

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
CLAIMS EVALUATION AND DETERMINATION

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 30

EFFECTIVE SEPTEMBER 1, 1991

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436-30-003 Applicability of Rules

(1) Except as provided in section (4) of this rule, these rules are effective December 26, 1990 and apply to all accepted claims for workers' compensation benefits.

(2) All orders or requests issued by Evaluation or the Appellate Unit are considered an "order or request of the director."

(3) These rules take the place of the rules adopted on December 15, 1987, by Workers' Compensation Department Administrative Order 13, 1987, and carry out the provisions of ORS 656.726(3), 656.206, 656.214, 656.268, 656.325, 656.262, and Section 48 of chapter 2 Oregon Laws 1990, Special Session.

(4) The provisions of OAR 436-30-009, 30-020, 30-030, and 30-050 apply to all determinations or claims for workers who become medically stationary after July 1, 1990; for claims in which the claimant becomes medically stationary prior to July 2, 1990 the provisions of OAR 436-30-020, 30-030, 30-050 as contained in WCD Administrative Order 13-1987 shall apply.

(5) The provisions of OAR 436-30-050 adopted pursuant to these temporary rules apply to all requests for reconsideration received by the Department on or after September 1, 1991.

History: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80
Renumbered from OAR 436-65-000, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88
Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp)
Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90
Amended 08/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp)

436-30-050 Reconsideration of Determination Orders or Notices of Closure

(1) A Determination Order or Notice of Closure shall be reconsidered by the Appellate Unit upon receipt by the Department of a written request for reconsideration by one of the parties. The request must be received within 180 days from the mailing date of the Determination

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Order or Notice of Closure.

(2) For the purpose of this rule, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure or Determination Order and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the Department. During a reconsideration proceeding, the Determination Order or Notice of Closure will be reconsidered in its entirety. All information to correct the record and any medical evidence **regarding to the claimant's condition at the time of claim closure** that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding.

(3) The time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the Notice of Closure or Determination Order to request a hearing. The 180-day time [frame] **limit** will be tolled upon receipt of the request for reconsideration until the date the reconsideration order is issued.

(4) [The director shall by Bulletin prescribe the form and format of a completed request for reconsideration.] **A "completed request for reconsideration" shall be submitted in the form and format as prescribed by the Director and attached hereto as Appendix A.** Pursuant to this section, a "completed reconsideration request" shall include, but not be limited to:

- (a) the Worker's Name, Social Security Number, Date of Injury and WCD File Number;
- (b) a statement in bold face print and capital letters, "REQUEST FOR RECONSIDERATION";
- (c) the date of closure, type of closure and the specific reason(s) for objection to the Determination Order or Notice of Closure;
- (d) whether there is disagreement with the specific impairment findings [of the attending physician] **used to determine permanent disability** at the time of claim closure and if so, an explanation **is required** of the specific areas of disagreement;
- (e) any information and documentation deemed necessary to correct any part of the claim record the party believes to be erroneous; and/or
- (f) any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at or before claim closure;
- (g) In accordance with section (5) of this rule, an affidavit, submitted with the reconsideration request, that certifies that the party requesting a reconsideration has provided copies of the request plus supporting evidence to all other interested parties.**

[g] **(h)** A statement in bold face print and capital letters:

NOTICE TO PARTIES: AT THE RECONSIDERATION PROCEEDING, THE WORKER OR THE INSURER OR SELF-INSURED EMPLOYER MAY CORRECT INFORMATION IN THE RECORD THAT IS ERRONEOUS AND MAY SUBMIT ANY MEDICAL EVIDENCE THAT SHOULD HAVE BEEN BUT WAS NOT SUBMITTED BY THE PHYSICIAN SERVING AS THE ATTENDING PHYSICIAN AT THE TIME

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OF CLAIM CLOSURE. (ORS 656.268)

IF YOU WISH ANY INFORMATION TO BE CONSIDERED AS PART OF THE RECONSIDERATION PROCEEDING, YOU MUST SUBMIT THE INFORMATION TO THE APPELLATE UNIT, WORKERS' COMPENSATION DIVISION, 210 LABOR & INDUSTRIES BLDG., SALEM, OREGON 97310, WITHIN [FIFTEEN (15)] SIX (6) WORKING DAYS FROM THE [MAILING] DATE [OF THIS] THE REQUEST FOR RECONSIDERATION IS RECEIVED BY THE DEPARTMENT.

(5) When requesting reconsideration of a Notice of Closure or Determination Order, [A]an insurer and a worker represented by an attorney must submit a "completed reconsideration request", pursuant to section (4) of this rule[,] and, **at the same time,** provide copies **of the "completed request for reconsideration"** [at the same time] to the other interested parties: [when requesting reconsideration of a Notice of Closure or Determination Order].

(a) The notice to the other parties must advise them of their right to correct information in the record and the time frames for submitting such information in accordance with section (7) of this rule.

(b) The requesting party must certify, by means of an affidavit submitted with the reconsideration request, that copies of the "completed reconsideration request" were provided to all other interested parties. This is the sole means of notifying other interested parties that a reconsideration request has been filed. When the requesting party fails to comply with this section, the Appellate Unit will not consider any correcting or clarifying evidence submitted with the reconsideration request, and such evidence will not be part of the record on reconsideration.

(c) If, within six working days from the request for reconsideration, the non-complying party subsequently certifies to the Department that other interested parties have received copies of the appropriate information, the additional information will be considered in the reconsideration proceeding.

(d) All information submitted to the Department by any interested party during the reconsideration process must be copied to all interested parties and be accompanied by certification that it has been provided to all interested parties. Failure to comply with this requirement will result in the information not being included as part of the record on reconsideration. [The parties shall have fifteen (15) working days from the mailing date of the request to submit additional information as outlined in section (4) above.]

(6) Upon receipt of a "completed" request for reconsideration," the Appellate Unit [shall notify the insurer, worker and the worker's representative, if any, of receipt of the request and] **will advise all parties of the date the request was received and the date the record will close. On all requests for reconsideration received on or after October 1, 1991, the Appellate Unit will also notify the parties of the last date an order on reconsideration can be issued and the status of their request if the Department falls to mail a reconsideration order pursuant to the time frames specified in ORS 656.268(6)(a), as amended by House Bill 3584 (1991 Regular Session).**

(7) [Fifteen] Six working days after the [mailing] date [of] the request for reconsideration is received, the request and all other **appropriate** information submitted by the parties shall

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become part of the record used in the reconsideration proceeding[.];

(a) Evidence received subsequent to the sixth (6) working day deadline may not be considered in the reconsideration proceeding.

(b) Upon review of the record the Appellate Unit may request, **in accordance with ORS 656.268(5)**, any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(c) When a basis for the Request for Reconsideration is a disagreement with the impairment findings used in rating the worker's disability at the time of claim closure, the Director shall refer the claim to a medical arbiter or panel of arbiters. On requests for reconsideration received on or after October 1, 1991, the department will, within 18 working days from the date the reconsideration request was received, mail notice to the parties that a medical arbiter review will be scheduled.

(d) All additional information, including the medical arbiter findings, if applicable, and the documents [used to issue] **upon which** the [previous] determination order or notice of closure **were based** shall also become part of the record used in the reconsideration proceeding to issue an order on reconsideration.

(8) Upon written notice by the worker, or the worker's representative, of the intent to request reconsideration of a Notice of Closure or Determination Order, or upon written notice that a reconsideration has been filed, the insurer or self-insured employer shall, within [10] **(5)** days of the mailing date of said notice, furnish the Department, **and** the worker or the worker's representative, without cost, a copy of all documents pertaining to the claim or the specific documents so requested. **When the request for reconsideration is made by an unrepresented worker or the insurer or self-insured employer has not received proper notice of the reconsideration request from a represented worker, the Department will request the record used to issue the Notice of Closure. The insurer or self-insured employer shall, within five (5) days of the mailing date of said request, furnish the Department and the worker a copy of all documents pertaining to the claim.**

(9) An insurer failing to provide information or documentation as set forth in sections 5, 6, 7, and 8 of this rule may be assessed civil penalties pursuant to OAR 436-30-580. Failure to comply with the requirements set forth in Sections 5, 6, 7, and 8 may also be grounds for extending the reconsideration proceeding **pursuant to ORS 656.268(5)**.

(10) Upon receipt of a request from an unrepresented worker the Appellate Unit **shall acknowledge receipt of the request and notify all parties of their right to correct information in the record and the time frames for submitting such information in accordance with section (7) of this rule.** The Appellate Unit shall **also** assist the worker in developing a completed request; inform the worker of the right to consult with the ombudsman or an attorney; and mail a copy to the insurer. Notwithstanding any other provision of this rule, the division may extend any time frames or request any information deemed necessary to assure the unrepresented worker's reconsideration request is complete.

(11) When a basis for the Request for Reconsideration is a disagreement with the impairment findings [of the attending physician] **used in rating the worker's disability** at the time of

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claim closure, the Director shall refer the claim to a medical arbiter or panel of arbiters [pursuant to ORS 656.268(7) and OAR 436-10-047.];

[12] **(a)** If the worker or the worker's representative requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the determination will be used to issue the reconsideration order.

[13] **(b)** If the insurer requests reconsideration and the worker fails without good cause to appear for the medical arbiter examination, the worker's benefits may be suspended pursuant to 436-60-085 and 436-60-095.

[14] **(12)** If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. If an increase in compensation results from new information obtained through a medical arbiter examination or from the promulgation of a temporary emergency rule, penalties will not be assessed.

[15] **(13)** For the purpose of section (14) of this rule, a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled.

[16] **(14)** Attorney fees may only be authorized when a request for reconsideration is submitted by an attorney representing a worker and a valid signed retainer agreement has been filed with the Appellate Unit. The reconsideration order shall order the insurer or self-insured employer to pay the attorney out of any additional compensation awarded an amount equal to 10 percent of any additional compensation awarded [but not more than 40 percent of the maximum attorney fee allowed in OAR 438-15-040(1) and (2) and OAR 438-15-045].

[17] **(15)** When a worker has received a lump sum payment, pursuant to OAR 436-60-060, of an award granted by a Notice of Closure or Determination Order, the Appellate Unit shall not consider the adequacy of that award in a reconsideration proceeding.

[18] **(16)** When the Appellate Unit determines it is necessary to promulgate an emergency rule(s) to rate a worker's disability not otherwise described in the Disability Rating Standards, the reconsideration proceedings shall be stayed for no more than 60 days to develop and issue the temporary rule(s). In the event emergency rules are required, the Department shall notify all affected parties within five working days of the need to defer action.

[19] **(17)** When the Appellate Unit finds, upon reconsideration, that the claim was closed prematurely, the Appellate Unit shall issue an order rescinding the Notice of Closure or Determination Order.

[20] **(18)** Compensation reduced in a Reconsideration Order shall be "in lieu of" any compensation awarded by the Notice of Closure or Determination Order.

[21] **(19)** Additional compensation awarded in a Reconsideration Order shall be "in addition to" any compensation awarded by the Notice of Closure or Determination Order.

[22] **(20)** Any compensation affirmed in a Reconsideration Order shall be so stated.

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[(23)] **(21)** A copy of the Reconsideration Order will be sent to the worker, employer, insurer, and attorney if the worker is represented.

History: Filed 6/30/78 as WCD Admin. Order 8-1978, eff. 7/10/78

Amended 3/20/80 as WCD Admin. Order 4-1980, eff. 4/1/80

Renumbered from OAR 436-65-100, May 1985

Amended 12/17/87 as WCD Admin. Order 13-1987, eff. 1/1/88

Amended 6/18/90 as WCD Admin. Order 7-1990, eff. 7/1/90, (temp)

Amended 12/10/90 as WCD Admin. Order 33-1990, eff. 12/26/90

Amended 8/20/91 as WCD Admin. Order 6-1991, eff. 9/01/91 (temp)



REQUEST FOR RECONSIDERATION

Oregon Department of Insurance & Finance

Workers' Compensation Division • Appellate Unit

Requesting Party: _____	Mailing Date: _____
Address: _____	Worker: _____
Phone No: _____	WCD No: _____
Requesting Party's Representative: _____	Insurer: _____
<i>(A valid signed retainer agreement is required for awarding an attorney fee)</i>	Claim No: _____
Address: _____	Date of Injury: _____
Phone No: _____	Social Security Number: _____
	Date of Determination Order (DO) or Notice of Closure (NOC) to be reconsidered: _____

NOTICE TO PARTIES: AT THE RECONSIDERATION PROCEEDING, THE WORKER OR THE INSURER OR SELF-INSURED EMPLOYER MAY CORRECT INFORMATION IN THE RECORD THAT IS ERRONEOUS AND MAY SUBMIT ANY MEDICAL EVIDENCE THAT SHOULD HAVE BEEN BUT WAS NOT SUBMITTED BY THE PHYSICIAN SERVING AS THE ATTENDING PHYSICIAN AT THE TIME OF CLAIM CLOSURE. (ORS 656.266)

IF YOU WISH ANY INFORMATION TO BE CONSIDERED AS PART OF THE RECONSIDERATION PROCEEDING, YOU MUST SUBMIT THE INFORMATION TO THE APPELLATE UNIT, WORKERS' COMPENSATION DIVISION, 210 LABOR & INDUSTRIES BLDG., SALEM, OREGON 97310, WITHIN SIX(6) WORKING DAYS FROM THE DATE THIS REQUEST FOR RECONSIDERATION IS RECEIVED BY THE DEPARTMENT.

Directions: You must check one of the boxes for each potential issue. "Yes" means you object to that aspect of the DO/NOC. *Explain the reasons on a separate sheet and attach to this form.* Please number your explanations to correspond with the issues.

- | | | |
|---------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 1. Medically stationary date. If you checked "yes," list the correct date: _____
Explain the reasons for your choice. List any documents supporting this date. |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 2. Premature closure. If you checked "yes," explain your reasons and list any documents which support your position. |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 3. Temporary total disability (TTD) or temporary partial disability (TPD) dates.
(Time loss payments) If you checked "yes," specify the correct dates. |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 4. Impairment findings used in rating the worker's disability at time of claim closure. If you checked "yes," explain your specific disagreement with the findings used to rate disability. List any medical reports supporting your position. (Note: Checking "Yes" may result in a Medical Arbitrator's Examination.) |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 5. Scheduled Permanent Partial Disability. If you disagree with the rating of disability by the Evaluation Section or the insurer, explain your reasons for disagreement. |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 6. Unscheduled Permanent Partial Disability— I disagree with the rating of impairment by Evaluation or the insurer. If you checked "yes," be as specific as possible about your reasons for disagreement. |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 7. Unscheduled Permanent Partial Disability— I disagree with the rating of Age, Education and Adaptability. If you checked "yes," specify your disagreement with the application of the Standards and supply evidence to support your position. |
| Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | 8. Other (Does not include any issue under 1 through 7). If you checked "yes," specify any other objection you have to the DO/NOC. State your reasons and list any supporting documents. |
| | | 9. <i>My signature certifies that all interested parties have been supplied with a copy of this Reconsideration Request and supporting evidence. I understand that failure to provide such copies will result in the Appellate Unit not considering additional evidence upon reconsideration.</i> |

Signature _____

Form and all separate sheets must be signed and dated by an authorized representative of the worker or insurer/self-insured employer, or by the worker if represented in this action.)

NOTE: Workers not represented by attorneys may contact the Appellate Unit for assistance in completing this form by calling 378-2384 or 1-800-452-0288. Workers may also wish to consult the Ombudsman at 378-3351 or 1-800-452-0288 or an attorney before signing this form.

Please send a completed and signed copy of this form, any of the above documents which have not already been submitted, and if applicable, a valid signed retainer agreement to:

Oregon Department of Insurance & Finance
Workers' Compensation Division Appellate Unit
210 Labor & Industries Building
Salem, OR 97310 (503) 378-2384