Current Tools – Claim Suspension

Item	Oregon Revised Statute	DCBS Administrative Rules
A claim can be suspended for refusing to attend or cooperate with an IME request.	ORS 656.325(1) requires a worker to submit to an independent medical examination (IME) at the request of an insurer or self-insured employer or by the DCBS Director. The statute allows suspension of workers' rights for compensation and suspension of payments if the worker refuses to or obstructs an IME, with approval from the DCBS Director.	OAR 436-060-0095(6) outlines processes for requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial, which includes: • A requirement for the insurer to send a copy of the suspension request simultaneously to the worker, their representative, and attending physician; and • How a worker can dispute the request for suspending compensation. Once a suspension is request is approved, an insurer must close the claim if the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order.
A claim can be suspended for insanitary or injurious practices.	ORS 656.325(2) allows the DCBS Director to approve suspension of a worker's rights to compensation, including payments, for any period of time that: 1. The worker commits insanitary or injurious practices which tend to either imperil or delay the worker's recovery; 2. Refuses to submit to such medical or surgical treatment reasonably essential to promote recovery; or 3. Fails to participate in a physical rehabilitation program. Medical or surgical treatment definition: Being under the care of a physician or authorized nurse practitioner or abide by a treatment regimen. A treatment regimen includes but is not limited to a prescribed diet, exercise, program, medical or other prescribed activity.	OAR 436-060-0105 outlines the processes for suspending or reducing benefits, which includes: • A notice containing required information that must be sent simultaneously to the worker, their representative, and attending physician; • Verification by the insurer whether the worker complied with the request for cooperation on the specified date in the notice; • Required information to accompany a benefits suspension or benefits reduction request to the DCBS Director; • The process after the Director approves a request; and • How a worker can dispute the request for suspending or reducing compensation.

Current Tools – Claim Suspension (continued)

<table>
<tr><th>Item</th><th>Oregon Revised Statute(s)</th><th>DCBS Administrative Rules</th></tr>
<tr><td>Benefits can be suspended if the worker fails to cooperate with investigation of the claim.</td><td>ORS 656.262(14) establishes that injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques.

ORS 656.262(15) establishes if the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim.</td><td>OAR 436-060-0135 outlines the processes for suspending benefits when a worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(14), which includes:
• Notice to the worker and worker's attorney that an interview or deposition has been scheduled, or of other investigation requirements;
• The worker must be given 14 days to cooperate with the notice;
• Required information to accompany a benefits suspension request to the DCBS Director; and
• Director notice to all parties that benefits will be suspended in five business days unless the worker or worker's attorney contacts the division by telephone or mails a letter documenting that the failure to cooperate was reasonable, or the insurer notifies the division that the worker is now cooperating.

If the worker makes no effort to cooperate within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(15) and OAR 436-060-0140(8).

If the worker reasonably cooperates with the investigation, the insurer must reinstate the worker's benefits immediately.</td></tr>
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Current Tools – Claim Suspension (continued)

Item	Oregon Revised Statute(s)	DCBS Administrative Rules
Payments can be cut off to workers who fail to appear for medical exams.	ORS 656.262(4)(e) establishes a process for time loss benefits to be suspended if a worker fails to appear at an appointment and fails to appear at a rescheduled appointment. Benefits can be reinstated when the worker appears at a rescheduled appointment.	OAR 436-060-0020(5) allows an insurer to suspend time loss benefits without authorization from the DCBS Director when the worker missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner, the insurer sends a letter by certified mail at least 10 days in advance of a rescheduled appointment to the worker and their representative. The letter must include notice and logistics of the rescheduled appointment, and specific verbiage regarding consequences if they do not attend the appointment, or the worker notifies the insurer that they cannot attend in advance of the appointment date. Upon missing a rescheduled appointment, the insurer must send a letter to the worker, their representative and DCBS regarding benefits suspension. The letter must include information on how benefits can be resumed – schedule and attend an appointment with their doctor who must verify their continued inability to work.

Current Tools – Claim Closure

Item	Oregon Revised Statute(s)	DCBS Administrative Rules
A claim can be closed when the worker fails to seek medical treatment for a 30-day period.	ORS 656.268 establishes conditions in which an insurer or self-employer must close a worker's claim. Subsection 1(c) allows closure without approval of the attending physician or authorized nurse practitioner when the worker fails to seek medical treatment for a 30-day period or attend a closing examination, unless the worker affirmatively demonstrates that the failure is for reasons beyond the worker's control.	OAR 436-030-0034 establishes processes and requirements for closing a claim when the worker is not medically stationary and the worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner and for reasons within the worker's control. The 30 day lack of treatment period must expire before the worker receives written notification via certified and regular mail, with a copy sent to their representative. A claim closes unless the worker establishes within 14 days from the date the notice was sent certified mail that treatment has resumed (attending an existing appointment or scheduling a new appointment), or the reasons were outside the worker's control. If applicable, the worker's attending physician or authorized nurse practitioner must be copied on all notification and denial letters applicable to this rule.

Current Tools – Provider Payments		
Item	**Oregon Revised Statute(s)**	**DCBS Administrative Rules**
Payments can be cut off to health care providers who fail to report on the injured worker's ability to return to work.	ORS 656.262(4)(f) **-** If an insurer or self-insured employer has requested and failed to receive verification of the worker's inability to work due to the claimed injury or disease, medical services provided by the attending physician or nurse practitioner are not compensable until such verification is submitted.	

Current Tools - Claim Management

Item	Oregon Revised Statute(s)	DCBS Administrative Rules
Insurers can require progress reports every 15 days.	ORS 656.252(2)(b) requires the attending physician or nurse practitioner to advise a insurer or self-insured employer of the worker's: • Anticipated date for release to return to employment; • The anticipated date that the worker will be medically stationary; and • The next appointment date. The insurer or self-insurer can request a medical report every 15 days, unless there was prior indication that temporary disability will not exceed 14 days.	OAR 436-010-0240(6) establishes that chart notes are sufficient for satisfying the request. If more information is required, the insurer may request a brief or complete narrative report. The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request. If the medical provider fails to provide information under this rule within 14 days of receiving a request sent by fax or certified mail, penalties may be imposed. The progress report must contain, if known: • The anticipated date of release to work (which cannot be considered as a date of release to return to work); • The anticipated date the patient will become medically stationary (the date of the exam, not a projected date); • The next appointment date; and • The patient's medical limitations.

Current Tools - Claim Management (continued)

<table>
<tr><th>Item</th><th>Oregon Revised Statute(s)</th><th>DCBS Administrative Rules</th></tr>
<tr><td>Modified job offers that are within the worker's restrictions.</td><td>ORS 656.268(4)(c) allows the insurer to end temporary total disability (TTD) benefits when:
The attending physician or nurse practitioner who has authorized temporary disability benefits advises the worker and documents in writing that the worker is released to return to modified work,
Modified work has been offered to the worker in writing, and
The worker fails to begin the modified work.
The worker can refuse the modified job offer without terminating TTD if the offer:
Requires a commute beyond the physical capacity of the worker, according to the attending physician or nurse practitioner;
Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pattern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;
Is not with the employer at injury;
Is not at a work site of the employer at injury;
Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or
Is not consistent with an existing shift change provision of an applicable collective bargaining agreement;</td><td>If the worker fails to begin employment, OAR 436-060-0030 (3) establishes the insurer must stop paying TTD benefits and start paying temporary partial disability (TPD) benefits as if the worker had begun the regular or modified job. However, specific conditions must be met, as follows.

The employer or insurer has notified the attending physician or authorized nurse practitioner of the physical tasks, and location of the modified work. The employer or insurer must also ask if the worker can, as a result of the compensable injury, physically commute to and perform the job.

The attending physician or authorized nurse practitioner has agreed the employment appears to be within the worker's capabilities, and considering the compensable injury the worker is physically able to commute the lesser of the distance from:
The worker's residence at the time of injury to the work site; or
The worker's residence at the time of the modified work offer to the work site;
The insurer or employer has confirmed the job offer in writing to the worker. The rule states required information that must be in the job offer, including specifics about the modified job, the conditions for refusing the offer without termination of TTD, and appeal process if the insurer reduces or stops TTD.</td></tr>
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Current Tools - Claim Management (continued)

Item	Oregon Revised Statute(s)	DCBS Administrative Rules
Insurer may request verification of the worker's inability to work.	ORS 656.262(4)(d) establishes temporary disability is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of the worker's inability to work resulting from the claimed injury or disease and the physician or nurse practitioner cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control.	OAR 436-060-0020(4) establishes steps the insurer must follow before withholding temporary disability, if the insurer has requested verification of inability to work, and the attending physician or authorized nurse practitioner cannot verify it. • The insurer must ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. The insurer must document their findings if no valid reason is found or the worker does not respond or cannot be located. • If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may stop temporary disability payments and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments. • When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of temporary disability, unless otherwise denied.

Current Tools - Claim Management (continued)		
Item	**Oregon Revised Statute(s)**	**DCBS Administrative Rules**
Insurer may contact a provider and negotiate a verbal release to work.	ORS chapter 656 does not specifically address verbal release to return to work.	OAR 436-060-0020(6) and 436-060-0030(8) establish if temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician or authorized nurse practitioner, and the worker has not been informed of the release by the attending physician or authorized nurse practitioner or returned to work, the insurer must: • Document the facts; • Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and • Advise the worker of their reinstatement rights under ORS chapter 659A.

Background on the rules regarding the verbal release to work (Rule added eff. 1/1/02):

From the issue doc:

"**Issue:** Workers are often not aware temporary disability will stop. Suggested that rules require the insurer write to the worker if TTD/TPD ends for any reason explaining why.

Discussion: Doctor releases worker to return to regular work. Informs insurer in writing, but doesn't inform worker (or does inform worker who doesn't realize impact) and modified work (reduced hours or wages) continues. EAC strongly felt it is the doctor's responsibility, don't shift it to the insurer. Worker's attorney voiced concerns about overpayments."

From Testimony and response, WCD response:

"**Response:** The term "negotiates" is excellent to clarify the intent of the proposed rule is to require insurers to notify the worker when the insurer negotiates a return to work via telephone with the attending physician when no return to work was previously authorized. The clarification of "if the worker has not already been informed by the attending physician or has not already returned to work" further clarifies the intent of the proposed language. There has not been a problem with doctors failing to inform workers of their release, unless the insurer contacts the doctor and negotiates a release when no return to work was previously authorized, thereby negating the physician's ability to comply with their statutory responsibility under ORS 656.252. The language will be modified to incorporate the concept of "negotiates a release when no return to work was previously authorized" and "if the worker has not already been informed by the attending physician or has not already returned to work." The problem of certified mail increasing costs to the system is well founded and will be removed. The rule will also be amended to clarify that the insurer's notice of the negotiated work release can be contained in a modified job offer to the worker."