statutory right.

Response: This language has existed in these rules for many years. In *Kathryn R. Cook v. Liberty Northwest Insurance Corporation*, 150 Or App 597 (1997), the Court of Appeals held this rule is reasonably required for the director to carry out the performance of his duties. The case also considered the issue the testimony presented concerning ORS 656.319(6). The current language will remain.

OAR 436-060-0180(8)

Testimony: Exhibit #22

The requirement that an insurer’s response to WCD be “adequate” is reasonable, but the insurer cannot know what WCD may perceive to be adequate. We suggest rewording to say that the insurer must respond “in good faith”.

Response: This language was patterned after OAR 436-060-0155(4) where it’s clear that inadequate means failing to answer specific questions or provide requested documents. The language in this rule will be modified to make it clear what the director considers inadequate by more closely mirroring the language in OAR 436-060-0155(4).

OAR 436-120-0004(2)(d)

Testimony: Exhibit # 13

Regarding the statement in the notice text in (d), “If you disagree with this decision, you should contact (person’s name and insurer) within five days of receiving this letter to discuss your concerns,” if the injured worker is required to contact the insurer to remain eligible, the time allowed should be longer.

Regarding the remaining notice text, add a reference to the worker’s attorney, as in “If you are still dissatisfied, you or your attorney must contact . . .”

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Response: The changes recommended were not included in the proposed rules. The division can not take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

OAR 436-120-0008(2)

Testimony: Exhibit # 13

Regarding statements of services for attorney fees, in addition to the hours spent on the case, consideration should be given to the difficulty involved as well as the likelihood of prevailing, because attorneys are only paid if they win.

The rule should be consistent with awards made by the Workers' Compensation Board, and not start a trend of requiring a statement of services.

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

OAR 436-120-0008(2)

Testimony: Exhibit # 23

Two additional factors should be considered in determining attorney fees:

- ‘“Professional hours devoted” shall be limited to those hours that a reasonable attorney, well-trained in workers’ compensation law, would expend on the matter at issue.’
- ‘Proof of “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.’

Response: SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of “extraordinary circumstances” the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of \$10,000.

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OAR 436-120-0008(4)(b)

Testimony: Exhibit #23

The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers’ Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): “. . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law.”

Response: The division agrees that the standard should be the one described in ORS 656.726(4)(a). The proposed rule will be changes to reflect agreement with ORS 656.726 (45)(a).

OAR 436-120-0340(2)(g)

Testimony: Exhibit #23

Regarding the Oregon Wage Information publication [of the Oregon Employment Department], the rules should require reference to the fifth percentile rather than the 10th percentile as proposed. The 5th percentile is better aligned with the standard now in use.

Response: The division compared the Oregon Wage Information (OWI) 5th and 10th percentile to the current use of the Oregon Automated Reporting System (OARS) median wage (Q2). A review by the Information Management Division of DCBS found the 10th percentile to be the closest to the Q2 statistic. In addition, the Oregon Department of Employment which publishes the OWI will only publish for general circulation statistics starting with the 10th percentile.

Given the divisions analysis of the 5th and 10th percentiles and in order to make the statistics as readily available as possible, the 10th percentile will be the standard.

OAR 436-120-0360(7)

Testimony: Exhibit # 14

Regarding proposed language for this section, “The worker returned to work prior to the worker becoming medically stationary, and the physician **later** [emphasis added] rescinded the release.” This section should include a time limit for rescission; otherwise, insurers could be compelled to complete an eligibility evaluation 12 months after the return to work if a physician later rescinds a release – even if the worker has not perfected a claim for aggravation. Recommended replacement language: “The worker returned to work prior to becoming medically stationary, and the physician *rescinds the release within 60 days of the date of the Notice of Closure.*”

Response: This rule is being moved from its present location as 436-120-0360 (9) to 436-120-0360(7). The only other change was change the word rescinds to rescinded. Time frames were not recommended for this rule and no discussions on the effect of adding time frames was part of the internal or external advisory committees. The present wording of this rule has not generated requests for reconsideration under the scenario presented in the testimony. While the recommendation may have merit, the division could not consider implementation of the

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recommended wording without further public input. The division will file the proposed wording for consideration future rule changes.

OAR 436-120-0710(7)

Testimony: Exhibit #23

This section should not provide for prepayment of the last month's rent, as this is not generally required in today's market and is inconsistent with OAR 436-110.

Response: This rule was not proposed for any changes and as such has not had any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

The current wording does not require the payment of last months rent but does state it is only payable . . ." if required prior to moving in."

OAR 436-120-0720

Testimony: Exhibit # 13

The advisory committee discussed increasing the dollar amount for direct worker purchases for training programs. The need was acknowledged by some of the insurer representative's. The proposed rules do not address this need.

Response: The division is proposing an increase in OAR 436-120-0720(3) for direct worker purchases in training programs. The increase in from \$14,256 to \$16,157, which is a 10% increase.

OAR 436-120-0720(2)

Testimony: Exhibit # 23

As proposed, this section, a worker may qualify as having an exceptional loss of earning capacity if additional services would yield just a 10% greater wage than a shorter program. For a 21-month training program, the TTD benefit alone may exceed \$80,000. The analysis to authorize extended benefits should include whether the program will result in significantly improved earning capacity over the likely period of post-training employment.

Response: The proposed rule recommends changes to the fee schedule for workers found to have an exceptional disability or exceptional loss of earning capacity and the percentage increase to be applied. The change recommended in the testimony proposes a change in how exceptional loss of wage earning capacity is determined, which is in OAR 436-120-0440(2)(b).

No changes were proposed for OAR 436-120-0440 and as such there has not been any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

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Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 12th day of March, 2004.

WORKERS' COMPENSATION DIVISION

/s/ Fred Bruyns

Fred Bruyns, Rules Coordinator
Policy Section
Workers' Compensation Division

**OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 120**

436-120-0001 Authority for Rules

The director has adopted OAR 436-120 by the director's authority under ORS 656.283(2), 656.340, and 656.726 (4).

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.262(6), 656.268, 656.283(2), 656.313, 656.331(1)(b), 656.340, 656.447, 656.740, 656.745, ORS Ch. 183, and section 15, chapter 600, Oregon Laws 1985

Hist: Filed 12/30/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temporary)
Amended 2/6/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-003, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01

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.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.012(2)(c), 656.258, 656.268(1), 656.283, 656.340, and section 15, chapter 600, Oregon Laws 1985

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-008, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

436-120-0003 Applicability of Rules

(1) These rules govern vocational assistance pursuant to 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 shall 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.

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[(4)] The renewal period of a certified vocational counselor certified as of June 1, 2000 is extended for three years, at which time the vocational counselor must meet the continuing education requirements set by these rules. Individuals currently certified as either a vocational rehabilitation counselor intern or a return to work specialist will have five years from June 1, 2000 to renew their certification pursuant to OAR 436-120-0820 by meeting the continuing education requirements.]

[(5)]**(4)** The requirement for the director's advance approval of services eligible for claims cost reimbursement pursuant to OAR 436-120-0720[(6)]**(7)** shall apply to any actions taken after the effective date of these rules.

[(6)] **(5)** Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive procedural rules as justice so requires.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.283(2), 656.340

Hist: Filed 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/26/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-004, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0004 Notices and Reporting Requirements

(1)The insurer shall inform a worker with a compensable injury of the employment reinstatement rights and responsibilities of the worker under ORS chapter 659A and this rule. This information shall be given:

(a) At the time of claim acceptance, pursuant to ORS 656.262(6);

(b) At the time of contact of the worker under OAR 436-120-0320 about the need for vocational assistance, pursuant to ORS 656.340(2); and

(c) Within five days of receiving knowledge of the attending physician's release of the worker to return to work, pursuant to ORS 656.340(3), the insurer shall inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659A.043 and 659A.046, and inform the employer about the worker's reemployment rights.

(2) All notices and warnings to the worker issued pursuant to OAR 436-120 shall be in writing, signed and dated, and state the basis for the decision, the effective date of the action, the relevant rule(s), the worker's appeal rights required pursuant to this rule, and the telephone number of the Ombudsman for Injured Workers. However, the insurer's response does not need to be in writing when the insurer approves a worker's request for a particular vocational service. All notices and warnings are subject to the following conditions:

(a) The following headings shall be used for the following notices. Should one notice be used for multiple actions, all appropriate headings shall be listed:

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(A) Eligibility: NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(B) Ineligibility: NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(C) Selection or change of provider: SELECTION OF (OR CHANGE OF) VOCATIONAL ASSISTANCE PROVIDER, EFFECTIVE (date)

(D) Category of assistance: NOTICE OF VOCATIONAL EVALUATION TO BEGIN (date) or NOTICE OF ENTITLEMENT TO TRAINING, EFFECTIVE (date) or NOTICE OF ENTITLEMENT TO DIRECT EMPLOYMENT SERVICES, EFFECTIVE (date)

(E) End of training: NOTICE OF TRAINING END, EFFECTIVE (date)

(F) End of eligibility: NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(b) Warning letters do not require specific language in the headings but should include a heading clearly indicating the purpose of the warning.

(c) The insurer shall simultaneously send a copy to the worker's representative. Failure to send a copy of the notice to the worker's representative stays the appeal period until the worker's representative receives actual notice.

(d) All notices and warnings except those notifying a worker of eligibility or entitlement to training shall contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact (person's name and insurer) 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: (address and telephone number of the Workers' Compensation Division)."

(3) If the insurer is unable to determine eligibility or make a decision regarding a particular vocational service because of insufficient data, the insurer shall explain what information is necessary and when it expects to determine eligibility or make a decision.

(4) Notice of Eligibility for vocational assistance shall include the following:

(a) Selection of the category of vocational assistance, if known;

(b) The worker's rights and responsibilities;

(c) Procedures for resolving dissatisfaction with an action of the insurer regarding vocational assistance;

(d) The current list of vocational assistance providers, and an explanation of the worker's participation in the selection of a vocational assistance provider. This notice shall include the

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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 contact the Workers' Compensation Division's toll free number (use appropriate telephone number)."

(e) Information about potential reemployment assistance under OAR 436-110.

(5) Notice of Ineligibility for vocational assistance is subject to the following conditions:

(a) The notice shall be sent to the worker by both regular and certified mail.

(b) The notice shall include information about services which may be available at no cost from the Employment Department or the [Vocational Rehabilitation Division]**Office of Vocational Rehabilitation Services**, and reemployment assistance under OAR 436-110.

(c) If the notice is based on a finding of "no substantial handicap," it shall list some suitable occupations.

(d) If the insurer is not required to determine eligibility pursuant to OAR 436-120-0320(2), no Notice of Ineligibility is required unless the worker or worker's representative requested a determination of eligibility. When the ineligibility is due to no permanent disability award, the notice must inform the worker of entitlement to an eligibility determination upon a final order granting permanent disability.

(6) Notice of Denial of Vocational Service shall be given by the insurer.

(7) Notice of Selection of Category of Vocational Assistance shall be given by the insurer. When direct employment services are selected, the notice shall state the worker is not entitled to training.

(8) The approved, denied or amended return-to-work plan shall be sent to the worker. Notification of Denial of Return-to-Work Plan shall [include] **identify** any components of the plan [which]**that** the insurer did not approve.

(9) Notice of End of Training shall state whether the worker is entitled to further training. The effective date of the end of training letter shall be the worker's last date of attendance.

(10) Notice of End of Eligibility for vocational assistance shall be sent by both regular and certified mail to the worker.

(11) Warnings to the worker shall state what the worker must do within a specified time to avoid ineligibility or the ending of eligibility or training.

(12) The insurer shall simultaneously send a copy of the following notices to the department:

(a) Notice of Eligibility;

(b) Notice of Ineligibility;

(c) Approved Return-to-Work Plan and any amendments;

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(d) Notice of End of Training; and

(e) Notice of Ending of Eligibility for Vocational Assistance.

(13) The insurer shall file a closing status report with the division for each eligible worker within 30 days after eligibility ends. The insurer shall report the following information:

(a) The date and reason for ending of eligibility, return-to-work and vocational assistance provider information.

(b) For post-1985 injuries, the insurer shall also report cost information for eligibility determination and vocational services provided under these rules as required by the director.

Stat. Auth.: ORS 656.340(9), 656.726(4), and 192.410 through 192.505

Stat. Impltd.: ORS 656.340(5), 656.340(7)

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended and Renumbered from OAR 436-120-0600, -0610, and -0620, as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0005 Definitions

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

(1) "Administrative approval" means approval of the director.

(2) "Cost-of-living matrix" is a chart issued annually by the director in Bulletin 124 or in an addendum to Bulletin 124 which publishes the conversion factors, effective July 1 of each year, used to adjust for changes in the cost-of-living rate from the date of injury to the date of calculation. The conversion factor is based on the annual percentage increase or decrease in the average weekly wage, as defined in ORS 656.211.

(3) "Division" refers to the Workers' Compensation Division of the Department of Consumer and Business Services.

(4) "Employer at injury" means an employer in whose employ the worker sustained the compensable injury, or occupational disease.

(5) "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.

(6) "Permanent employment" is a job with no projected end date or a job which had no projected end date at time of hire. Permanent employment may be year-round or seasonal.

(7) "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.

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(a) Sedentary Work (S): Exerting up to 10 pounds of force occasionally and/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, and/or up to 10 pounds of force frequently, and/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; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/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, and/or 10 to 25 pounds of force frequently, and/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, and/or 25 to 50 pounds of force frequently, and/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, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.

(8) "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, 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.

(9) "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. (*Oregon Occupational Projections Handbook, 2002-2008*)

(10) "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.

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(11) "Substantial handicap to employment" 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.

(12) "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 which offer employment opportunities;

(c) Which pays or would average on a year-round basis a suitable wage as defined in section (13) of this rule; and

(d) Which 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 (13) of this rule.

(13) "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 and/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.

(14) "Transferable skills" means the knowledge and skills demonstrated in past training or employment which make a worker employable in suitable new employment. More general characteristics such as aptitudes or interests do not, by themselves, constitute transferable skills.

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(15) "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.

(16) "Vocational assistance provider" means an insurer or other public or private organization, authorized under these rules to provide vocational assistance to injured workers.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Sta. Impltd.: ORS 656.340

Hist: Filed 6/30/66 as WCD Admin. Order 7-1966, eff. 6/30/66
Amended 12/20/73 as WCD Admin. Order 6-1973, eff. 1/11/74
Amended 11/5/74 as WCD Admin. Order 45-1974, eff. 11/5/74 (Temporary)
Amended 2/6/75 as WCD Admin. Order 4-1975, eff. 2/26/75
Amended 3/29/76 as WCD Admin. Order 1-1976, eff. 4/1/76
Amended 9/29/77 as WCD Admin. Order 3-1977, eff. 10/4/77 (Temporary)
Amended 2/1/78 as WCD Admin. Order 1-1978, eff. 2/1/78
Amended 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-005, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 12/11/96 as WCD Admin. Order 96-073, eff. 2/1/97
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 12/14/01 as WCD Admin. Order 01-066, eff. 1/2/02 (Temporary)
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

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)

Stat. Impltd.: ORS 656.283(2), 656.313

Hist: Amended and Renumbered from OAR 436-120-001 and 210, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02

436-120-0007 Establishing the Adjusted Weekly Wage to Determine Suitable Wage

To determine a suitable wage as defined in OAR 436-120-0005 (13), the insurer shall 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

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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 an employer 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 shall be 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 shall 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 shall 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 shall 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

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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) When the worker held more than one job at the time of injury or aggravation and/or received unemployment insurance benefits, the worker's average weekly wage is determined by combining the worker's earned income and any unemployment insurance payments received during the 52 weeks prior to the injury or aggravation. The total shall be divided by 52 weeks, or if the worker worked less than 52 weeks by the number of weeks worked plus the number of weeks the worker received unemployment benefits. Extended gaps from all jobs are not included as weeks worked.

(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 convert to the adjusted weekly wage as described in section (6) of this rule.

(6) Adjusted weekly wage: After arriving at the weekly wage pursuant to this rule, establish the adjusted weekly wage by determining the percentage increase or decrease from the date of injury or aggravation, or last day worked prior to aggravation, to the date of calculation, as follows:

(a) Contact the employer at injury or aggravation regarding any cost-of-living or collective bargaining adjustments for workers performing the same job. When the worker held two or more jobs at aggravation, contact the employer for whom the worker worked the most hours. Adjust the worker's weekly wage by any percentage increase or decrease;

(b) If the employer at injury or aggravation 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; or

(c) If the employer at injury or aggravation 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.

Stat. Auth.: ORS 656.340(9), ORS 656.726(3)

Stat. Impltd.: ORS 656.340(5) and (6)

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Amended and Renumbered from OAR 436-120-025, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96

Amended and Renumbered from OAR 436-120-0310, 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

Amended 12/14/01 as WCD Admin. Order 01-066, eff. 1/2/02 (Temporary)

Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

436-120-0008 Administrative Review[and Contested Cases]

(1) **Administrative review of vocational assistance matters:** Under ORS 656.283(2) and 656.340(4), a worker wanting review of any vocational assistance matter must apply to the

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director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0320 (10) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer shall 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 shall 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 shall 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 shall provide available information within 14 days of the request. The insurer shall 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 shall 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 shall 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 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 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;

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(B) The agreement was based on misrepresentation; [or]

(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 shall issue a final order, including the notice of record contents. The parties will have 60 days from the issuance of the order to request a contested case hearing before the director.

(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 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 for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case 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 shall 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 must request a contested case hearing.

(2) Attorney fees: In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director shall award an attorney fee to be paid by the insurer or self-insured employer as provided in ORS 656.385 (§2, ch. 756, OL 2003). The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration shall be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed \$2000, nor fall outside the ranges for fees as provided in the following matrix:

<u>Estimated Benefit Achieved</u>	Professional Hours Devoted				
	<u>1-2 hours</u>	<u>2.1-4 hours</u>	<u>4.1-6 hours</u>	<u>6.1-8 hours</u>	<u>8.1-12 hours</u>
<u>\$1-\$2000</u>	<u>\$100-400</u>	<u>\$200-700</u>	<u>\$300-750</u>	<u>\$600-1000</u>	<u>\$800-1250</u>
<u>\$2001-\$4000</u>	<u>\$200-500</u>	<u>\$400-800</u>	<u>\$600-900</u>	<u>\$800-1300</u>	<u>\$1050-1500</u>
<u>\$4001-\$6000</u>	<u>\$300-700</u>	<u>\$600-1000</u>	<u>\$800-1250</u>	<u>\$1000-1450</u>	<u>\$1300-1750</u>
<u>\$6001-\$10000</u>	<u>\$400-900</u>	<u>\$800-1300</u>	<u>\$1050-1600</u>	<u>\$1350-1800</u>	<u>\$1550-2000</u>

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(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the case if greater than two hours. In the absence of such a statement, the director shall assume the time spent on the case was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to the following:

(A) Where there is a return-to-work plan that includes the disputed service(s), the assumed value is the cost of the disputed service(s) as projected in the plan;

(B) Where the service(s) have not been incorporated in an existing return-to-work plan, the assumed value is the actual or projected cost of the service(s) up to the amount allowed in the fee schedule provided in OAR 436-120-0720;

(C) For the purposes of applying the matrix, the value of an eligibility determination is assumed to be the maximum allowed in the fee schedule provided in OAR 436-120-0720 for completing an eligibility evaluation; the value of vocational assistance or a training plan, unless determined to be otherwise, is assumed to fall within the highest category provided in the above matrix; or

(D) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above \$2000, they may submit a written or faxed statement of the extraordinary circumstances to the director.

(d) In order to provide parties an opportunity to inform the director of agreements, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any statements provided to the director must simultaneously be provided to all other parties to the dispute.

(e) An assessed attorney fee shall be paid within 30 days of the date the order authorizing the fee becomes final.

[2] **(3) Contested cases regarding the director's administrative review:** Under ORS 656.283, orders issued under subsection (1) (f) of this rule and dismissals issued under subsection (1)(d) of this rule may be appealed to the director for a contested case hearing as follows:

(a) The party must send the request for hearing in writing to the administrator of the Workers' Compensation Division and shall simultaneously send a copy of the request to the other party(ies). The request must specify the grounds upon which the order is contested.

(b) The [party must mail the]request [to] **must be received by** the division within 60 days of the date of the order.

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(c) The [division] **hearing** will **be** conducted [the hearing] in accordance with the rules governing contested case hearings in OAR 436-001.

[(3)] **(4) Contested cases regarding jurisdiction or reimbursement of costs:** Under ORS 183.310 through 183.550 and ORS 656.704(2), a worker may appeal an order of dismissal based on lack of jurisdiction under subsection (1)(d) of this rule, or, under ORS 183.310 through 183.550 and ORS 656.704(2), an insurer may appeal department denial of reimbursement for vocational assistance costs under OAR 436-120-0730, as follows:

(a) The party must send the request for hearing to the administrator of the Workers' Compensation Division. The party must also simultaneously send a copy of the request to the other party(ies). The request must specify the grounds upon which the denial is contested.

(b) The [party must mail the] request [to] **must be received by** the division no later than the 30th day after the party received the dismissal or written denial.

(c) The [division] **hearing** will **be** conducted [the hearing] in accordance with the rules governing contested case hearings in OAR 436-001.

[(4)] **(5) Contested case hearings of civil penalties:** Under ORS 656.740 (**§9, ch. 170, OL 2003**) an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty pursuant to 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 [mail] **file** the request [to] **with** the division [no later than the 60th day] **within 60 days** after [the insurer or employer received] **the mailing date of the** notice of the proposed order or assessment.

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

(d) The Hearings Division shall conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

[(5)] **(6) Contested case hearings of sanctions and denials of certification or authorization** by the director: Under ORS 183.310 through 183.550, an insurer sanctioned pursuant to ORS 656.447 and OAR 436-120-0900, a vocational assistance provider or certified individual sanctioned pursuant to ORS 656.340(9)(b) and OAR 436-120-0915, a vocational assistance provider denied authorization pursuant to ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification pursuant to ORS 656.340(9)(a) and OAR 436-120-0810 may appeal as follows:

(a) The party must send the request for administrative review in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the action is contested.

(b) The [party must mail the] request [to] **must be received by** the division no later than the 60th day after the party received notification of the action, unless the director determines there was

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good cause for delay or that substantial injustice may otherwise result.

(c) The [division] **hearing** will **be conducted** [the hearing] in accordance with the rules governing contested case hearings in OAR 436-001.

Stat. Auth.: ORS 656.704(2), 656.726(4)

Stat. Impltd.: ORS 183.310 through 183.555, 656.283(2), 656.340, 656.447, 656.740 (**§9, ch. 170, OL 2003**), 656.745

Hist: Filed 5/26/82 as WCD Admin. Order 9-1982, eff. 6/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Filed 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-191, 5/1/85
Renumbered from OAR 436-61-970, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/1/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-210 and 260, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 12/11/96 as WCD Admin. Order 96-073, eff. 2/1/97
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13//01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 12/14/01 as WCD Admin. Order 01-066, eff. 1/1/02 (Temporary)
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended 12/12/03 as WCD Admin. Order 03-066, eff. 1/1/04 (Temporary)
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0320 Determining Eligibility for Vocational Assistance and Selection of Vocational Assistance Provider

(1) Unless one of the provisions in section (2) below applies, the insurer shall contact a worker with an accepted disabling claim or claim for aggravation to begin the eligibility determination within five days of the following:

(a) The insurer's receipt of a request for vocational assistance from the worker. If the insurer does not know the worker's permanent limitations, the insurer shall contact the attending physician within 14 days of receiving the request for vocational assistance. The insurer shall notify the worker if the eligibility determination is postponed until permanent restrictions are known or can be projected.

(b) The insurer's receipt of a medical or investigative report sufficient to document a need for vocational assistance, including medical verification of projected or actual permanent limitations due to the injury.

(c) The insurer's knowledge that the claim qualifies for closure because the worker is medically stationary. 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.

(d) The worker is granted a permanent disability award.

(2) The insurer is not required to determine eligibility if:

(a) Eligibility has previously been determined under the current opening of the claim and there are no newly accepted conditions;

(b) The worker has returned to regular or other suitable employment with the employer at injury or aggravation; or

(c) The worker's claim was closed with no permanent disability award. The following by

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themselves do not make a worker ineligible for vocational assistance:

(A) A finding that a worker is not entitled to an additional award of permanent disability on aggravation, or

(B) A finding that a worker is not entitled to a permanent disability award because of an offset of permanent disability from a prior claim, or

(C) The worker disposes of permanent disability through a claim disposition agreement (CDA).

(3) If the insurer receives a request for vocational assistance from the worker or the worker's representative and the insurer is not required to determine eligibility under section (2), the insurer shall notify the worker **in writing, within 14 days of the request** and provide:

(a) The reasons the insurer is not required to determine eligibility,

(b) The circumstance which would require the insurer to determine eligibility, and

(c) The appropriate telephone number of the division, with instructions to contact the division with questions about vocational assistance eligibility requirements and procedures.

(4) Nothing in these rules prevents the insurer from finding a worker eligible and providing vocational assistance at any time.

(5) The insurer shall complete the eligibility determination within 30 days of the contact required in section (1) or if the eligibility determination was postponed within 30 days of receipt of verification of projected or actual permanent limitations.

(6) A vocational counselor certified under OAR 436-120 shall determine if a worker meets eligibility criteria.

(7) The insurer shall provide the vocational counselor with all existing relevant medical information regarding the worker's physical capacities and limitations.

(8) After the worker's permanent limitations are known or can be projected, the worker shall, upon written request from the insurer, provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(9) A worker entitled to an eligibility evaluation is eligible for vocational services if all the following additional conditions are met:

(a) The worker is authorized to work in the United States.

(b) The worker is available in Oregon for vocational assistance. The insurer shall consider the worker available in Oregon if the worker lives within commuting distance of Oregon or documents, in writing, willingness to relocate to or within commuting distance of Oregon within 30 days of being found eligible. The worker is responsible for costs associated with being available in Oregon. The requirement that the worker be available in Oregon for vocational assistance does not apply if the Oregon subject worker [neither worked nor lived] **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:

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- (A) Is not able to return to regular employment;
- (B) Is not able to return to any other 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) None of the reasons for ineligibility under OAR 436-120-0350 applies under the current opening of the claim.
- (10) Upon determining the worker eligible, the insurer and worker shall jointly select a vocational assistance provider. No later than 20 days from the date the insurer determined the worker eligible, the insurer shall either notify the worker of the selection of vocational assistance provider, or if the parties are unable to agree, refer the dispute to the director. The worker and insurer shall follow the same procedure to select a new vocational assistance provider.
- (11) Unless all parties otherwise agree in writing, vocational assistance will be due at any given time with respect only to one claim of the worker. If the worker is eligible for vocational assistance under two or more claims, and there is a dispute about which claim gives rise to the need for vocational assistance pursuant to these rules, the director will select the claim for the injury which results in the most severe vocational impact. If services are provided under more than one claim at a time pursuant to a written agreement of all parties, time and fee limits may extend beyond the limits otherwise imposed in these rules.

Stat. Auth.: ORS 656.726(4), 656.340(9)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temp.)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-111, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-060, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-035, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended and renumbered from OAR 436-120-0330 and -0370, as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0340 Determining Substantial Handicap

- (1) A certified vocational counselor shall perform a substantial handicap evaluation as part of the eligibility determination unless the insurer finds that the worker has a substantial handicap to employment.
- (2) To complete the substantial handicap evaluation the vocational counselor shall 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(13);

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(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, which pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g) below;

(g) An analysis of the worker's labor market utilizing standard labor market reference materials including but not limited to Employment Department (OED) information such as [the **Oregon Wage Information (OWI)**, Oregon Comprehensive Analysis File and other publications of the Occupational Program Planning System (OPPS) [and Oregon Automated Reporting System (OARS) wages-offered data,] and material developed by the division. [When using OARS wages-offered data, the vocational counselor shall use the median wage (Q2) unless there is sufficient evidence that a higher or lower wage is more appropriate.]

When using the OWI data, the presumed standard shall be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate. When such data is not sufficient to make a decision about substantial handicap, the vocational counselor shall perform individual labor market surveys as described in OAR 436-120-0410(6); and

(h) Consideration of the vocational impact of any limitations which existed prior to the injury.

[(3) The vocational counselor who determines whether the worker is eligible for vocational assistance based on a substantial handicap assessment shall sign the following statement:

My signature certifies I have reviewed and analyzed the material referenced in this evaluation report in making my decision regarding whether this worker is eligible for vocational assistance.]

Stat. Auth.: ORS 656.726(4)

Stat. Impltd.: ORS 656.340(5) and (6)

Hist: Filed 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074 eff., 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0350 Ineligibility and End of Eligibility for Vocational Assistance

A worker is ineligible or the worker's eligibility ends when any of the following conditions apply:

(1) The worker does not or no longer meets the eligibility requirements as defined in OAR 436-120-0320. The insurer must have obtained new information which did not exist or which the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility.

(2) The worker is determined not to have permanent disability after a finding of eligibility.

(3) The worker's lack of suitable employment is not due to the limitations caused by the injury or which existed before the injury.

(4) The worker has been employed at least for 60 days in suitable employment after the injury or aggravation and any necessary worksite modification is in place.

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(5) The worker, prior to beginning an authorized return-to-work plan, refused an offer of suitable employment, or left suitable employment after the injury or aggravation for a reason unrelated to the limitations due to the compensable injury. If the employer-at-injury offers employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(6) 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 finding the worker ineligible or ending eligibility, the insurer shall document the existence of one or more suitable jobs which would have been available for the worker upon successful 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.

(7) The worker, after completing an authorized training plan, refused an offer of suitable employment.

(8) The worker has declined or has become unavailable for vocational assistance for reasonable cause. If the insurer does not believe the worker had reasonable cause, the insurer shall warn the worker prior to finding the worker ineligible or ending the worker's eligibility under this section.

(9) The worker has failed, after written warning, to participate in the vocational assistance process, or to provide relevant information. No written warning is required if the worker refuses a suitable training site after the vocational counselor and worker have agreed in writing upon a return-to-work goal.

(10) The worker has failed, after written warning, to comply with the return-to-work plan. No written warning is required if the worker **fails to attend 2 consecutive training days** ^[stops attending training without reasonable cause, or without notifying] **and fails, without reasonable cause, to notify** the vocational counselor or the insurer.

(11) 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.

(12) The worker has misrepresented a matter material to evaluating eligibility or providing vocational assistance.

(13) The worker has refused, after written warning, to return property provided by the insurer or reimburse the insurer after the insurer has notified the worker of the repossession; or the worker has misused funds provided for the purchase of property or services. No vocational assistance shall be provided under the current or subsequent openings of the claim until the worker has returned the property or reimbursed the funds.

(14) The worker physically abused any party to the vocational process, or after written warning, has continued to sexually harass or threaten to physically abuse any party to the vocational process. This section does not apply if such behavior is the result of a documented medical or mental condition. In such a situation, eligibility should be ended under section (11) of this rule.

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(15) The worker has entered into a claim disposition agreement (CDA) which disposes of vocational assistance eligibility. The parties may agree in writing to suspend vocational services pending approval by the Workers' Compensation Board (Board). The insurer shall end eligibility when the Board approves the CDA. No notice regarding the end of eligibility is required.

(16) The worker has received maximum direct employment services and is not entitled to other categories of vocational assistance.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temp.)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-126, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-090, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-045, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 12/14/01 as WCD Admin. Order 01-066, eff. 1/1/02 (Temporary)
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0360 Redetermining Eligibility for Vocational Assistance

If a worker was previously found ineligible or the worker's eligibility ended for any of the reasons specified [below] **in sections (1) through (8), or any of the conditions described in sections (9) through (11) exists**, [upon notification of a change of circumstances] the insurer shall redetermine eligibility **upon notification of a change of circumstances**. The insurer shall complete the eligibility evaluation within 35 days of [one of] the following:

(1) The worker, for reasonable cause, declined or was not available for vocational assistance, or the barrier causing the worker's lack of suitable employment could not be resolved by providing vocational assistance, and those circumstances have changed. The insurer may require the worker to provide documentation the barrier no longer exists, including medical or psychological reports relating to noncompensable conditions.

(2) The worker was not available in Oregon, and the worker becomes available. The worker must request redetermination within six months of the worker's receipt of the insurer's notice.

(3) The worker's claim was denied, and the claim is later accepted and all appeals exhausted.

(4) The worker was not awarded permanent disability and the worker is later awarded permanent disability.

(5) The worker was not authorized to work in the United States, and the worker is now authorized to work in the United States. The time limit set in this section applies to any worker found ineligible or whose eligibility ended because the worker was not authorized to work in the United States regardless of the date the notice of ineligibility or end of eligibility was issued. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

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(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 United States Immigration and Naturalization Service (INS). The worker shall promptly provide the insurer with a copy of any decision by the INS. The insurer shall redetermine eligibility upon receipt of documentation of the worker's authorization to work in the United States.

(6) The worker was unavailable for vocational assistance due to short-term incarceration for a matter unrelated to the worker's claim and is now available. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker is now available to participate in vocational assistance.

(7) The worker returned to work prior to the worker becoming medically stationary, and the physician later rescinded the release.

(8) The worker returned to work prior to becoming medically stationary, and the worker requests a redetermination within 60 days of the mailing date of the Notice of Closure.

[(7) **(9)** Prior to claim closure a worker's limitations due to the injury became more restrictive.

[(8) **(10)** Prior to claim closure the insurer accepts a new condition which was not considered in the original determination of the worker's eligibility.

(11) The worker's temporary disability compensation is redetermined and increased. The worker must make a written request to the insurer to redetermine vocational eligibility within 60 days of receiving notification of the increase in temporary disability compensation.

[(9) The worker returned to work prior to the worker becoming medically stationary, and the physician later rescinds the release.

[(10) The worker returned to work prior to becoming medically stationary, and the worker requests a redetermination within 60 days of the mailing date of the Notice of Closure.]

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-095, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-055, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 12/11/96 as WCD Admin. Order 96-073, eff. 2/1/97
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 12/14/01 as WCD Admin. Order 01-066, eff. 1/1/02 (Temporary)
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0400 Selection of Category of Vocational Assistance

(1) The insurer shall select the category of vocational assistance within 30 days of the date of the insurer's referral to a vocational assistance provider, but no later than 50 days after the

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determination of eligibility. The insurer shall notify the worker and document the reason for its decision.

(2) The insurer shall select one of the following categories of assistance:

(a) **A vocational evaluation**, if the insurer lacks sufficient information to choose between training and direct employment services or to determine if the worker can benefit from vocational assistance.

(b) **Direct employment services**, if the worker has the necessary transferable skills to obtain suitable new employment.

(c) **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.

(3) The insurer shall reconsider the category of vocational assistance within 30 days of the insurer's knowledge of a change in circumstances including, but not limited to, the following:

(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.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340(7)

Hist: Filed 12/17/87 as Admin. Order 11-1987, eff. 1/1/88

Amended and Renumbered from OAR 436-120-083 and 085, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96

Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

436-120-0410 Vocational Evaluation

(1) When the insurer selects this category of vocational assistance, a certified vocational counselor shall complete the evaluation and report within 45 days, and provide a copy to all parties.

(a) **Vocational testing** shall be administered by an individual certified to administer the test.

(b) A work evaluation shall be performed by a Certified Vocational Evaluation Specialist (CVE), certified by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists.

(2) **On-the-job evaluations** shall evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job environment.

(a) First, the vocational counselor shall perform a job analysis to determine if the job is within the worker's capacities. The insurer shall submit the job analysis to the attending physician if there is any question about the appropriateness of the job.

(b) The evaluation should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

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(c) The evaluation does not establish any employer-employee relationship.

(d) A written report shall evaluate the worker's performance in the areas originally identified for assessment.

(3) **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.

(a) 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.

(b) The assessment should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(4) **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.

(5) **Job analysis** is a detailed description of the physical and other demands of a job based on direct observation of the job.

(6) **Labor market surveys** are obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.

(a) A labor market survey 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, which must be addressed with employers to determine if a reasonable labor market exists.

(b) 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.

(c) The labor market survey report shall 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.

(d) Specific openings found in the course of a labor market survey are not, in themselves, proof a reasonable labor market exists.

(7) **The vocational evaluation report** shall include an analysis of all vocational information, and a recommendation of the category of vocational assistance needed for the worker to obtain suitable employment. The report must include the worker's signature indicating the worker has read and received a copy of the report. [Certain information may be excluded from the report, as allowed by ORS 192.525.] The signature does not imply the worker's agreement with the conclusions of the evaluation. The worker may attach written comments to the evaluation report.

(8) Upon receipt of the vocational evaluation report, the insurer shall notify the worker within 10 days whether the worker will receive direct employment services or training, or that the worker is unable to benefit from vocational assistance.

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Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Implt.: ORS 656.340(7)

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-081, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended and Renumbered from OAR 436-120-0420, 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. xx/xx/xx

436-120-0430 Direct Employment

(1) The insurer shall provide an eligible worker with four months of direct employment services dating from the date the insurer approves a direct employment plan or the completion date of an authorized training plan. Direct employment services include, but are not limited to, the following:

(a) Vocational evaluation, if needed.

(b) Employment counseling.

(c) 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 looking for suitable new employment.

(d) Job development, which assists the worker to contact appropriate prospective employers, and with related return-to-work activities.

(e) Job analysis.

(2) The insurer shall 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 which enables the worker to continue the employment.

(3) Direct employment services are available for more than four months if the worker was unable to participate for reasonable cause.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Implt.: ORS 656.340(7)

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)
Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-060, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended and Renumbered from OAR 436-120-030, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-075 and 083, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 12/14/01 as WCD Admin. Order 01-066, eff. 1/1/02 (Temporary)
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

436-120-0440 Training

(1) Training services include a vocational evaluation if needed, plan development, training, monthly monitoring of training progress, and job placement services as necessary.

(2) Training is limited to an aggregate of 16 months, subject to extension to 21 months by the director for a worker with an exceptional disability resulting from the compensable condition(s) and any limitations which existed prior to the injury or an exceptional loss of earning capacity.

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(a) "Exceptional disability" is defined as disability equal to or greater than the complete loss, or loss of use, of both legs. Exceptional disability also includes brain injury which results in impairment equal to or greater than Class III as defined in OAR 436-035.

(b) 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 "significantly closer," as described in OAR 436-120-0400(2)(c), to the worker's adjusted weekly wage and at least 10 percent greater than could be expected with a shorter training program.

(3) A worker enrolled and actively engaged in training shall receive temporary disability compensation subject to OAR 436-060, and payment of awards of permanent disability are suspended. At the insurer's discretion, training costs may be paid for periods longer than 21 months, but in no event shall temporary disability compensation be paid for a period longer than 21 months.

(4) The selection of plan objectives and kind of training shall attempt to minimize the length and cost of training necessary to prepare the worker for suitable employment. Notwithstanding OAR 436-120-0320 (9) (b), the director may order the insurer, or the insurer may elect, to provide training outside Oregon if such training would be more timely, appropriate or cost effective than other alternatives. The plan must be developed and monitored by a vocational assistance provider certified pursuant to these rules.

(5) 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; and

(c) A period of illness or recuperation which does not prevent completion of the training by the planned date.

(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 shall be considered first in developing a training plan. The following conditions apply:

(a) Training time is limited to a duration of 12 months.

(b) The on-the-job training contract between the training employer, the insurer, and the worker shall include, but is not limited to, the worker's name; the employer's legal business name, Workers' Compensation Division Employer Registration number, and the name of the individual providing the training; the training plan start and end dates; the job title, the job duties, and the skills to be taught; the base wage and the terms of wage reimbursement; and an agreement that the employer will pay all taxes normally paid on the entire wage and will maintain workers' compensation insurance for the trainee. If the training prepares a worker for a job unique to the training site, the contract must acknowledge that the training may not prepare the worker for jobs elsewhere.

(c) The insurer shall not reimburse the training employer 100 percent of the wages for the entire contract period.

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- (d) The insurer shall pay temporary disability compensation as provided in ORS 656.212.
- (e) The worker's schedule shall be the same as for a regular full-time employee. The schedule may be modified to accommodate the worker's documented medical condition or class schedule.
- (7) Skills training is offered through a community college, based on predetermined curriculum, at the training employer's location. Skills training is subject to the following conditions:
- (a) Training is limited to 12 months.
- (b) Training does not establish any employer-employee relationship with the training employer. The activity is primarily for the worker's benefit. The worker does not receive wages. The training employer makes no guarantee of employing the worker when the training is completed.
- (c) 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.
- (d) The worker's schedule shall be the same as for a regular full-time employee. The schedule may be modified to accommodate the worker's documented medical condition or class schedule.
- (8) Rehabilitation facilities training provides evaluation, training and employment for severely disabled individuals.
- (9) 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. It is limited to six months.
- (10) Formal training may be offered through a vocational school licensed by an appropriate licensing body, or community college or other post-secondary educational facility which is part of a state system of higher education. Course load shall be consistent with the worker's abilities, limitations and length of time since the worker last attended school. Courses shall relate to the vocational goal.
- (11) The worker is entitled to job placement assistance after completion of training.
- (12) When the worker returns to work following training, the insurer shall monitor the worker's progress for at least 60 days to assure the suitability of employment before ending eligibility.
- (13) Training ends and the plan shall be re-evaluated when any of the following occurs:
- (a) A change in the worker's limitations which renders the training inappropriate.
- (b) The worker's training performance is unsatisfactory and training is not likely to result in employment in that field. In an academic program, the worker fails to maintain at least a 2.00 grade point average for at least two grading periods or to complete the minimum credit hours required under the training plan. The vocational counselor shall report any unsatisfactory performance and the insurer shall give the worker a written warning of the possible end of training at the first indication of unsatisfactory performance.

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(14) The insurer shall not provide any further training to a worker who has completed one training plan unless the worker has sustained a compensable aggravation or newly accepted condition which renders the worker incapable of obtaining suitable employment, or the previous plan was inadequate to prepare the worker for suitable employment because of an error or omission by the insurer.

(15) Training shall end if any of the following applies:

(a) The worker has successfully completed training; or

(b) The worker is not enrolled and actively engaged in the training. However, none of the following will be considered as ending the worker's training status:

(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 which does not prevent completion of the training by the planned date.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temporary)

Filed 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83

Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84

Renumbered from OAR 436-61-060, 5/1/85

Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86

Amended and Renumbered from OAR 436-120-030, 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Amended and Renumbered from OAR 436-120-075 and 085, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

Amended and renumbered from OAR 436-120-0450, 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01

Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

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 shall not use optional services to circumvent the intent of these rules.

Stat. Auth.: ORS 656.283, 656.340, 656.704, 656.726

Stat. Impltd.: ORS 656

Hist: Amended and renumbered from OAR 436-120-0910, 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

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 shall review the plan and plan support with the worker. Certain information may be excluded, as allowed by **OAR 436-010**[ORS 192.525]. 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 shall confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature. The counselor shall submit copies signed by the vocational counselor and the worker to all parties no later than 30 days after the selection of direct

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employment or 60 days after the selection of training. Circumstances beyond the insurer's and worker's control may necessitate an extension of this time frame.

(2) Within 14 days of receipt of the signed return-to-work plan, the insurer shall approve or reject the plan and notify the parties. If the insurer lacks sufficient information to make a decision, the insurer shall advise the parties what information is needed and when it expects to make a decision.

(3) If, during development of a return-to-work plan, an employer offers the worker a job, the insurer shall 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 [(13)] **(12)**. If the job is suitable, the insurer shall help the worker return to work with the employer. The insurer shall 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 shall immediately resume development of the return-to-work plan.

(4) If the vocational goal or category of assistance is later changed, the insurer shall amend the plan. All amendments to the plan shall be initialed by the insurer, vocational assistance provider, and the worker.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340(9)

Hist: Filed 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 Temporary)
Filed 6/30/83 as WCD Admin. Order 1-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-20-177, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-105 and 170, 10/31/94 as Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 12/11/96 as WCD Admin. Order 96-073, eff. 2/1/97
Amended and Renumbered from OAR 436-120-0600, 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0510 Return-to-Work Plan Support

(1) The injured worker and vocational counselor shall work together to develop a return-to-work plan that includes consideration of the following:

- (a) [t]The injured worker's transferable skills;
- (b) [t]The injured worker's physical and mental capacities and limitations;
- (c) [t]The injured worker's vocational interests;
- (d) [t]The injured worker's educational background and academic skill level;
- (e) [t]The injured worker's pre-injury wage; and
- (f) [t]The injured worker's place of residence and that labor market.

(2) Return-to-work plan support shall contain, but is not limited to, the following:

- (a) Specific vocational goal(s) and projected return-to-work wage(s).

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- (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, Dictionary of Occupational Titles codes or other standardized job titles and codes, and specific job duties.
- (d) If a direct employment plan, a description of the worker's transferable skills which 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 shall explain why the goals are appropriate.
- (g) A summary of current labor market information which 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 survey as prescribed in 436-120-0410(6), if needed.
- (i) If the labor market information does not support the goals, the vocational assistance provider shall explain why the goals are appropriate. The worker and worker's representative, if any, shall 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 shall 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 shall 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 or vocational evaluation, the insurer may attach a copy of the evaluation to the plan.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-105, 10/31/94 as Admin. Order 94-058, eff. 1/1/95
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02

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Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0520 Return-to-Work Plan: Responsibilities of the Eligible Worker and the Vocational Assistance Provider

(1) The worker shall participate and maintain contact with the vocational counselor throughout plan development and as required in the plan, and shall inform the vocational counselor of anything which might affect the worker's participation in or successful completion of 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 shall 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 shall help the worker plan the curriculum and help the worker enroll. The vocational assistance provider shall contact the worker, trainers and training facility counselors to the extent necessary to assure the worker's participation and progress.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Amended and Renumbered from OAR 436-120-115, 10/31/94 as Admin. Order 94-058, eff. 1/1/95

Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

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 shall 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 shall, 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.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84

Renumbered from OAR 436-61-172, 5/1/85

Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86

Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88

Amended and Renumbered from OAR 436-120-170 and 215, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95

Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96.

Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

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436-120-0700 Direct Worker Purchases

(1) The insurer shall 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 shall 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 shall approve the purchase or notify the worker of its denial.

(5) The insurer shall 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 shall reimburse costs within 28 days of receiving the written request from the worker and any required supporting documentation.

(b) The insurer shall 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 shall assign to the worker right and title to the nonexpendable direct worker purchases paid by the insurer as follows:

(a) The insurer shall make such assignment no later than the 60th day of continuous employment unless the worker remains eligible and the suitability of the employment is 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)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-087, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

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436-120-0710 Direct Worker Purchases: Kinds

The insurer shall 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 [except as specifically stated]. **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 shall 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 shall 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 by the instructional facility, trainer or employer. The insurer shall pay the cost in full, and shall not require the worker to apply for grants to pay for tuition, books or other expenses associated with training.

(2) **Wage reimbursement for on-the-job training.** The amount shall 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 shall be paid at public transportation rates when public transportation is available; otherwise, mileage shall be paid at the rate of reimbursement for State of Oregon classified employees. Costs incidental to mileage, such as parking fees, also shall be paid. For workers receiving temporary total disability or equivalent income, private car mileage shall 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 shall 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 shall be reimbursed at the rate of reimbursement for State of Oregon classified employees.

(c) **Special travel costs.** Payment shall 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 shall 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.

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(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 shall 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 shall 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 shall 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 shall 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 shall be limited to initiation fees, or back

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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 shall 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.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-087, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff., 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0720 Fee Schedule and Conditions for Payment of Vocational Assistance Costs

(1) The director has established the following fee schedule for professional costs and direct worker purchases. The schedule sets maximum spending limits per claim opening for each category; however, the insurer may spend more than the maximum limit if the insurer determines the individual case so warrants. Spending limits are to be adjusted annually, effective July 1. The annual adjustment is based on the conversion factor described in OAR 436-120-0005(2) and published with the cost-of-living matrix. The amounts in section (2)(3) do not include the adjustment effective July 1, [2002] **2004**.

(2) **For workers found to have an exceptional disability or exceptional loss of earning capacity as defined in OAR 436-120-0440 the fee schedule spending limits for the Training category and DE/Training Combined category listed below shall be increased by 30%.**

(3) Amounts include professional costs, travel/wait, and other travel expenses:

Categories of Vocational Assistance	Professional Spending Limits	Direct Worker Purchases Spending Limits
Eligibility determination without substantial handicap analysis	[\$351] \$364	Not applicable (NA)
Substantial handicap analysis	[\$702] \$728	NA
Vocational evaluation	[\$1,320] \$1,360	[\$1,056] \$1,088
Direct Employment	[\$4,752] \$4,896	[\$2,376] \$2,448
Training	[\$11,880] \$12,240	[\$14,256] \$16,157
DE/Training Combined	[\$13,200] \$13,600	NA
Dispute Resolution	[\$396.00] \$408	NA

(3)(4) Wage reimbursement for on-the-job training contracts, and the living expense allowance during vocational evaluation, are not covered by the fee schedule.

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[(4)]**(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.

[(5)]**(6)** The insurer shall pay, within 60 days of receipt, the vocational assistance provider's billing for services provided under the insurer-vocational assistance provider agreement. The insurer shall 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.

[(6)]**(7)** An insurer entitled to claims cost reimbursement pursuant to OAR 436-110 for services provided pursuant to OAR 436-120 is subject to the following limitations:

(a) Optional services are not reimbursable.

(b) The director must approve eligibility before any services are provided. The request must be submitted on Form 1084.

(c) The insurer must obtain the director's approval in advance of the following actions:

(A) Notifying the worker of eligibility for vocational services;

(B) Any waiver of the provisions of OAR 436-120; or

(C) Exceeding the fee schedule.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340, 656.258

Hist: Filed 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temp)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-120, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-215 and 070, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0730 Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries

(1) This rule applies only to pre-1986 injuries, and carries out the provisions of section 15, chapter 600, Oregon Laws 1985. A reference to "pre-1986 injuries" relates to injuries sustained before January 1, 1986, and encompasses original claims, claims for aggravation, new medical condition claims, and claims for omitted conditions.

(2) For costs to be reimbursable, services must be approved in advance by the Workers' Compensation Division. Both direct worker purchases and professional services shall be billed on the Vocational Reimbursement Request (Form 1592). The insurer shall not request reimbursement of costs the insurer has not paid. Requests to exceed the fee schedule must be submitted on Form 1084. Original insurer signatures (not photocopied signatures) must be provided on all reimbursement requests. Staff certification number(s) must be provided for all reimbursement request charges with the exception of direct worker purchases. The insurer shall submit all reimbursement requests no later than one year after the date of service.

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Stat. Auth.: ORS 656.726(4)

Stat. Impltd.: Section 15, chapt. 600, Oregon Laws 1985, ORS 656.340

Hist: Filed 5/22/80 as WCD Admin. Order 6-1980, eff. 6/1/80
Amended 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 12/29/82 as WCD Admin. Order 11-1982, eff. 1/1/83 (Temp.)
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-300, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/87
Amended and Renumbered from OAR 436-120-220 and 255, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

436-120-0800 Authorization of Vocational Assistance Providers

- (1) A vocational assistance provider must be authorized by the director under this rule.
- (2) A vocational assistance provider must submit an application which includes the following:
 - (a) A description of the specific vocational services to be provided and verification of staff certifications pursuant to these rules;
 - (b) The plan for supervising and training staff; and
 - (c) Evidence of compliance with applicable state and federal requirements.
- (3) The director may approve or deny authorization based on the completed application and the department's certification records.
 - (a) The authorization shall specify the scope of authorized vocational services as determined by the vocational assistance provider's staff certifications.
 - (b) Vocational assistance providers whose authorization is denied under this rule may appeal as described in OAR 436-120-0008.
- (4) An authorized vocational assistance provider shall:
 - (a) Notify the division within 30 days of any changes in office address, telephone number, contact person or staff, and update the roster of certified staff which includes staff certification numbers.
 - (b) Adequately train and supervise certified staff; and
 - (c) Provide each certified staff person with department rules, bulletins, and other information, as provided by the director.
 - (d) The vocational assistance provider shall maintain the worker's vocational assistance files for four years after the end of vocational assistance with that vocational assistance provider, or in a pre-1986 case, for five years after the end of vocational assistance with that provider.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82.
Amended 12/31/81 as WCD Admin. Order 8-1981, eff. 1/1/82 (Temp.)
Amended 5/26/82 as WCD Admin. Order 9-1982, eff. 6/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-180, 5/1/85

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Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-200 and 203, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02

436-120-0810 Certification of Individuals

Individuals determining workers' eligibility and providing vocational assistance shall be certified by the director and on the staff of an authorized vocational assistance provider, insurer, or self-insured employer.

(1) An applicant for certification shall 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(1)(b).

(3) The director may approve or disapprove an application for certification based on the individual's application.

(a) Certification shall be granted for five years. A vocational counselor who is nationally certified as described in OAR 436-120-0830(1)(a) shall be granted an initial certification period to coincide with their national certification.

(b) 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)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-205, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00

436-120-0820 Renewal of Certification

(1) A certified individual shall 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); or

(b) Verification of a minimum of 60 hours of continuing education units pursuant to this rule within the five years prior to renewal. At least seven and one-half hours must be for training in ethical practices in rehabilitation counseling.

(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

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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 shall 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)

Stat. Impltd.: ORS 656.340

Hist: Filed 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

436-120-0830 Classification of Vocational Assistance Staff

Individuals providing vocational assistance shall 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 12 months of direct experience. 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 shall co-sign and assume responsibility for all the intern's eligibility determinations, vocational evaluations, return-to-work plans, vocational and billing reports.

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(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 and labor market survey; 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 and/or 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.

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(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 which is less than full time shall be prorated. For purposes of this rule, full time shall 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.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-205, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 2/2/96 as WCD Admin. Order 95-074, eff. 3/1/96
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0840 Professional Standards for Authorized Vocational Assistance Providers and Certified Individuals

(1) Authorized vocational assistance providers and certified individuals shall:

(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 pursuant to OAR 436-120 and reemployment assistance pursuant to 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[, except as limited by ORS 192.525;] and

(g) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Authorized vocational assistance providers and certified individuals shall 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

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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 authorization 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 which is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9), 656.726(4)

Stat. Impltd.: ORS 656.313, 656.340

Hist: Filed 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88g
Amended and Renumbered from OAR 436-120-207, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02
Amended xx/xx/xx as WCD Admin. Order 04-XXX, eff. 4/1/04

436-120-0900 Audits, Penalties and Sanctions

(1) Insurers and employers at injury shall 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 may be assessed a civil penalty pursuant to ORS 656.745 for any violation of OAR 436-120.

(3) Insurers or employers at injury who fail to comply with a director's order, to give notices required by OAR 436-120-0004, or to provide materials requested by the director may be assessed civil penalties pursuant to this matrix.

Violations in a Calendar Year:	1	2	3	4	5+

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Days Late:					
1 to 7	\$100	\$200	\$300	\$500	\$1,000
8 to 14	\$200	\$300	\$500	\$1,000	\$2,000
15 to 21	\$300	\$500	\$1,000	\$2,000	\$2,000
22+	\$500	\$1,000	\$2,000	\$2,000	\$2,000

(4) In determining the amount of a civil penalty to be assessed in matters not listed in section (3) of this rule, 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.

(5) Pursuant to ORS 656.447, the director may suspend or revoke an insurer's authority to issue guaranty contracts upon determination that the insurer has failed to comply with these rules.

Stat. Auth.: ORS 656.340, 656.726(4)

Stat. Impltd.: ORS 656.340, 656.447, 656.745(1) and (2)

Hist: Filed 12/4/81 as WCD Admin. Order 4-1981, eff. 1/1/82
Amended 6/30/83 as WCD Admin. Order 2-1983, eff. 6/30/83
Amended 12/14/83 as WCD Admin. Order 5-1983, eff. 1/1/84
Renumbered from OAR 436-61-981, 5/1/85
Amended 12/12/85 as WCD Admin. Order 7-1985, eff. 1/1/86
Amended 12/17/87 as WCD Admin. Order 11-1987, eff. 1/1/88
Amended and Renumbered from OAR 436-120-255 and 270, 10/31/94 as WCD Admin. Order 94-058, eff. 1/1/95
Amended 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

436-120-0915 Sanctions of Authorized Vocational Assistance Providers and Certified Individuals

(1) Vocational assistance providers and certified individuals shall 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 authorized 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 authorization or certification to determine

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eligibility and provide vocational assistance to Oregon injured workers for a specified period of time. The vocational assistance provider or individual may reapply for authorization 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 authorization or certification to determine eligibility and provide vocational assistance to Oregon injured workers.

(3) The director shall investigate violations of OAR 436-120 and may impose a sanction under these rules. Before issuing a suspension or revocation, the director shall send a notice of the proposed action and provide the opportunity for a show-cause hearing. The process is as follows:

(a) The director shall send by certified mail a written notice of intended suspension or revocation and the grounds for such action. The notice shall 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 shall become final.

(d) If the vocational assistance provider or individual requests a show-cause hearing, the director shall send a notification of the date, time and place of the hearing.

(e) After the show-cause hearing, the director shall issue a final order which may be appealed as described in OAR 436-120-0008(5).

(4) 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)

Stat. Impltd.: ORS 656.340

Hist: Amended and Renumbered from OAR 436-120-0850, 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Amended 4/13/01 as WCD Admin. Order 01-053, eff. 5/15/01
Amended 5/30/02 as WCD Admin. Order 02-057, eff. 7/1/02.

[436-120-0920 Service of Orders

(1) When the director imposes a sanction or assesses a penalty under the provisions of OAR 436-120-0900 or 436-120-0915, the order, including a notice of the party's appeal rights, shall be served on the party.

(2) The director shall serve the order by delivering a copy to the party in the manner provided by Oregon Rules of Civil Procedure 7D, or by sending a copy to the party by certified mail with return receipt.]

Stat. Auth.: ORS 656.704, 656.726, 656.283, 656.340

Stat. Impltd.: ORS Ch. 656

Hist: Filed 4/27/00 as WCD Admin. Order 00-055, eff. 6/1/00
Repealed xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx