

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

In the Matter of the Amendment of: )  
436-060, Claims Administration ) SUMMARY OF  
 ) TESTIMONY AND  
 ) AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency’s conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated Oct. 1, 2016. On Oct. 24, 2016, a public rulemaking hearing was held as announced at 2 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record was held open for written comment through Oct. 28, 2016.

Three people testified at the public rulemaking hearing, recorded below as exhibit 3. However, as the hearing was for testimony on several rule divisions, only one person testified on division 060. The public submitted six written documents as testimony.

**Testimony list:**

<b>Exhibit</b>	<b>Testifying</b>
<u>1</u>	Theodore P. Heus, Preston/Bunnell, LLP, Trial Lawyers
<u>2</u>	Lynn Hamers, Intermountain Claims
<u>3</u>	Transcript of public rulemaking hearing of Oct. 24, 2016 a) Amber McMurry, Multnomah County b) John Jones (no testimony on division 060) c) Jaye Fraser, SAIF Corporation (no testimony on division 060)
<u>4</u>	Theodore P. Heus, Preston/Bunnell, LLP, Trial Lawyers
<u>5</u>	Jaye Fraser, SAIF Corporation
<u>6</u>	Bob Livingston, Oregon State Fire Fighters Council
<u>7</u>	Chris Frost, Oregon Trial Lawyers Association

**Testimony: OAR 436-060-0010(1)(a)**

***Exhibit 5***

(1)(a) States that an employer must provide the worker an 801 form immediately after receiving notice or knowledge of a potential compensable injury. The proposed revision conflicts with ORS 656.265(6), which expressly requires an employer to supply injury reporting forms "to injured workers upon request of the injured worker or some other person on behalf of the

worker." The current version of the rule is consistent with the statute. To ensure consistency with the statute and employer compliance, SAIF suggests that the director maintain the original language.

**Response:**

The rule revision was intended, in part, to increase use of Form 801 in compliance with ORS 656.262(3)(a), which requires employers to "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," and OAR 436-060-0010(2). The division recognizes that the worker's notice does not need to be given using Form 801 to initiate the claim, and that an employer may report the claim to their insurer by providing the information required by Form 801 without using the form itself under OAR 436-060-0010(3).

The division maintains, however, that the insurer is responsible for securing a signed Form 801, or its electronic equivalent, unless the form cannot be obtained from the employer or worker because the employer or worker cannot be located, refuses to cooperate, or is physically unable to complete the form. It is the division's position that requiring the employer to provide Form 801 to the worker upon notice or knowledge of an accident that may involve a compensable injury is a reasonable requirement to ensure the worker is supplied with the Form 801, and receives all of the information included on Form 801 and Form 3283 in a timely matter, and that the change falls under the director's rulemaking authority under ORS 656.726(4)(a).

To clarify that these requirements fall under different statutory authority, OAR 436-060-0010(1)(a) has been amended to read:

Form 801, "Report of Job Injury or Illness," must be readily available for workers to report their injuries. The employer must provide Form 801 to the worker:

- (A) Immediately upon request by the worker or worker's attorney under ORS 656.265(6); and
- (B) Upon receiving notice or knowledge of an accident that may involve a compensable injury under ORS 656.262(3)(a).

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**Testimony: OAR 436-060-0010(6)**

***Exhibit 2***

"\* \* \* My recommendation was to include information advising of our inability to direct medical treatment on the 801 Form. I had one thought after the rulemaking discussion though.... The industry is going more toward submitting electronic forms and our access to actual signatures is becoming more limited. I know the idea of having people sign to indicate that they read and understand that employer/insurers are not allowed to direct treatment. I don't think our luck getting a real signature related to that issue will be any better than signing the 801 itself indicating the filing of a claim. With electronic filing progressing, this will only get further diluted. \* \* \*"

**Response:** The division agrees that the increase in electronic reporting presents challenges to maintaining uniform and verifiable reporting mechanisms. However, OAR 436-060-0011(1)(c) requires electronic forms to include the same fields and elements as their paper counterparts. For the Form 801, this requirement includes the information about the worker's right to choose a

medical service provider. The division will continue to take steps to ensure that workers of employers who report claims using an electronic or telephonic system receive the same information and notices as other workers.

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**Testimony: OAR 436-060-0010(6)**

***Exhibit 3a***

“\* \* \* This has to do with the new language being proposed to be added to the 801. In the worker’s section, above their signature line it says in bold, “I understand I have a right to choose a healthcare provider of my choice, subject to certain restrictions.” In the employer’s section, above the employer’s signature line, is also a bold statement, “I understand I may not restrict the worker’s choice of access to a health care provider. If I do it could result in civil penalties under ORS 656.260.” The concern I have with this is nowhere on this form does it indicate to the worker or the employer where they can receive or review that information that may restrict them, or what those restrictions may be. So I propose that if that statement is to stay on the 801, that it is added in to that statement for them to reference 436-060-0010, subsection (6). \* \* \*”

**Response:**

The division agrees that it is important for the worker to have access to information about their rights, and what may restrict their choice of health care provider. The division will include a reference to ORS 656.260 and 656.325 in the statement on Form 801.

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**Testimony: OAR 436-060-0017(3)(f)**

***Exhibit 5***

“(3)(f) Requires the continuation of discovery under the Board's rules (OAR Chapter 438) after a hearing request is withdrawn or the hearing record has closed. The proposed rule is not supported by statute. The Board's authority to make rules of practice and procedure, including for discovery of documents, only extends to those that, "are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278." ORS 656.726(5)(a). \* \* \* The Board's duties do not include making rules that govern discovery for claims not in litigation. Making all other rules associated with the administration of Chapter 656 is the director's responsibility. ORS 656.726(4).

“\* \* \* When a hearing is completed and the order is final, the hearings division loses jurisdiction over the matter.

“The effect of the proposed rule change would be to require insurers, once a hearing has been requested, to continue to provide discovery of newly received documents every seven days, indefinitely. This would add significant administrative burden and cost to insurers and self-insured employers, without any known benefit to injured workers. Claimant's attorneys may not want to receive this level of information, and there is no mechanism under the Board's rule to turn it off. Most notices on the claim are already required to be copied to the worker's attorney.

“\* \* \* If the director feels that the close of the hearing record is too soon to bring discovery back under OAR 436-060-0017, SAIF would not oppose a rule that is consistent with its current practice. Keeping discovery under the Board's rule when the Board no longer has any jurisdiction over a matter, however, is both legally unsupported and onerous.”

**Response:** The division did not intend to substantively change the jurisdiction of claims under discovery. OAR 436-060-0017(3)(f) has been revised to retain its original language with minor nonsubstantive changes to improve clarity:

“If a hearing is requested before the Workers’ Compensation Board, the release of documents is controlled by OAR chapter 438 until the hearing request is withdrawn or the hearing record is closed, provided a request for documents is renewed.”

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**Testimony: OAR 436-060-0018**

***Exhibit 5***

“SAIF agrees with the proposed rule changes and agrees that the proposed changes are consistent with the testimony and discussion at the August 23, 2016 advisory meeting with the exception of OAR 436-060-0018(3)(b), which conflicts with ORS 656.277(1)(a).”

**Response:** The division believes the amended rule makes the process for requesting reclassification of a claim more consistent for injured workers, and improves clarity of expectations for insurers, self-insured employers, and service companies. These improvements would not have been possible without the advice of our stakeholders.

The division also has considered testimony we received regarding the change to OAR 436-060-0018(3)(b), to provide an insurer 14 days from the receipt of a worker’s request for reclassification to review and respond. Please see the division’s response to the testimony given in Exhibit 1 for a detailed explanation.

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**Testimony: OAR 436-060-0018(3)(b)**

***Exhibit 1***

“\* \* \* The Workers’ Compensation Division (WCD) proposes to amend subsection (3)(b) to require insurer to review a reclassification request and respond within 14 days *of receipt* of the workers' request. (Emphasis added). With respect, that is not what the statute requires. ORS 656.277(1)(a) provides, “The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days *of the request*.” (Emphasis added). The addition of “receipt” as the event triggering the 14-day response period is not supported by the statute, as the statute does not mention “receipt.” Rather it is the “request” that triggers the time period. “It is well established that the WCD cannot expand or limit a statutory requirement. \* \* \*

“Further, an administrative rule dictating when an insurer must respond to a request for reclassification could create a conflict or confusing double standard applicable to that process. Specifically, while ORS 656.277(1)(a) is a processing statute, ORS 656.386(3) is an attorney fee statute, which provides, “If a claimant requests claim reclassification as provided in ORS 656.277 and the insurer or self-insured employer does not respond within 14 days *of the request* \* \* \* the director, Administrative Law Judge, board or court may assess a reasonable attorney fee.” (Emphasis added). As such, insurers may comply with the proposed rule by *processing* the worker’s request with 14 days from receipt, but still be held liable for an *attorney fee* under ORS 656.386(3).

“\* \* \* I recommend retaining the current rule that mirrors the statutory language.

**Response:** As stated in the testimony, ORS 656.277(1)(a) provides “the insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days of the request” and this language is mirrored in ORS 656.386(3). Neither statute specifies if this was intended to mean “14 days of the mailing date of the request” or “14 days of the receipt of the request.”

ORS 656.277(1)(a) also provides “the worker may ask the Director \* \* \* to review the

classification by the insurer \* \* \* by submitting a request for review within 60 days *of the mailing* of the classification notice \* \* \*.”

The division believes that if the legislature intended for the insurer to be required to classify the claim within *14 days of the mailing of the request*, they would have used similar language.

This issue was originally raised by a stakeholder who was concerned that requiring an insurer response within 14 days of the request was inconsistent with other insurer timeframes that typically are triggered by the date of receipt. The issue was discussed at an advisory committee meeting on September 10, 2015. Several stakeholders commented that the mailing date standard was not appropriate for the shorter response timeframes typically provided to insurers. The division also identified potential issues with verification of the mailing date of a worker’s request that is sent by regular mail, given that an insurer is required to date stamp documents it receives, but not necessarily retain the postmark.

In addition, the division believes that providing the insurer 14 days from the receipt of the request is reasonable, given the need for the insurer to conduct a reasonable investigation of the worker’s claim classification and respond to the worker appropriately. The division is concerned that not providing adequate time for this process may result in increased refusals to reclassify or failures to respond to requests, which can both delay benefits to workers.

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**Testimony: OAR 436-060-0018(3)(d)**

***Exhibit 1***

“\* \* \* The changes to this subsection are not comprehensive. I propose the following language for subsection (3)(d), with recommend additions in italics: \* \* \*

*(A) The worker’s request to reclassify the claim shall be deemed de facto refused, and the worker may appeal to the director under subsection (3)(c) of this rule; and* \* \* \*

“At the August 23, 2016 advisory meeting, a question arose of how to handle situations in which the insurer does not respond to a worker’s request to reclassify within 14 days or before a request for review is initiated. The WCD’s solution has been to dismiss the appeal without prejudice. The WCD appears to question its authority to deem such a nonresponse a “de facto” refusal subject to adjudication. That belief is not supported by the law.

\* \* \*

“\* \* \* WCD clearly has the authority and duty to consider a refusal to respond to a request to reclassify the claim as a “de facto” refusal to reclassify the claim and adjudicate the matter as a refusal. As such, the WCD should adopt that application to allow the parties to adjudicate the issue of classification when an insurer fails to respond timely to a worker’s request.”

**Response:** The division has reviewed its policy of dismissing a request for review of an insurer’s classification decision when the insurer has failed to respond to a worker’s request for reclassification.

Upon further consideration, the division agrees that the requirement for a worker to request reclassification from an insurer before requesting review by the director under ORS 656.277(1)(a) was not intended to prevent a worker from seeking the director’s review if the insurer fails to meet its obligation to respond.

As a result, the division will treat an insurer's failure to respond to a reclassification request as equivalent to a refusal to reclassify, and will review the classification decision of the insurer upon receipt of a worker's request following the end of the 14 day response timeframe.

To accommodate this process, OAR 436-060-0018(3)(d) has been amended to provide:

“ \* \* \* If the insurer does not respond to the worker's request for reclassification within 14 days of receipt of the worker's request:

- (A) The worker may request review by the director under section (7) of this rule as if the insurer issued a Notice of Refusal to Reclassify;
- (B) The director may assess civil penalties under OAR 436-060-0200;
- (C) The director may assess an attorney fee under ORS 656.386(3) \* \* \*

OAR 436-060-0018(7) has also been amended to provide:

**(7) Appeal of insurer's classification decision.**

If a worker disagrees with an insurer's decision to not reclassify the worker's claim from nondisabling to disabling, or to reclassify the claim from disabling to nondisabling, the worker may appeal the decision by requesting review by the director:

- (a) The request must be in writing and mailed to the director within 60 days from the date of the insurer's notice ; and
- (b) The worker may use Form 2943, "Worker Request for Claim Classification Review," for requesting review of the insurer's claim classification decision.

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**Testimony: OAR 436-060-0018(3)(f)**

***Exhibit 1***

“ \* \* \* WCD should add OAR 436-060-0018(3)(f), and I propose the following language:

“(f) If claimant appeals to the director under subsection (3)(c) of this rule, the director must issue an order classifying the claim.

“My August 19, 2016 letter to the WCD and my testimony at the August 23, 2016 advisory meeting explains why this rule is needed. Briefly, the WCD has adopted an internal policy of dismissing “appeals”—requests for administrative review— of refusals to reclassify. \* \* \* This subverts the intent of ORS 656.277(1)(b), which requires an “order from the director reclassifying the claim” in order to award an attorney fee.

“Clarification that the WCD must issue an order classifying the claim avoids the recurring tactic of voluntarily accepting the claim as disabling after the worker's attorney initiates an appeal, thus avoiding exposure to fees, despite the work of claimant's attorney before the director. Unless the WCD truly lacks subject matter jurisdiction, such as when the appeal is untimely or the claim has been classified a non-disabling for more than one year, the director should issue an order as described under ORS 656.277(1)(b).”

**Response:** The division has considered its policies regarding dismissals of requests for review of the insurer's classification decision following a voluntary reclassification of a claim or failure to respond to a workers' request.

The division maintains that it is not appropriate for the division to classify a claim by order after the insurer has voluntarily reclassified the claim from non-disabling to disabling and issued a Modified Notice of Acceptance. The insurer is responsible for reclassifying a nondisabling claim to disabling within 14 days of receiving information that the claim meets the disabling criteria in OAR 436-060-0018(2). It is important that reclassification happens in a timely manner to avoid additional delays in benefits to workers.

This policy is not a subversion of the intent of ORS 656.277(1)(b), which provides “\* \* \* if the worker is represented by an attorney and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may award the attorney a reasonable assessed attorney fee.” The statute is clear that the order must reclassify a claim from nondisabling to disabling, but does not provide for the director to award an attorney fee when the claim has already been voluntarily reclassified.

While the division has decided it will not make the requested amendment to the rule, the division will review the form of the dismissal to resolve the matter of jurisdiction and establish appeal rights.

The division has also reviewed its policy of dismissing a worker’s appeal following an insurer’s failure to respond to a workers classification request. Upon further consideration, the division agrees that the requirement for a to worker request reclassification from an insurer before requesting review by the director under ORS 656.277(1)(a) was not intended to prevent a worker from seeking the director’s review if the insurer fails to meet its obligation to respond.

As a result, the division will treat an insurer’s failure to respond to a reclassification request as equivalent to a refusal to reclassify, and will review the classification decision of the insurer upon receipt of a worker’s request following the end of the 14 day response timeframe.

See the response to testimony above for specific rule changes.

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**Testimony: OAR 436-060-0018(3)**

***Exhibit 4***

“I attended the public hearing held on October 24, 2016. \* \* \* I noted that there was no opposition testimony to my prior recommendations regarding reclassification. \* \* \* I want to offer concrete examples of pending cases that have directly resulted from the concerns expressed in my letters. In short, the Workers’ Compensation Division’s summary dismissal of cases requesting administrative review of de facto refusals to reclassify, and voluntary reclassifications after a request has been initiated, are creating confusion among forums as to which forum has subject matter jurisdiction to address the issues.

“For example, I represent a client on behalf of whom I requested administrative review of an insurer’s express refusal to reclassify the claim. After the WCD acknowledged the request, the insurer voluntarily issued a modified notice of acceptance, indicating the claim had been accepted for a disabling condition. On March 25, 2016, the WCD summarily, and sua sponte, dismissed my client’s request for review. The order stated that my client could appeal the order by requesting a hearing with the Worker’s Compensation Board’s (WCB) Hearings Division. I did so on behalf of my client.

“\* \* \* WCB dismissed the request for hearing for lack of jurisdiction. Indeed, both the parties and the judge agreed that the WCB lacked jurisdiction to review the WCD’s dismissal because it was not an order classifying the claim and ORS 656.277 conferred jurisdiction to the WCB only for appeal of such orders. The matter now languishes back before the WCD to reissue an order with correct appeal rights according to law.

“In a different case, a colleague, on behalf of her client, requested a hearing before the WCB for an insurer’s failure to respond at all to a request for reclassification. She understood the WCD’s policy of summarily dismissing requests for administrative review in such cases, and asked the WCB for relief. The judge dismissed the dispute for lack of subject matter jurisdiction, stating that the WCD, not the WCB, has initial jurisdiction to consider the issue. Notably, the judge accepted employer’s argument that a failure to respond at all to a request for reclassification is “*equivalent to a notice of classification as nondisabling*, which triggers claimant’s right to request [WCD] review.” (Emphasis added). The judge’s reasoning directly conflicts with the WCD’s informal policy that the WCD does not have jurisdiction to address an insurer’s complete failure to respond to an initial request for reclassification and its policy to not treat that failure as a *de facto* refusal to reclassify.

“\* \* \* Attorneys on both sides are spending considerable resources and effort attempting to discern which forum has jurisdiction to address grievances regarding claim classification. As it stands, neither the WCD nor the WCB appears willing to assume jurisdiction to resolve such disputes. This not only creates a confusing procedural problem that needs to be resolved, but implicates larger constitutional issues.

“My prior recommended changes to OAR 436-060-0018 would alleviate much of that confusion. The recommendations clarify the party’s rights and, more importantly, the forums’ respective jurisdiction to resolve the disputes. As such, I urge the WCD to implement my recommendations. Ignoring them will simply result in further confusion and litigation.”

**Response:** The division appreciates the testimony provided, as well as the concrete examples. While the division cannot comment on the particular cases discussed, the division has taken the testimony into consideration. Please see the responses above for detailed explanation and specific rule changes.

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**Testimony: OAR 436-060-0020(3)(c)**

***Exhibit 5***

“(3)(c) States that “Temporary disability compensation is authorized when: The director determines there is sufficient contemporaneous medical documentation to reasonably reflect the worker’s inability to work under ORS 656.268.” This proposed rule appears to derive from current OAR 436-060-0020(4), which states in part, “The insurer at claim closure, or the division at reconsideration of the claim closure, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker’s inability to work.” To be consistent with the current standard, SAIF suggests modifying the proposed rule to state “Temporary disability compensation is authorized when: At reconsideration of the claim closure, the director determines there is sufficient contemporaneous medical documentation to reasonably reflect the worker’s inability to work.”

**Response:** The proposed language was derived from the previous language in OAR 436-060-0020(4). The change was not intended to expand the director’s authority to determine that

temporary disability compensation is authorized. OAR 436-060-0020(4)(c) has been amended to provide:

“The director determines, at reconsideration of claim closure, there is sufficient contemporaneous medical documentation to reasonably reflect the worker’s inability to work under ORS 656.268.”

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**Testimony: OAR 436-060-0020(9)**

***Exhibit 5***

“(9) Provides for the payment of temporary disability once a denied claim is determined to be compensable. SAIF proposes inserting the word "finally" between "has been" and "determined" because retroactive time loss is due once the order setting aside a denial is final.”

**Response:** The division agrees that the proposed language is consistent with the provisions of ORS 656.313. OAR 436-060-0020(9) has been amended to provide:

“If a denied claim has been determined to be compensable by final order, the insurer must begin temporary disability payments under ORS 656.262 \* \* \*”

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**Testimony: OAR 436-060-0025**

***Exhibit 7***

“OTLA opposes the proposed change to OAR 436-060-0025, calculation of time-loss that will average worker’s wages rather than multiply the current rate by the hours worked. This change will lower time-rates for all injured workers who had a wage rate increase at any time in the 52 weeks prior to the date of injury. Given that many workers find it difficult to live on their time-loss benefits while recovering from injuries, we oppose this rule change that will negatively impact these workers.

“We understand this change was made to simplify calculating TL benefits, but it isn’t clear why the current formula would be so much more difficult.

“Finally, ORS 656.202 requires benefits be determined on the date of injury. It is hard to see how a wage increase can be ignored, and time-loss be based on the previous wage that is no longer applicable.”

**Response:** The division believes the simplification of the calculation method is necessary to ensure workers receive accurate and predictable benefits.

The previous method of calculation, which multiplied the average weekly hours worked by the wage at injury was based on the incorrect assumption that the variability in workers’ earnings is driven solely by variation in the number of hours worked during a week.

This may be true for some workers, but many workers receive multiple wages or types of wages during the course of their work. For example, a worker may receive a differential in wages for working an undesirable shift or doing a risky job, many workers receive overtime pay, bonus pay, and incentive pay. Many of the specific provisions that were removed from the rule tried to account for the variability in worker’s wages, by requiring the insurer to estimate both the worker’s wage at injury and the hours worked to determine the worker’s average weekly wage.

The division determined that the complex and sometimes overlapping nature of these provisions

was a primary contributor to the continuing poor performance in payment accuracy. The division believes that basing the average weekly wage on the worker's average weekly earnings is not only a simpler method of calculation, but one that provides a more comprehensive estimation of the worker's income at the time of injury.

This change is within the director's statutory authority. ORS 656.202(2) does tie the rate of compensation to "the law in force at the time the injury giving rise to the right to compensation occurred," but does not determine how those rates of compensation are calculated. ORS 656.210(2)(e) provides the director "by rule, may prescribe methods for establishing the worker's weekly wage" for workers who are not regularly employed, or workers whose remuneration is not based solely upon daily or weekly wages.

The division would also like to emphasize that while some workers who received a pay increase in the 52 weeks prior to injury may face a marginal decrease in their rate of compensation under the new calculation method, we expect these losses to be partially offset by the expansion of the types of earnings that are included in the average.

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**Testimony: OAR 436-060-0025**

***Exhibit 7***

"\* \* \* We also see many positive changes proposed. Simplifying the extended gap rule is one such change that will likely help both insurers and workers figure out proper benefits."

**Response:** The division agrees that establishing a clearer definition of what is considered to be an extended gap will improve consistency in the calculation of the worker's weekly average wage.

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**Testimony: OAR 436-060-0025**

***Exhibit 6***

"\* \* \* we are concerned with the proposed rule change as it relates to time loss benefits and would request that you hold the record open for additional comment. \* \* \* due to the importance of this rule change and the impact that it may have on injured workers time loss benefits, we would respectfully request that the agency at a minimum hold the record open longer for a better understanding by stakeholders, and in the absence of this action, would oppose the proposed rule as drafted."

**Response:** The division has been soliciting input from stakeholders on this issue since late 2014. We met with a Stakeholder Advisory Committee three times in August and September of 2015, and again in July and then August of this year. While OAR 436-060-0025 was not the subject of every meeting, we discussed the rule at length in several of our meetings. The division also sent notice about the proposed rule changes to more than 3,800 customers on Sept. 19, 2016. We announced a hearing date of Oct. 24, and we left the record open for written testimony through Oct. 28.

At this point, the division has received adequate advice and testimony on the proposed rule change to make our decision without extending the period for testimony. The division will continue to communicate the changes to workers, insurers, and the public, and will continue to solicit feedback and advice for future rulemaking activities.

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**Testimony: OAR 436-060-0025**

***Exhibit 6***

“\* \* \* it is also my understanding that perhaps MLAC was not made aware of this change and while this type of change may not rise to the level of discussion of MLAC, it does serve as a way to ensure the various stakeholders are aware of changes that may impact employee benefits - particularly when calculating time loss benefits. \* \* \*”

**Response:** The division welcomes input from MLAC, and strives to keep the committee informed about its rulemaking activity. During this rulemaking, the division solicited advice from MLAC members on this issue, and invited members to attend our Stakeholder Advisory Committee meetings. In addition, each MLAC member was sent notice of the proposed changes on Sept. 19, 2016.

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**Testimony: OAR 436-060-0025**

***Exhibit 6***

“\* \* \* it is my understanding that this rule was made to make it easier to calculate benefits. We are not sure that this should be the reasoning behind a rule change - particularly when it comes to ensuring the benefits of an injured worker. In fact, it has and should be the goal of the agency to ensure that an injured worker receives accurate and timely benefits. \* \* \*”

**Response:** The primary goal of this rule change is to improve the accuracy of temporary disability benefits. In late 2014, the division held three focus group meetings with stakeholders to discuss ways to improve the accuracy of temporary disability payments to workers, which has been a persistently poor performance area for insurers, employers, and service companies. Participants cited the complexity of the average weekly wage calculation rules for workers with irregular earnings to be contributing to the problem of inaccurate payments, and identified the need for a simpler, easier method of calculating the workers weekly wage. This rule change reflects the division’s best alternative to achieve this goal.

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**Testimony: OAR 436-060-0025**

***Exhibit 6***

“\* \* \* as you may be aware, recent law changes have made it clear that when it comes to ensuring proper payment of workers when it comes to their wages, employers must ensure that this information is readily available on a workers paycheck, and many employers are having to make changes to paycheck stubs in order to comply with this law. It appears that this new rule may be inconsistent with this law which was intended to make sure that employers and employees alike understand important information that is essential in ensuring wages are clearly understood and accurately accounted for. Again, this new rule as written appears to create confusion along with the propensity to reduce the benefits rightly owed by many workers.”

**Response:** One of the objectives of this rule was to bring the wage information used to calculate the workers’ average weekly wage more in line with the wage information reported to other regulatory agencies. We believe the new rule will reduce confusion by streamlining the calculation method and eliminating many of the exceptions to what types of wages and other earnings must be included when determining the worker’s rate of compensation that were particular to this rule.

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**Testimony: OAR 436-060-0025(4) and (4)(a)**

***Exhibit 5***

“(4) Provides the wage calculation for workers who are not "regularly employed." Missing from the proposed changes is language that limits the calculation to earnings from the job at injury. This limitation is present in ORS 656.210(2)(d), which states, "The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury." Proposed 436-

060-0020(3) mirrors this provision. ORS 656.210(2)(e) grants the director discretion to prescribe methods for establishing a worker's weekly wage for workers not "regularly employed". To maintain consistency and avoid ambiguity, SAIF suggests adding the phrase "with the employer at injury" between "average of the worker's total earnings" and "for the period up to 52 weeks." "

“(4)(a) To maintain consistency as noted above, SAIF suggests adding the phrase "with the employer at injury" to the end of this proposed rule for the same reasons.”

**Response:** While the division agrees that benefits due under ORS 656.210(2)(e) are based on the worker's total earnings at the employer at injury, the calculation method under OAR 436-060-0025(4) may also apply to supplemental disability benefits due an eligible worker under ORS 656.210(2)(a)(B) and OAR 436-060-0035. These benefits are based on wages from all eligible employment, including wages from a secondary employer who is not “the employer at injury.” To add more specificity to the rule the division has amended OAR 436-060-0060(4)(a) to provide:

“Total earnings” means all wages, salary, commission and other remuneration for services rendered under the worker's wage earning agreement with the employer.”

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**Testimony: OAR 436-060-0025(4)(a)(B)**

***Exhibit 5***

“(4)(a)(B) Excludes payment for expenses incurred due to the job and paid for by the employer. SAIF proposes adding "or advanced" between "reimbursed" and "by the employer" to capture those employer-related payments paid in advance to the worker to cover anticipated expenses incurred due to the job.”

**Response:** In keeping with the findings of the Court of Appeals decision in SAIF v Sparks, 258 Or. App. 227 (2013), the division has determined that when funds are advanced to a worker to supplement their hourly wage, as in the case of travel pay, those funds should be considered wages to be included in the worker's total earnings when calculating the rate of temporary disability. The rule will remain as proposed, to provide that incurred expenses that are reimbursed may be excluded from the worker's total earnings.

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**Testimony: OAR 436-060-0025(4)(b)(A)**

***Exhibit 5***

“(4)(b)(A) Simplifies whether a gap in employment qualifies as an extended gap that is excluded from the temporary disability rate calculation. SAIF suggests increasing the number of days considered to be a gap in employment to 60 days. SAIF reasons that due to the seasonal nature of many industries including construction, firefighting and logging, a gap of 60 days captures those employment relationships that are seasonal and cyclical. In addition, SAIF suggests adding "reasonably" between "not" and "anticipated" to create a standard of reasonableness. For employers and workers who have been in the same industry for several years, there typically are anticipated gaps in employment that were not specifically discussed as part of the wage earning agreement because such gaps are already anticipated by both parties, based on their experience within that particular field, at the time of hiring.”

**Response:** With advice from stakeholders, the division has determined that a gap of employment of more than 14 days was sufficient to be considered extended, particularly for workers with less than 52 weeks of wage earnings. This provision applies more broadly than to just seasonal and cyclical workers, and increasing the number of days required for a gap to be considered extended

from 14 to 60 would reduce the average weekly wage for workers who experience significant gaps in employment.

The division expects that the determination that an extended gap was or was not anticipated in the wage earning agreement will be made on a case by case basis. The issue of creating a standard of reasonableness for these determinations was not discussed with the stakeholder advisory committee, and will be addressed in future rulemaking.

---

**Testimony: OAR 436-060-0025(5)(b) & (5)(l)**

***Exhibit 5***

“(5) Removes current OAR 436-060-0025(5)(b) and -0025(5)(1), which provide specific temporary disability rate calculations for workers employed through a temporary service provider and school teachers or workers paid in a like manner. SAIF suggests retaining these rules to maintain the accurate calculation of the temporary disability rate in these unique employment situations. The proposed rules streamline and simplify the calculation of the temporary disability rate for most injured workers but may not capture the unique employment situation of school teachers and temporary workers.”

**Response:** The division has considered the effect of the rule change on school teachers and workers employed by a temporary service provider or worker leasing company.

The division does not believe that school teachers or workers paid in a like manner will be affected by the new rule. The temporary disability benefits of workers who are paid an annual salary should be calculated under OAR 436-060-0025(5)(c). The benefits should continue to extend over the calendar year. The division will work with insurers and other stakeholders to make sure this expectation is understood.

The division does, however, recognize that the proposed rules may result in an unintended change in how benefits are calculated for temporary and leased workers. The division has added a new paragraph to OAR 436-060-0025(4)(b), so that the section provides:

(b) If, on the date of injury or verification of disability caused by occupational disease, the worker had been employed by the employer at injury for four weeks or more, the insurer must average the workers’ total earnings for the period up to 52 weeks of employment before the date of injury or verification of disability caused by occupational disease, subject to the following:

(A) The insurer may not include any gap in employment of more than 14 days that was not anticipated in the wage earning agreement, when calculating the average earnings; and

(B) If the worker’s wage earning agreement changed due to reasons other than only a change in rate of pay, including but not limited to a change of hours worked or a change of job duties, in the 52 weeks before the date of injury or verification of disability caused by occupational disease, the insurer must average earnings only for the weeks worked under the most recent wage earning agreement; and

**(C) For the purposes of this section, a job assignment from a temporary service provider or worker leasing company as defined in OAR 436-050 is not considered to be a new wage earning agreement.**

---

**Testimony: OAR 436-060-0030(6)(a)**

***Exhibit 5***

“(6)(a) Removes the phrase "includes but are not". SAIF suggests striking out the words "limited to" so that "includes but are not limited to" is removed.”

**Response:** The division has corrected the rule language in OAR 436-060-0030(6)(a) to provide:

“This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.”

---

**Testimony: OAR 436-060-0035(4) & (11)**

***Exhibit 5***

“(4) Removes the provision that precludes a penalty under ORS 656.262(11) if a delay in payment of a higher disability rate is due to the worker 's failure to provide verifiable documentation of secondary employment. The revised rules moved the penalty provision to OAR 436-060-0035(11), which states, in part, "Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation requested under this rule will not result in the assessment of a civil penalty." A civil penalty and a penalty under ORS 656.262(11) are not interchangeable: a civil penalty is payable to the director whereas an ORS 656.262(11) penalty is payable to the worker with a penalty-related fee to the worker's attorney.

“SAIF suggests either retaining the last sentence of current OAR 436-060-0035( 4) and re-numbering it as OAR 436-060-0035(4)(D) or replacing the phrase "civil penalty" under OAR 436-060-0035(11) with "ORS 656.262(11) penalty," and renumbering the last sentence of proposed rule OAR 436-060-0035(11) as OAR 436-060-0035(4)(D).”

**Response:** The division agrees that civil penalties and penalties under 656.262(11) are not interchangeable. The division has restored the language under OAR 436-060-0035(4) as OAR 436-060-0035(4)(c):

“Any delay in the payment of a higher disability rate because of the worker’s failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).”

The division has also removed the reference to ORS 656.262(11) penalties in OAR 436-060-0035(11).

---

**Testimony: OAR 436-060-0035(7)**

***Exhibit 5***

“(7) SAIF suggests adding the words "eligible for supplemental temporary disability" between "When the worker" and "has post-injury" to avoid the impression that the insurer must calculate the temporary partial disability rate using wages from all jobs in cases in which the worker has not been determined eligible for this benefit.”

**Response:** The division agrees that the suggested language improves the clarity of the rule. OAR 436-060-0035(7) has been amended to provide:

“When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job \* \* \*”

**Dated this 28<sup>th</sup> day of November, 2016.**

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September 30, 2016

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RE: Workers Compensation Division  
Proposed Rule Changes to OAR 436-060-0018

Dear Mr. Bruyns,

Please accept these comments to the proposed rule changes affecting OAR 438-060-0018, governing claim classification.

**Proposed OAR 436-060-0018(3)(b)**

The Workers' Compensation Division (WCD) proposes to amend subsection (3)(b) to require insurer to review a reclassification request and respond within 14 days *of receipt* of the workers' request. (Emphasis added). With respect, that is not what the statute requires. ORS 656.277(1)(a) provides, "The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days *of the request*." (Emphasis added). The addition of "receipt" as the event triggering the 14-day response period is not supported by the statute, as the statute does not mention "receipt." Rather it is the "request" that triggers the time period.

It is well established that the WCD cannot expand or limit a statutory requirement. *Miller v. Employment Div.*, 290 Or 285 (1980) ("An agency may not amend, alter, enlarge or limit the terms of a legislative enactment by rule.") (citing *University of Oregon Coop. Store. v. Dept. of Rev.*, 273 Or 539, 550 (1975)). If legislature intended the 14-day period to run from receipt, it would have said so. *See, e.g., Dept. of Consumer & Bus. Servs. v. Muliro*, 359 Or 736 (2016) (interpreting statutes expressly using the term "received" and "mailed"). That makes sense, as payment of temporary disability is particularly time sensitive, and any rules that extend the time in which payment is required harms workers greatly.

Further, an administrative rule dictating when an insurer must *respond* to a request for reclassification could create a conflict or confusing double standard applicable to that process. Specifically, while ORS 656.277(1)(a) is a *processing* statute, ORS 656.386(3) is an *attorney fee* statute, which provides, "If a claimant requests claim reclassification as provided in ORS 656.277 and the insurer or self-insured employer does not respond within 14 days *of*

*the request*\* \* \* the director, Administrative Law Judge, board or court may assess a reasonable attorney fee.” (Emphasis added). As such, insurers may comply with the proposed rule by *processing* the worker’s request with 14 days from receipt, but still be held liable for an *attorney fee* under ORS 656.386(3).

For example, consider a request for reclassification mailed on January 1, 2017. Insurer receives the request on January 3, 2017. It issues a Modified Notice of Acceptance on January 17, 2017, 14 days after it received the request. In such circumstance, insurer has complied with the amended rule, but is still liable for a fee for failing to respond within 14 days of the request. As such, I recommend retaining the current rule that mirrors the statutory language.

**Proposed OAR 436-060-0018(3)(d)**

The changes to this subsection are not comprehensive. I propose the following language for subsection (3)(d), with recommend additions in italics:

(d) If the insurer does not respond to the worker’s request for reclassification within 14 days<sup>1</sup> of the worker’s request:

*(A) The worker’s request to reclassify the claim shall be deemed de facto refused, and the worker may appeal to the director under subsection (3)(c) of this rule; and*

*(B) The director may assess civil penalties under OAR 436-060-0200, attorney fees under ORS 656.386(3), or both.*

At the August 23, 2016 advisory meeting, a question arose of how to handle situations in which the insurer does not respond to a worker’s request to reclassify within 14 days or before a request for review is initiated. The WCD’s solution has been to dismiss the appeal without prejudice. The WCD appears to question its authority to deem such a nonresponse a “*de facto*” refusal subject to adjudication. That belief is not supported by the law.

There is clear authority allowing an agency to consider an insurer’s failure to issue a notice timely a *de facto* action. In *SAIF v. Allen*, 320 Or 192 (1994), the court explained that statutory duty to accept or deny a claim within the allowed period of time is absolute, and failure to do one or the other gives rise to a *de facto* denial, the compensability of which the Workers’ Compensation Board (WCB) has authority to address.

Similarly, the WCB considers a failure to issue a Notice of Closure or a Notice of Refusal to Close within 10 days of a worker’s request for closure under ORS 656.268(5)(d) a “*de facto*” refusal to close subject to adjudication. See *Adrienne Dombrosky*, 60 Van Natta 185 (2008)

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<sup>1</sup> Notice that “receipt” is also omitted from this subsection for the same reasons discussed above. The WCD does not have authority to expand or limit deadlines contained in a statute, and any “receipt” requirement that expands the time will surely be challenged in the courts.

(interpreting ORS 656.268(5)(d) as giving rise to a *de facto* refusal to close the claim when no response is given to a worker's request for closure within the statutory time frame).

Based on the above, the WCD clearly has the authority and duty to consider a refusal to respond to a request to reclassify the claim as a "de facto" refusal to reclassify the claim and adjudicate the matter as a refusal. As such, the WCD should adopt that application to allow the parties to adjudicate the issue of classification when an insurer fails to respond timely to a worker's request.

**Proposed OAR 436-060-0018(3)(f)**

Finally, the WCD should add OAR 436-060-0018(3)(f), and I propose the following language:

(f) If claimant appeals to the director under subsection (3)(c) of this rule, the director must issue an order classifying the claim.

My August 19, 2016 letter to the WCD and my testimony at the August 23, 2016 advisory meeting explains why this rule is needed. Briefly, the WCD has adopted an internal policy of dismissing "appeals"—requests for administrative review—of refusals to reclassify.<sup>2</sup> This subverts the intent of ORS 656.277(1)(b), which requires an "order from the director reclassifying the claim" in order to award an attorney fee.

Clarification that the WCD must issue an order classifying the claim avoids the recurring tactic of voluntarily accepting the claim as disabling after the worker's attorney initiates an appeal, thus avoiding exposure to fees, despite the work of claimant's attorney before the director. Unless the WCD truly lacks subject matter jurisdiction, such as when the appeal is untimely or the claim has been classified a non-disabling for more than one year, the director should issue an order as described under ORS 656.277(1)(b).

Thank you for considering of my suggestions. As always, if you have questions, please let me know.

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<sup>2</sup> Please refer to my August 19, 2016 letter for more detail of the law and the problem. For convenience, a copy of the letter is attached.

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August 19, 2016

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RE: Rule Making Advisory Committee – OAR Chapter 436, Division 060 –  
Fees in Claim Classification Disputes

Dear Mr. Bruyns,

Thank you for the invitation to participate in the Rulemaking Advisory Committee, scheduled to meet August 23, 2016. I have reviewed the committee's agenda, and I wish to offer my comments on the proposed alternatives to Issue #2, concerning attorney fees in claim classification disputes.

The Workers' Compensation Division's (WCD) summary of the problem is accurate. Essentially, insurers are avoiding fees by issuing Modified Notices of Acceptances, which accepts the claim as disabling, after a claimant has requested administrative review before the WCD. This is because the WCD has made an internal policy decision to dismiss requests for review, instead of issuing an order reclassifying the claim. Because the statute, ORS 656.277(1)(b), provides for an attorney fee only when an attorney is "instrumental in obtaining an order from the director that reclassifies the claim," the insurer avoids paying a fee because a dismissal is not an order reclassifying the claim.

The WCD correctly recognizes the legislative purpose of amending ORS 656.277(1)(b). The statute was intended to create a process in which insurers were allowed a period of time to voluntarily reclassify the claim without being exposed to fees. However, if insurer refused to do so timely, then a worker was permitted to raise a formal dispute and the insurer thereafter would be exposed to fees based on the efforts of the attorney if successful in getting the claim reclassified.

Thus, there are several problems with the WCD's current dismissal process. Specifically, it is not authorized by law, and even if it were, the rationale for the process is incorrect. The best alternative is to resolve the dispute by issuing an order of reclassification, regardless of the insurer's actions taken after the request for administrative review is initiated.

No statute or rule expressly permits the WCD to dismiss a request for review of a classification decision. Specifically, ORS 656.277(1)(a) provides, "The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or self-insured employer by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or self-insured employer. If any party objects to the classification of the director, the party may request a hearing under ORS 656.283 within 30 days

from the date of the director's order." Nothing in that statute suggests that dismissal is appropriate once claimant requests review of a refusal to reclassify.

The WCD's sole rationale for dismissing a request for review is that if an insurer voluntarily accepts a disabling claim after review, "there is nothing left to decide." That rationale fails on several levels. First, to the extent that such rationale invokes the notion of "mootness," the mootness doctrine does not apply to, and is not available to, Oregon agencies.

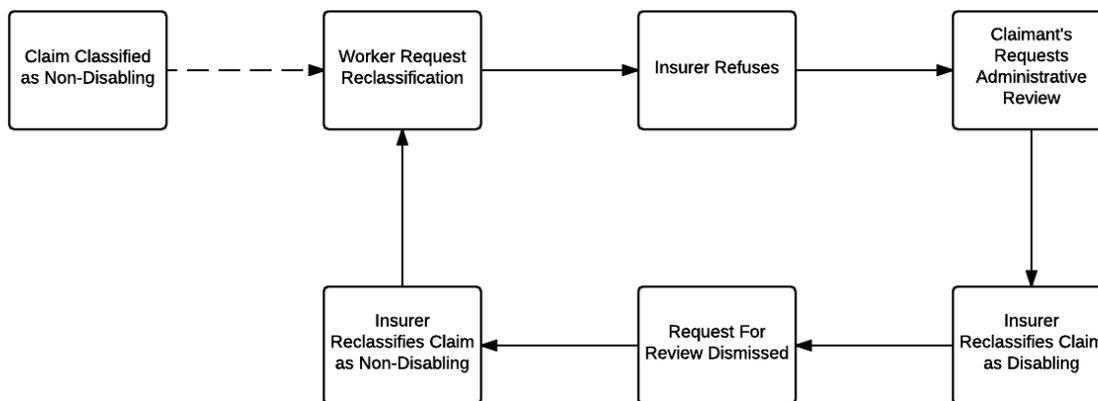
"'Mootness' is a term of art concerning the authority of the courts to exercise the judicial power conferred by Article VII of the Oregon Constitution. It is an aspect of justiciability that *applies only to the courts and not to local governments or administrative agencies.*" *Leupold & Stevens, Inc. v. City of Beaverton*, 206 Or App 368, 374 (2006) (citing *Just v. City of Lebanon*, 193 Or App 132, 142 (2004)) (emphasis added). Because the judicial doctrine does not apply to agencies, an agency may consider mootness only if expressly authorized by statute. There is no such statute applicable to the workers' compensation division.

Further, even assuming that the mootness doctrine is available, reclassification disputes are not mooted by an insurer's Modified Notice of Acceptance. Such action is a concession of fact, but does not conclusively resolve all of the issues concerning reclassification.

The mootness doctrine applies only when circumstances change such that the "exercise of authority would no longer 'have some practical effect on the rights of the parties to the controversy.'" *Thunderbird Hotels, LLC v. City of Portland*, 218 Or App 548, 556 (2008) (quoting *Leupold*, 206 Or App at 374). An order unequivocally affects the rights of the parties in, at least, two specific ways: preclusion and attorney's fees.

An order precludes an insurer from reclassifying the claim again as non-disabling. Specifically, OAR 436-060-0018(12) provides, "If a claim has been classified as disabling and the insurer determines the criteria for a disabling claim were never satisfied, the insurer may reclassify the claim to nondisabling." Procedurally, this rule allows an insurer to voluntarily classify the claim as disabling, and then change that classification again to nondisabling. Thus, a voluntary Modified Notice of Acceptance does not legally bind the insurer, as it can later unilaterally reclassify a claim as non-disabling.

A order of dismissal does nothing to prevent this. Under the current rules, something like this can occur:<sup>1</sup>



<sup>1</sup> To be clear, this likely does not occur. However, only an order prohibits this from occurring, and thus affects the parties rights.

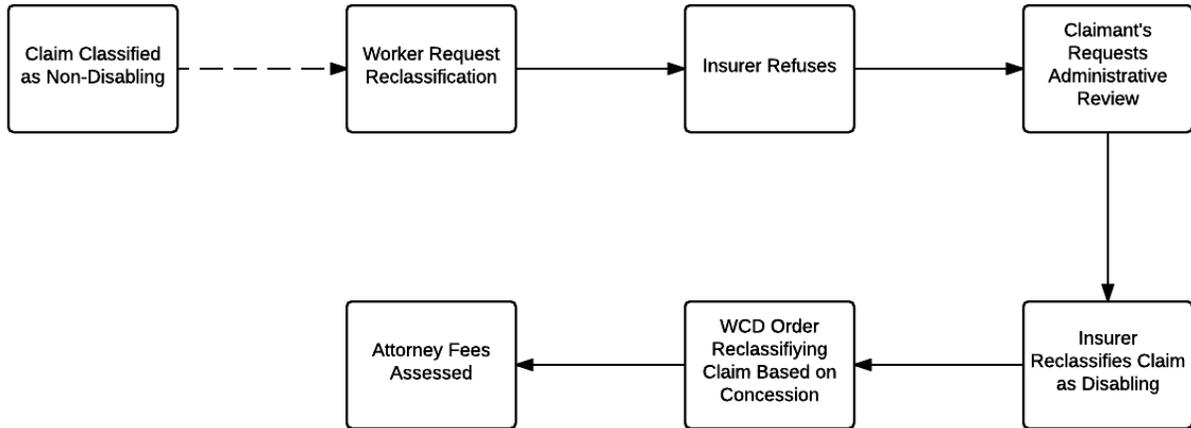
In contrast if an order issues, the order necessarily makes findings of fact and conclusions of law that preclude later reclassification. The final preclusive effect of an order is a substantive effect on the parties' rights.

In addition to preclusion, the parties' rights and obligations regarding an attorney fee are determined by an order. The right to a fee remains at least until the order is issued or the matter dismissed. Thus, an order would have a substantive affect on the parties' rights and obligations, and a dismissal because of alleged mootness is circular reasoning; he WCD cannot dismiss a dispute because there are no remaining issues because it dismissed the dispute! Based on the above, mootness is not legal basis to dismiss a request for review.

The WCD also seems to have a limited notion of what claim classification means. Neither "classification" nor "reclassification" is defined by statute or rule. Although ORS 656.262(6)(b)(B) provides, "[t]he notice of acceptance shall \* \* \* [a]dvice the claimant whether the claim is considered disabling or nondisabling," it does not dictate that a notice of acceptance is the definitive method to claim classification. Rather, classification depends on the factual context of the claim. Specifically, in the context of a dispute, the WCD is charged with making factual findings to determine if 1) temporary disability is due and payable, 2) the worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or 3) the worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary. See OAR 436-060-0018(2)(a)-(c); *Jimmie L. Wilson*, 68 Van Natta 1330, 1330 n1 (2016) ("An injury is not disabling if no temporary disability benefits are due and payable, unless there s a reasonable expectation that permanent disability will result from the injury.") (citing OAR 436-060-0018(2)); *Donna Halpin*, 55 Van Natta 4350, 4351-52 (2003) (same) (citing former OAR 436-030-0045(5), *renumbered* OAR 436-060-0018).

A Modified Notice of Acceptance is not evidence of temporary disability being due and payable, it is not evidence of medically stationary status, and it is not evidence of actual or expected permanent disability. As such, a Modified Notice of Acceptance does *not* provide the necessary factual basis necessary to determine if a claim is, in fact, disabling or not. Thus, a dismissal cannot be appropriate based solely on a Modified Notice of Acceptance.

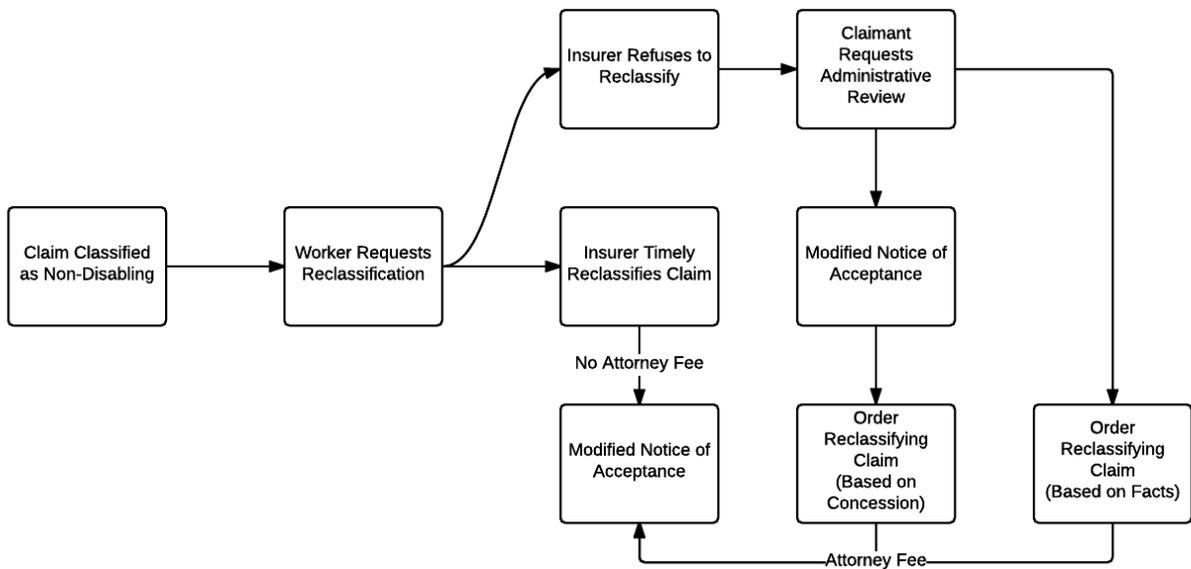
However, a Modified Notice of Acceptance accepting a disabling claim *may* be considered a unilateral concession that the claim is, factually, disabling for one or more of the reasons identified above. Thus, a procedurally correct alternative to dismissal would be to issue an order reclassifying the claim based on the insurer's factual concession, as represented by is Modified Notice of Acceptance, that that the claim is disabling for at least one of the reasons that make a claim disabling. Again, the order does not issue by operation of law because the insurer "reclassified the claim," rather the WCD's decision and order remains a fact-based order. The WCD is simply able to reach its conclusion that the claim was or has become disabling under the three potential ways based on insurer's concession. That process would look something like this:



Finally, the current proposed “alternative,” restricting an insurer’s ability to reclassify the claim during the period of review is unworkable. First, I question the WCD’s legal authority to prohibit an insurer from issuing a Modified Notice of Acceptance. No statute suggest the WCD possesses such authority. Further, I question the wisdom of such a prohibition, as it could conflict with an insurer’s other obligations deadlines. For instance, a “freeze” on accepting a claim could cause an insurer to delay accepting a new or omitted condition claim or otherwise processing the claim.

Further, such an alternative is poor policy. Forcing parties to litigate an issue that one party is willing to concede is in no party’s best interest. Rather, a party should be allowed to concede an issue, pay what is due under the law, and move on.

Based on the above, I envision a properly functioning reclassification process looks something like this:



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**BRUYNS Fred H \* DCBS**

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**From:** Lynn Hamers <lynnh@intermountainclaims.com>  
**Sent:** Friday, October 14, 2016 12:46 PM  
**To:** BRUYNS Fred H \* DCBS  
**Subject:** RE: Input on proposed division 060 rules

Hi Fred,

Thanks so much for checking with me. Yes it was earlier in the process when Sheri Sundstrom was gathering information.

My recommendation was to include information advising of our inability to direct medical treatment on the 801 Form. I had one thought after the rulemaking discussion though....

The industry is going more toward submitting electronic forms and our access to actual signatures is becoming more limited.

I know the idea of having people sign to indicate that they read and understand that employer/insurers are not allowed to direct treatment.

I don't think our luck getting a real signature related to that issue will be any better than signing the 801 itself indicating the filing of a claim.

With electronic filing progressing, this will only get further diluted.

I hope this makes sense.

Thanks,

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Intermountain Claims  
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503-626-6966 X2201  
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**From:** BRUYNS Fred H \* DCBS [<mailto:Fred.H.Bruyns@oregon.gov>]  
**Sent:** Friday, October 14, 2016 11:37 AM  
**To:** Lynn Hamers <[lynnh@intermountainclaims.com](mailto:lynnh@intermountainclaims.com)>  
**Cc:** CLARK Christopher M \* DCBS <[Christopher.M.Clark@oregon.gov](mailto:Christopher.M.Clark@oregon.gov)>; BRUYNS Fred H \* DCBS <[Fred.H.Bruyns@oregon.gov](mailto:Fred.H.Bruyns@oregon.gov)>  
**Subject:** Input on proposed division 060 rules

Hello Lynn,

I think you met with some WCD staff this morning, including Chris Clark. Chris said you mentioned you had provided input regarding the proposed division 060 rules, so I thought I should let you know that I have not received testimony from you. You might have been referring to advice given earlier in the process, but if you would like to provide testimony, we are open for written testimony through 10/28, or you may provide oral testimony at the public hearing on 10/24, 2 p.m., in Room 260 of the Labor & Industries Building.

Feel free to call me if you have questions.

Thank you!

Fred Bruyns, policy analyst/rules coordinator  
Department of Consumer and Business Services

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

**PUBLIC RULEMAKING HEARING**

In the Matter of the Amendment of OAR:	)	TRANSCRIPT OF TESTIMONY
436-050, Employer/Insurer Coverage Responsibility	)	
436-060, Claims Administration	)	
436-105, Employer-at-Injury Program	)	
436-110, Preferred Worker Program	)	
436-120, Vocational Assistance to Injured Workers	)	

The proposed amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated Oct. 1, 2016. On Oct. 24, 2016, a public rulemaking hearing was held as announced at 2 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record will be held open for written comment through Oct. 28, 2016.

**INDEX OF WITNESSES**

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<a href="#"><u>Jaye Fraser, SAIF Corporation</u></a> .....	<a href="#"><u>4</u></a>

**TRANSCRIPT OF PROCEEDINGS**

**Hearing officer:**

Good afternoon and welcome. This is a public rulemaking hearing. My name is Fred Bruyns, and I’ll be the presiding officer for the hearing. The time now is 2 p.m. on Monday, October 24, 2016. We are in Room 260 of the Labor & Industries Building, 350 Winter St. NE, in Salem, Oregon. We are making an audio recording of today’s hearing.

If you wish to present oral testimony today, please sign in on the “Testimony Sign-In Sheet” on the table by the entrance. If you plan to testify over the telephone, I will sign-in for you.

The Department of Consumer and Business Services, Workers’ Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically:

- Division 050, Employer/Insurer Coverage Responsibility,
- Division 060, Claims Administration,
- Division 105, Employer-at-Injury Program,
- Division 110, Preferred Worker Program, and

- Division 120, Vocational Assistance to Injured Workers.

The department has summarized the proposed rule changes in the Notice of Proposed Rulemaking Hearing. This hearing notice, a Statement of Need and Fiscal Impact, and proposed rules with marked changes, are on the table by the entrance. I also have put out some testimony we received before the hearing. It's on the table there.

The Workers' Compensation Division filed the Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact with the Oregon Secretary of State on Sept. 15, 2016. We mailed the Notice and Statement to the postal and electronic mailing lists, notified Oregon Legislators as required by ORS chapter 183, and posted public notice and the proposed rules to the division's website. The Oregon Secretary of State published the hearing notice in its Oregon Bulletin dated Oct. 1, 2016.

This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including Oct. 28, 2016, and will make no decisions until all of the testimony is considered. We are ready to receive testimony. If you are reading from written testimony and give the agency a copy of that testimony, we will add it to the rulemaking record. Could someone bring me the sign-in sheet from the back of the room, maybe one of the WCD people? Thanks. Cathy, could you put back the blanks in case somebody comes in? Thanks.

Could Amber McMurry of Multnomah County come up and testify?

Mike Mischkot, CIS: Fred, I'm sorry. Was that sheet for testimony only or just attendance?

**Hearing officer:** Ah – sometimes – it's for testimony.

Mike Mischkot: Scratch my name off. Thank you. I'm glad I realized it now.

**Amber McMurry:**

Hi. I'm Amber McMurry, and I'm with Multnomah County, Oregon. We are part – I am part of a group called employers empowering return to work, or EERTW. We're a group that meets to share ideas, concepts, and promote return to work and the utilization of EAIP and PWP. I'm here to testify about the division 105.

Today, our proposal is to return the reimbursement amount of EAIP percentage of wages back to 50 percent from the current 45 percent. The rules effective July 1<sup>st</sup> 2013 had reduced the percentage of the wage subsidy from 50 percent to 45 percent in order to resolve a deficit in the WBF reserves. Here are the reasons that we would like to propose this:

- At the rules advisory committee on 7-19-16, the department had indicated the deficit in the WBF reserves had been resolved, and the advisory committee participants requested the percentage of the wage subsidy reimbursement be restored to 50 percent.
- The EAIP is a significant incentive to help offset the costs associated with providing transitional duty or light duty to injured workers.

Oct. 24, 2016

- Historically EAIP wage reimbursement has been 50 percent. This reduction in 2013 was understood to be a temporary measure.
- A 50 percent reimbursement is consistent with the percentage of wage reimbursement allowed under the Preferred Worker Program.

Attached is an email from John Shilts and an excerpt below, which I'll read in a moment, supporting one of the points that returns this to the 50 percent level of reimbursement. This is the excerpt:

"These changes come about in order to meet the legal requirement to maintain a WBF balance of approximately 12 months of expenditures. We are currently at that level; without making any changes like these, we would violate the law. If the revenue to the WBF returns sufficiently to allow us to return or make progress toward our traditional benefit and assessment levels, that is what we will do." That was from John Shilts in 2014.

Some examples of the significance to employers can be demonstrated by these following numbers:

- Tri-Met's total EAIP reimbursements for 2013 to 2015 equaled \$510,895. The additional five percent would have provided another \$25,545.
- Multnomah County's total reimbursements from EAIP for 2013 through 2015 totaled \$313,891. That five percent would have added another \$15,695. You can see this is a significant amount to employers who are returning people to work.

Again we would like to request that the reimbursement of these wages be re-adjusted to the 50 percent level. Members of our committee include Multnomah County, Portland Public Schools, CIS, SDAO, City of Portland, Tri-Met, Davis and Associates – I believe that's all of them.

Thank you.

**Hearing officer:**

Thank you very much Amber. And, Amber also provided written testimony just before the hearing, which we will post to our website, probably this afternoon, but certainly by tomorrow. So, you may want to look on our website to see what testimony comes in, because we will try to keep up with it.

Ah, I think Rob – you said you're not going to testify this morning. Ah, John Jones?

**John Jones:**

Thank you. My name is John Jones. I'm actually just here privately. I formerly worked with an employer that utilized the EAIP program, and I actually stumbled upon the hearing just the other day when I was trying to look up some information, so I figured it was important that I attend.

I think the program is an awesome program. You know, I've gotten to work with quite a few people that otherwise would not be returned to light duty without the EAIP program. Being a former employer I wish I'd known a little bit more about it when I owned my own business, for when I encountered the injuries. So I definitely think it could be a little heavier advertised. But,

more specifically why I came in today was to talk about a little more clarity on the program as far as abuse, and when there is abuse with the program, who does it get reported to. You know, as a former employee from a company that utilized the program, I have struggled to try and report abuse of the program and actual fraud in utilizing the EAIP program. I've contacted the Workers' Comp Division, and they said, well, you need to contact the insurer. I contacted the insurer, and they said, well, it's not really our program. I contacted the Department of Revenue because it is actually a tax on the public, on the employee, that it's coming out of their paycheck for every hour worked, through the Workers' Benefit Fund, as well as other employers. So I contacted the Department of Revenue, and they told me to contact the IRS. I explained to them that the IRS – I actually replied to the email and explained that it's a state program. I was a little baffled that I had to tell the Department of Revenue that, but I think that there needs to be a little more clear reporting on something like this, if it was wage withholding, you know, or an employer with tax evasion, we know where to report it. I'm still struggling to report it, and I've reached out now to the Department of Justice and the Attorney General's Office, because thousands of dollars that could have increased reimbursement for wages up to 50 percent have been illegally obtained by an employer, and there's really nowhere to report it to or nobody to, well, listen to it. So, I think that needs to definitely be added to division 105.

**Hearing officer:**

Thank you very much John. Appreciate it.

And, Roger, you must have just signed in when you came in, right?

Jaye Fraser, SAIF Corporation?

**Jaye Fraser:**

Good afternoon. Jaye Fraser, SAIF Corporation. First of all I would like to thank the division for all of its hard work on these rules. I know that there were many, many hours spent. We appreciate the opportunity to participate in the process and to have our voice heard on behalf of Oregon insurers and Oregon policy holders and Oregon injured workers.

We plan to submit written testimony. We're still working on it, but I had a couple of points that we wanted to highlight, emphasize as areas of a little bit more concern than just passing.

Specifically, in the preferred worker program, there was a change to, it would be section 240, subsection (4), sub (c), regarding obtaining permanent restrictions for pre-closure CDAs. SAIF Corporation understands that permanent restrictions are needed when a worker decides they want to access preferred worker benefits, but we were concerned that this would slow the claim settlement process down, that it actually could end up hurting injured workers who have the desire to close their claim, even pre-closure, even before their restrictions are known. It's up to the worker; it's the worker's right to do that. I have a little bit more significant testimony on that, but I just wanted to raise that issue.

And then, in division 110, 035, sub (4), sub (a), we were kind of confused by the change here. This requires the department, apparently, to determine whether or not premium exemption can be put on to a policy for an employer who has hired preferred worker. Up to this point that has been

a conversation between the policy holder and the insurer. And, it's fine if the department has decided that they want to do this, but what we're concerned about is, policy holders, particularly small policy holders who maybe haven't accessed the program before, hired a preferred worker, may be put off by the fact that then they then have to call the regulator to say hey, I think I'm hiring a preferred worker. And then, the preferred worker program would be the one to tell us to put premium exemption on. And I guess part of what we're concerned about is that we are requiring another step of employers, and we would hate to see that step end up with us having preferred workers who maybe lost a job opportunity.

And then, a couple of minor things in the – not minor but I did want to highlight them in the voc. rules. It would be in 0005(13)(b) – there's a change in the definition of suitable wage to be not less than 80 percent. And I think that that's – of the average weekly wage – and our concern in that instance is it doesn't give us any flexibility and latitude that we believe is present in the statute. When a worker, for the worker's own reasons, wants to take a job that is at a wage that is less than the 80 percent of the average weekly wage. We think that the worker should be entitled to make that decision. When a program manager mentioned to me that there are instances where the worker could have a better job if they moved, but they would rather not move. So we just think that that flexibility should be there. It doesn't happen that often, but we'd like to see that maintained.

And then, also in division 120, 0115, sub (7), up to this point we've had the ability if we don't have sufficient information on determining eligibility, to let the worker know that we are going to extend the time out, because we're still waiting, for example, for additional medical reports. This seems to suggest that we won't be able to do that any longer. And again, it would put the insurer in the position of potentially having to make a decision about eligibility without all of the information that we need, which could end up in a worker being determined not to be eligible, because we don't have that information, and we're bumping up against a time frame. So, that's a concern, and frankly, again that is another one of those instances where it is – it just doesn't happen that often. So we would hate to see a rule put in place for those occasions that it does happen and end up – end up hurting the worker.

Oh, and then on again division 120, 0177, sub (1), sub (b), this has a provision that would allow us to start a worker at less than the 80 percent of average weekly wage, but then the insurer would be in the position of making some determinations on whether or not the worker would attain a greater wage. And that's one of those things that – first of all we feel that we're not experts in that area, and there are also many, many things that would go into the worker's ability to actually reach a higher wage, for example their performance, whether the employer – I mean, it's just whether the employer continues to be able to employ them. Anyway, we just think that that is potentially problematic, for workers especially.

Thank you. We will, SAIF will be submitting additional testimony, but we did want to highlight those particular provisions.

**Hearing officer:**

Thank you very much, Jaye. Would anyone else like to testify this afternoon? Is there anyone on the telephone who would like to testify?

It's our policy to leave the hearing open a minimum of one-half an hour just in case someone arrives late or dials in late. We were actually expecting one other person on the telephone to provide some testimony, so they may actually reach us soon. But before, if you decide to not stay with us for the half hour, I'll understand, although you are welcome to remain. I just wanted to remind you that the record remains open for written testimony through and including October 28. You may submit testimony in any written form, whether hard copy or electronic. I encourage you to submit your testimony by email or as attachments to email. However, you may also use fax, USPS, courier, or you may hand deliver testimony to the Workers' Compensation Division central reception on this floor. On the table by the entrance are business cards that include my contact information, and I will acknowledge all testimony received.

This hearing is recessed at 2:19.

And, we're back on the record. So, the hearing is resumed at 2:25, and Amber, you may go ahead and testify now.

**Amber McMurry:**

I notice another concern, and this is with division 060, 0010, and number (6). This has to do with the new language being proposed to be added to the 801. In the worker's section, above their signature line it says in bold, "I understand I have a right to choose a healthcare provider of my choice, subject to certain restrictions." In the employer's section, above the employer's signature line, is also a bold statement, "I understand I may not restrict the worker's choice of access to a health care provider. If I do it could result in civil penalties under ORS 656.260." The concern I have with this is nowhere on this form does it indicate to the worker or the employer where they can receive or review that information that may restrict them, or what those restrictions may be. So I propose that if that statement is to stay on the 801, that it is added in to that statement for them to reference 436-060-0010, subsection (6). Thank you.

**Hearing officer:**

Thank you very much Amber. And, while I still have the record open, would anyone else like to testify?

I'm going to go ahead and recess again at 2:27.

This hearing is resumed at 2:30.

I'll ask again, would anyone else like to testify this afternoon? You would? Oh – okay.

Again, thank you for coming. This hearing is adjourned. It's about 2:31. Have a safe drive, and that's the end of the hearing.

**Transcribed from a digital audio recording by Fred Bruyns, Oct. 25, 2016.**

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October 26, 2016

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**Via Email Also: fred.h.bruyns@oregon.gov**

RE: Workers Compensation Division  
Proposed Rule Changes to OAR 436-060-0018

Dear Mr. Bruyns,

I attended the public hearing held on October 24, 2016. Although the hearing was brief, I noted that there was no opposition testimony to my prior recommendations regarding reclassification. Further, in addition to my comments submitted on September 30, 2016 and August 23, 2016, I want to offer concrete examples of pending cases that have directly resulted from the concerns expressed in my letters. In short, the Workers' Compensation Division's summary dismissal of cases requesting administrative review of *de facto* refusals to reclassify, and voluntary reclassifications after a request has been initiated, are creating confusion among forums as to which forum has subject matter jurisdiction to address the issues.

For example, I represent a client on behalf of whom I requested administrative review of an insurer's express refusal to reclassify the claim. After the WCD acknowledged the request, the insurer voluntarily issued a modified notice of acceptance, indicating the claim had been accepted for a disabling condition. On March 25, 2016, the WCD summarily, and *sua sponte*, dismissed my client's request for review. The order stated that my client could appeal the order by requesting a hearing with the Worker's Compensation Board's (WCB) Hearings Division. I did so on behalf of my client.

Despite following the stated appeal rights, the WCB dismissed the request for hearing for lack of jurisdiction. Indeed, both the parties and the judge agreed that the WCB lacked jurisdiction to review the WCD's dismissal because it was not an order classifying the claim and ORS 656.277 conferred jurisdiction to the WCB only for appeal of such orders. The matter now languishes back before the WCD to reissue an order with correct appeal rights according to law.

In a different case, a colleague, on behalf of her client, requested a hearing before the WCB for an insurer's failure to respond at all to a request for reclassification. She understood the

WCD's policy of summarily dismissing requests for administrative review in such cases, and asked the WCB for relief. The judge dismissed the dispute for lack of subject matter jurisdiction, stating that the WCD, not the WCB, has initial jurisdiction to consider the issue. Notably, the judge accepted employer's argument that a failure to respond at all to a request for reclassification is "*equivalent to a notice of classification as nondisabling*, which triggers claimant's right to request [WCD] review." (Emphasis added). The judge's reasoning directly conflicts with the WCD's informal policy that the WCD does not have jurisdiction to address an insurer's complete failure to respond to an initial request for reclassification and its policy to not treat that failure as a *de facto* refusal to reclassify.

These are real cases happening right now, and the two examples are not exhaustive. Attorneys on both sides are spending considerable resources and effort attempting to discern which forum has jurisdiction to address grievances regarding claim classification. As it stands, neither the WCD nor the WCB appears willing to assume jurisdiction to resolve such disputes. This not only creates a confusing procedural problem that needs to be resolved, but implicates larger constitutional issues.

My prior recommended changes to OAR 436-060-0018 would alleviate much of that confusion. The recommendations clarify the party's rights and, more importantly, the forums' respective jurisdiction to resolve the disputes. As such, I urge the WCD to implement my recommendations. Ignoring them will simply result in further confusion and litigation.

Thank you for considering of my suggestions. As always, if you have questions, please let me know.

PRESTON BUNNELL, LLP

Theodore P. Heus  
[tedh@prestonbunnell.com](mailto:tedh@prestonbunnell.com)

Enclosures: 3/25/16 WCD Order of Dismissal; 10/7/16 Order – Judge Lipton; 7/19/16 Order – Judge Sencer

Before The Director of the  
Department of Consumer and Business Services  
of the State of Oregon  
Workers' Compensation Division  
Dispute Resolution Section

RECEIVED  
MAR 28 2016  
PRESTON BUNNELL, LLP

In the Matter of Claim Classification for:

March 25, 2016

SIOCHY S ARULONG )  
4317 NE 66TH AVE #H-84 )  
VANCOUVER, WA 98661 )  
 )  
WCD File No: CBU4425 )  
Insurer: INSURANCE COMPANY OF THE )  
STATE OF PENNSY )  
Claim No: 710962296 )  
Date/Injury: 07/21/2015 )

Director's Classification Review  
Dismissal Order

Pursuant to ORS 656.277 and OAR 436-030-0007(1)(c), on February 23, 2016, the Appellate Review Unit on behalf of the Director received a request for a Classification Review of the Insurer's Refusal to Reclassify dated February 16, 2016.

Pursuant to ORS 656.277 and OAR 436-030-0007(1)(c), on February 23, 2016, the Appellate Review Unit on behalf of the Director received a request for a Classification Review of the Insurer's Refusal to Reclassify dated February 16, 2016.

The insurer issued a Modified Notice of Acceptance on March 4, 2016, which reclassifies the claim to disabling.

**ORDER**

Therefore, **IT IS ORDERED** that the request for a Director's Classification Review of the Insurer's Refusal to Reclassify dated February 16, 2016, is dismissed.

Any party to the claim has the right to request a hearing for a period of 30 days from the date of this Order on Reconsideration. A hearing request must be submitted to the Workers' Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282.

Dated this 25th day of March, 2016  
Department of Consumer and Business Services  
Workers' Compensation Division  
Appellate Review Unit  
  
CHARITY S DONTHIT, Director Representative

CBU4425 / 2349  
cc: PRESTON BUNNELL LLP Attn: THEODORE P HEUS 1200 NW NAITO PKWY STE 690 PORTLAND, OR 97209  
INSURANCE COMPANY OF THE STATE OF PENNSY REGULATORY REPORTING DIVISION 100 CONNELL DR STE 2100 BERKELEY HEIGHTS, NJ 07922-2732  
AIG CLAIMS, INC. 222 SW COLUMBIA ST STE 700 PORTLAND, OR 97201  
QUANTEM AVIATION SERVICES LLC 175 AMMON DR MANCHESTER, NH 03103



- (4) In-person: Workers' Compensation Board office in Salem, Portland, Eugene, or Medford
- (5) Website portal: For attorneys, self-insured employers and insurers that are registered users

You must also provide a copy of your request to all other parties to this proceeding within the same 30-day period. All other parties will have the remainder of the 30-day period, and in no case less than 10 days, to request Board review. The 10-day minimum is provided even if it extends the time allowed to request Board review beyond 30 days.

Failure to provide a timely request for review to the Board and provide copies to all other parties within the time allowed will result in the loss of your right to appeal this Order and the Board will be unable to review the Administrative Law Judge's decision.

Entered at Portland, Oregon, on OCT 07 2016 , with copies mailed to:

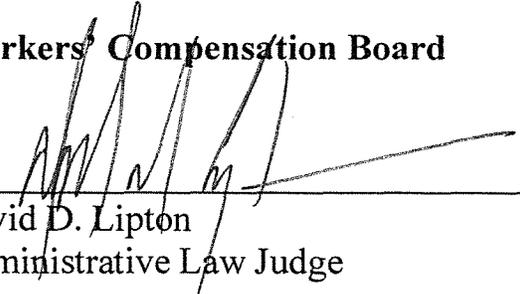
SIOCHY S ARULONG, 4701 NE 72ND AVE # 161, VANCOUVER WA 98661  
PRESTON BUNNELL LLP, 1200 NW NAITO PKWY STE 690,  
PORTLAND OR 97209-2829

BOREAS HOLDINGS, 175 AMMON DR, MANCHESTER NH 03103-3311  
AIG - CHARTIS CLAIMS INC, 222 SW COLUMBIA ST STE 700,  
PORTLAND OR 97201-6655

REINISCH WILSON WEIER, 10260 SW GREENBURG RD # 1250,  
PORTLAND OR 97223

Info copy electronically transmitted to: DCBS WCD Operations

**Workers' Compensation Board**



\_\_\_\_\_  
David D. Lipton  
Administrative Law Judge



BEFORE THE WORKERS' COMPENSATION BOARD  
STATE OF OREGON  
HEARINGS DIVISION

In the Matter of the Compensation	)	WCB Case No. 16-00513
	)	Claim No. 301429399560001
of	)	DOI: 9/15/2014
	)	WCD File No. ABU6642
	)	
<b>TINA L. JUERGENS,</b>	)	
Claimant	)	<b>ORDER OF DISMISSAL</b>

Pursuant to notice, the hearing in this matter is scheduled to convene on August 16, 2016 before the undersigned Administrative Law Judge. Constance L. Wold represents claimant. Kindra F. Long represents the employer, 7 Eleven – Store #35340H, and its processing agent, Sedgwick CMS.

The employer has moved to dismiss claimant’s request for hearing on the basis of lack of jurisdiction. For the following reasons, the employer’s motion is granted.

Claimant filed a request for hearing on February 3, 2016 raising the issue of “Failure to Respond to 12/14/2015 Request for Reclassification.” The employer notes, and claimant concedes, that claimant never asked the Director of the Department of Consumer and Business Services (the “director”) to review the employer’s classification decision.

Pursuant to ORS 656.277(1), the director has initial jurisdiction to review an employer’s reclassification decision. Under that statute the jurisdiction of the Workers’ Compensation Board (the “Board”) may be invoked by a party who objects to the director’s classification decision. Specifically, the statute provides,

“If any party objects to the classification of the director, the party may request a hearing under ORS656.283 within 30 days from the date of the director’s order.”

Claimant argues that the Board has jurisdiction based on the employer's failure to respond to her request for reclassification. Claimant characterizes the employer's inaction as improper claims processing and an unreasonable resistance to compensation. The employer responds, in effect, that its failure to respond to claimant's request for reclassification within the statutory 14 day period is equivalent to a notice of classification as nondisabling, which triggers claimant's right to request director review.

The Board has previously addressed the issue of its jurisdiction to review an allegedly invalid notice of classification. In *Hope E. Martinez*, 66 Van Natta 1964,1965 (2014), the Board held,

“Pursuant to ORS 656.277(1), claimant must appeal a reclassification decision to WCD. Accordingly, her contentions regarding the procedural validity of the modified acceptance notice (and attendant request for penalties and attorney fees) arising from that “reclassification/validity” question are first subject to WCD’s authority. Likewise, the matter of the insurer’s compliance with the administrative rule regarding simultaneous notice to claimant’s attorney (and related penalty/attorney fee issues) regarding the insurer’s reclassification decision is also first subject to WCD’s authority.”

Consistent with *Martinez*, I conclude that claimants must seek director review of a reclassification dispute. The jurisdiction of the Board over classification issues does not attach until the director has issued an order. *See also, Jeffrey J. McHenry*, 52 Van Natta 2187 (2000)(Failure of insurer to send notice of claim classification to claimant did not allow claimant to bypass statutory procedure in ORS 656.277.)

Based on the foregoing, I conclude that the Hearings Division lacks subject matter jurisdiction over the issue raised in claimant's Request for Hearing. Accordingly claimant's Request for Hearing is dismissed.

IT IS SO ORDERED.

**Notice to all parties: If you are dissatisfied with this Order, you may request Board review. A request for review must be submitted within thirty (30) days after the mailing date on this Order. You must timely submit your request for review by any of the following methods:**

- (1) Mail: Workers' Compensation Board  
2601 25<sup>th</sup> St SE, Suite 150  
Salem, OR 97302-1280
- (2) E-mail: [request.wcb@oregon.gov](mailto:request.wcb@oregon.gov)
- (3) Fax: 503-373-1600
- (4) In-person: Workers' Compensation Board office in Salem,  
Portland, Eugene, or Medford
- (5) Website portal: For attorneys, self-insured employers and insurers  
that are registered users

**You must also provide a copy of your request to all other parties to this proceeding within the same 30-day period. All other parties will have the remainder of the 30-day period, and in no case less than 10 days, to request Board review. The 10-day minimum is provided even if it extends the time allowed to request Board review beyond 30 days.**

**Failure to provide a timely request for review to the Board and provide copies to all other parties within the time allowed will result in the loss of your right to appeal this Order and the Board will be unable to review the Administrative Law Judge's decision.**

Entered at Portland, Oregon, on July 19, 2016, with copies mailed to:

TINA L. JUERGENS, 2217 SE KANE AVE., GRESHAM, OR 97080  
HOOTON WOLD & OKRENT LLP, PO BOX 569, BEAVERTON, OR 97075  
7 ELEVEN - STORE # 35340H, 18222 SE DIVISION ST.,  
GRESHAM, OR 90305

SEDGWICK CMS - PORTLAND OR, PO BOX 14514,  
LEXINGTON, KY 40512-4514

REINISCH WILSON WEIER, 10260 SW GREENBURG RD., # 1250,  
PORTLAND, OR 97223

Info copy electronically transmitted to: DCBS WCD Operations

Workers' Compensation Board



NICHOLAS M. SENCER  
Administrative Law Judge



October 28, 2016

Fred Bruyns, Rule Coordinator  
Workers' Compensation Division  
350 Winter Street NE  
Salem, OR 97309-0405

RE: SAIF Corporation testimony for proposed workers' compensation rules:

OAR 436-060, Claims Administration  
OAR 436-105, Employer-at-Injury Program (EAIP)  
OAR 436-110, Preferred Worker Program (PWP)  
OAR 436-120, Vocational Assistance to Injured Workers

Dear Fred:

SAIF Corporation submits the following comments for the Workers' Compensation Division's proposed claims administration rules (OAR 436-060); employer-at-injury program (EAIP) rules (OAR 436-105), preferred worker program (PWP) rules (OAR 436-110); and vocational assistance to injured workers rules (OAR 436-120). As always, SAIF appreciates the opportunity to provide feedback to the Workers' Compensation Division. The significant effort made to clarify and simplify these rules for system users is apparent. We hope our comments will assist the Division in its endeavor.

**OAR 436-060, Claims Administration**

**1. OAR 436-060-0010:**

(1)(a) States that an employer must provide the worker an 801 form immediately after receiving notice or knowledge of a potential compensable injury. The proposed revision conflicts with ORS 656.265(6), which expressly requires an employer to supply injury reporting forms "to injured workers *upon request* of the injured worker or some other person on behalf of the worker." The current version of the rule is consistent with the statute. To ensure consistency with the statute and employer compliance, SAIF suggests that the director maintain the original language.

**2. OAR 436-060-0017:**

(3)(f) Requires the continuation of discovery under the Board's rules (OAR Chapter 438) after a hearing request is withdrawn or the hearing record has closed. The proposed rule is not supported by statute. The Board's authority to make rules of practice and procedure, including for discovery of documents, only extends to those that, "are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278." ORS 656.726(5)(a). The Board's duties include administration of and responsibility for the Hearings

Division as well as reviewing appealed orders of Administrative Law Judges, exercising own motion jurisdiction, "providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law." ORS 656.726(2) and (3). The Board's duties do not include making rules that govern discovery for claims not in litigation. Making all other rules associated with the administration of Chapter 656 is the director's responsibility. ORS 656.726(4).

The Board's policy on discovery of documents is "to promote the full and complete discovery of all relevant facts and expert opinion bearing on a claim being litigated before the Hearings Division." OAR 4380-007-0015(8). It does not extend to claims no longer being litigated. When a hearing is completed and the order is final, the hearings division loses jurisdiction over the matter.

The effect of the proposed rule change would be to require insurers, once a hearing has been requested, to continue to provide discovery of newly received documents every seven days, indefinitely. This would add significant administrative burden and cost to insurers and self-insured employers, without any known benefit to injured workers. Claimant's attorneys may not want to receive this level of information, and there is no mechanism under the Board's rule to turn it off. Most notices on the claim are already required to be copied to the worker's attorney.

SAIF Corporation's current practice is to follow the Board's discovery rule until a legal order issues, and then to revert to producing documents according to the director's rule. If the director feels that the close of the hearing record is too soon to bring discovery back under OAR 436-060-0017, SAIF would not oppose a rule that is consistent with its current practice. Keeping discovery under the Board's rule when the Board no longer has any jurisdiction over a matter, however, is both legally unsupported and onerous.

### **3. OAR 436-060-0018**

SAIF agrees with the proposed rule changes and agrees that the proposed changes are consistent with the testimony and discussion at the August 23, 2016 advisory meeting with the exception of OAR 436-060-0018(3)(b), which conflicts with ORS 656.277(1)(a).

### **4. OAR 436-060-0020:**

(3)(c) States that "Temporary disability compensation is authorized when: The director determines there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work under ORS 656.268." This proposed rule appears to derive from current OAR 436-060-0020(4), which states in part, "The insurer at claim closure, or the division at reconsideration of the claim closure, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work." To be consistent with the current standard, SAIF suggests modifying the proposed rule to state "Temporary disability compensation is authorized when: At reconsideration of the claim closure, the director determines there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work."

(9) Provides for the payment of temporary disability once a denied claim is determined to be compensable. SAIF proposes inserting the word "finally" between "has been" and "determined" because retroactive time loss is due once the order setting aside a denial is final.

**5. OAR 436-060-0025:**

(4) Provides the wage calculation for workers who are not "regularly employed." Missing from the proposed changes is language that limits the calculation to earnings from the job at injury. This limitation is present in ORS 656.210(2)(d), which states, "The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury." Proposed 436-060-0020(3) mirrors this provision. ORS 656.210(2)(e) grants the director discretion to prescribe methods for establishing a worker's weekly wage for workers not "regularly employed". To maintain consistency and avoid ambiguity, SAIF suggests adding the phrase "with the employer at injury" between "average of the worker's total earnings" and "for the period up to 52 weeks."

(4)(a) To maintain consistency as noted above, SAIF suggests adding the phrase "with the employer at injury" to the end of this proposed rule for the same reasons.

(4)(a)(B) Excludes payment for expenses incurred due to the job and paid for by the employer. SAIF proposes adding "or advanced" between "reimbursed" and "by the employer" to capture those employer-related payments paid in advance to the worker to cover anticipated expenses incurred due to the job.

(4)(b)(A) Simplifies whether a gap in employment qualifies as an extended gap that is excluded from the temporary disability rate calculation. SAIF suggests increasing the number of days considered to be a gap in employment to 60 days. SAIF reasons that due to the seasonal nature of many industries including construction, firefighting and logging, a gap of 60 days captures those employment relationships that are seasonal and cyclical. In addition, SAIF suggests adding "reasonably" between "not" and "anticipated" to create a standard of reasonableness. For employers and workers who have been in the same industry for several years, there typically are anticipated gaps in employment that were not specifically discussed as part of the wage earning agreement because such gaps are already anticipated by both parties, based on their experience within that particular field, at the time of hiring.

(5) Removes current OAR 436-060-0025(5)(b) and -0025(5)(l), which provide specific temporary disability rate calculations for workers employed through a temporary service provider and school teachers or workers paid in a like manner. SAIF suggests retaining these rules to maintain the accurate calculation of the temporary disability rate in these unique employment situations. The proposed rules streamline and simplify the calculation of the temporary disability rate for most injured workers but may not capture the unique employment situation of school teachers and temporary workers.

**6. OAR 436-060-0030:**

(6)(a) Removes the phrase "includes but are not". SAIF suggests striking out the words "limited to" so that "includes but are not limited to" is removed.

**7. OAR 436-060-0035:**

(4) Removes the provision that precludes a penalty under ORS 656.262(11) if a delay in payment of a higher disability rate is due to the worker's failure to provide verifiable documentation of secondary employment. The revised rules moved the penalty provision to OAR 436-060-0035(11), which states, in part, "Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation requested under this rule will not result in the assessment of a civil penalty." A civil penalty and a penalty under ORS 656.262(11) are not interchangeable: a civil penalty is payable to the director whereas an ORS 656.262(11) penalty is payable to the worker with a penalty-related fee to the worker's attorney.

SAIF suggests either retaining the last sentence of current OAR 436-060-0035(4) and re-numbering it as OAR 436-060-0035(4)(D) or replacing the phrase "civil penalty" under OAR 436-060-0035(11) with "ORS 656.262(11) penalty," and renumbering the last sentence of proposed rule OAR 436-060-0035(11) as OAR 436-060-0035(4)(D).

(7) SAIF suggests adding the words "eligible for supplemental temporary disability" between "When the worker" and "has post-injury" to avoid the impression that the insurer must calculate the temporary partial disability rate using wages from all jobs in cases in which the worker has not been determined eligible for this benefit.

**OAR 436-105, Employer-at-Injury Program (EAIP)**

**1. OAR 436-105-0006**

(2) States that EAIP and PWP benefits may not overlap. SAIF agrees with this amendment, however, SAIF suggests that the rules describe what situation or factors constitute the end of EAIP and PWP eligibility. For example, is premium exemption considered a PWP benefit and thus discontinues EAIP benefits?

**2. OAR 436-105-0500**

(5)(e)(C) Describes the appropriate action to take when a medical release does not have an end date. SAIF supports this amendment, however respectfully requests the addition of "/or" in the second line after the word "and". Adding this language would allow the insurer to continue current practice and end benefits if the worker has ceased treating or has given no indication that they will continue to treat.

(6)(d) Requires payroll records be "compiled in accordance with generally accepted accounting procedures." SAIF is concerned that the proposed rules do not define "generally accepted accounting procedures." Of greater concern, however, is the imposition of bookkeeping procedures on small employers who may not have the resources or business need to follow complicated accounting rules. SAIF suggests that the information required in (6)(d)(A) is sufficient to protect the workers benefit fund without imposing onerous requirements on small businesses.

SAIF also would appreciate instruction on the effective date of this rule. SAIF suggests that the EAIP period start date should be used for rules that change documentation standards.

### **3. OAR 436-105-0512**

Removes old subsection (4) that allows an insurer to end the employer at injury program at any time while the workers' claim is open. There are any number of reasons an insurer may need to terminate the program. SAIF urges WCD to retain current subsection 4, allowing the insurer to manage the program and claims.

## **OAR 436-110, Preferred Worker Program (PWP)**

### **1. OAR 436-110-0006**

(2) Clarifies that EAIP and PWP benefits may not overlap. SAIF agrees with this amendment, however, SAIF suggests that the rules describe what situation or factors constitute the end of EAIP and PWP eligibility. For example, is premium exemption considered a PWP benefit and thus discontinues EAIP benefits?

### **2. OAR 436-110-0240**

(4)(c) Requires the insurer to obtain permanent restrictions for claim disposition agreements (CDA) even when the CDA is approved before the worker is medically stationary.

If the injured worker is not medically stationary permanent restrictions likely cannot be determined. SAIF cannot force the injured worker to seek further treatment or to determine permanent restrictions after a CDA is approved if the worker chooses not to do so. SAIF agrees and supports the need for permanent restriction determination once an injured worker seeks preferred worker benefits. Insurers must provide this assistance to the worker. At this point an injured worker is willing to be assessed, whereas they may not be willing to submit to a medical exam during the CDA approval process.

SAIF suggests the addition of the italicized language below to provide a solution to WCD's concern that insurers provide injured workers with permanent restrictions when they wish to utilize preferred worker benefits, but allows an insurer and a worker to settle a claim before an injured worker's condition is medically stationary.

(c) Approval of a claim disposition agreement, if documented medical evidence indicates permanent restrictions exist as a result of the injury or disease, and the worker is unable to return to regular work. If the claim disposition agreement is approved before the claim has been closed under ORS 656.268, the insurer must obtain medical information to determine the worker's permanent restrictions for purposes of the Preferred Worker Program upon the following:

- (i) medical information indicates the worker's condition is medically stationary,*
  - (ii) the insurer notifies the worker in writing of the worker's eligibility for the Preferred Worker Program within ten days of receipt of the information in (i),*
- and*

(iii) *the worker elects in writing to pursue Preferred Worker Program benefits.*

#### **4. OAR 436-110-0325**

(4)(a) Changes the notification and approval process for premium exemption. Currently the rules require the employer to notify its insurer within 90 days from eligibility or hire of a preferred worker. The amendment requires the employer to notify the division of the hiring and gives the director the responsibility to either approve or deny premium exemption.

SAIF is unaware of problems that give rise to this proposed change. The PWP process can be lengthy and confusing to employers, particularly those who have no prior experience and limited understanding of the program. Some employers may be reluctant to contact WCD or otherwise engage in the process without assistance from the insurer. The result may reduce utilization of this valuable benefit which could harm both the injured workers and their employers.

Removing the insurer from approving premium exemption puts the burden on the employer to notify the division, and removes the insurer from the process. Applying premium exemption to a policy can be complicated by multiple entities and business locations, and class code exposure. The current rules allow the insurer to work directly with the employer to determine appropriate placement for premium exemption. Delays in implementing this benefit and confusion are reduced as much as possible with direct employer and insurer interaction.

SAIF urges WCD to reconsider this proposed rule. If WCD does adopt this proposed provision, SAIF respectfully requests that WCD clarify the process it will use so employers can provide WCD timely and accurate information. Additionally, SAIF requests WCD clarify for employers and insurers WCD's intended notification process and its proposed timeframes for notice to employers and insurers that premium exemption has been approved.

#### **5. OAR 436-110-0330**

(1)(e) Requires insurers be able to prove through *loss reports* that PWP claim data is not used to determine the employer's rates or dividend. SAIF's systems are automated to insure that claim data for preferred worker claims are not reported to NCCI for experience rating purposes and general ratemaking. SAIF concurs that, when requested, insurers should be able to provide adequate proof that it has not used this data for these purposes. We are uncertain, however, what WCD means by the term "loss reports." SAIF suggests that it may be appropriate to define "loss reports." SAIF likewise suggests that WCD consider adding language that states "or by other means acceptable to the Director" to (1)(e).

#### **OAR 436-120, Vocational Assistance to Injured Workers**

##### **1. 436-120-0003**

(3)(b) Gives the Director "the right" to verify whether employment is suitable. The amendment does not specify under what circumstances the Director would exercise

this right. SAIF suggests the department clarify whether the rule extends the Director's authority beyond the dispute resolution process.

## **2. 436-120-0005**

(10) Removes the definition of "likely eligible" even though "likely eligible" is used throughout Division 120 and Oregon Revised Statutes.

SAIF suggests the department retain the definition for "likely eligible" to maintain a consistent interpretation of "likely eligible." SAIF proposes the following definition:

*"Likely eligible means that a worker is expected to be awarded work disability, has objective or permanent or projected injury caused restrictions, and is not currently suitably employed."*

## **3. 436-120-0005**

(13)(b) Changes the definition of suitable wage to one that is as close as possible to the average weekly wage (AWW), but not less than 80% of the adjusted weekly wage. This amendment appears to be in conflict with ORS 656.340 (5) which states that the objective of vocational assistance is to get a worker to a wage as close as possible to the worker's AWW, even if this is less than 80%. With limits in the length, cost, and types of training, it can be impossible for training to result in employment within 80% of the AWW. In addition, workers may agree to a wage less than 80% in order to secure a position that meets certain personal requirements (e.g. location). Lastly, all parties agree to the wage prior to training.

Because the proposed rule could limit options for suitable employment currently provided in the rules to the detriment of the injured worker, SAIF suggests retaining the current definition of "suitable wage."

## **4. 436-120-0115**

(7) Limits the number of days that a determination of eligibility may be extended beyond the initial 30 days from medically stationary status, to an additional 30 days. Current rules allow the insurer to notify the worker when the initial 30 day timeframe will not be met, the required additional information, and the expectation of when the eligibility determination will be made. Further, the insurer then has 30 days from receipt of the additional information to determine eligibility.

Often the eligibility determination depends on the insurer's ability to obtain permanent restrictions from the treating doctor, which may or may not accompany a determination of medically stationary status. Obtaining permanent restrictions may require an IME/WCE which can take several weeks to complete. Under the proposed rule, insurers may need to determine eligibility prior to obtaining all the necessary information in order to meet the additional 30 day timeframe.. Consequently, the evaluation may not fully reflect the workers' actual condition and/or eligibility.

SAIF suggests the director retain the current timeframe for determining eligibility as outlined in OAR 436-120-0125(2), (3) and OAR 436-120-0135(5).

**5. OAR 436-120-0145**

(2)(B); (C). Removes the requirement that the worker be available in Oregon for vocational assistance. This amendment appears to conflict with the several Oregon revised statutes stating that an Oregon certification is required to provide vocational assistance, and that the worker be returned to work that is as close to regular work and wage at injury as possible. ORS 656.340 In addition, it could allow the worker to choose vocational goals that have no market in Oregon, requiring out-of-state relocation for both training and employment.

SAIF suggests the department retain the current eligibility criteria under OAR 436-0120-0145(2).

**6. OAR 436-120-0165**

(3) Requires insurers to send form 2800 to DCBS when eligibility is ended. Currently insurers are allowed 30 days from the end of eligibility to file form 2800, which allows time for final costs to be included in the report. Without allowing an insurer 30 days to obtain additional information the form may be incomplete. Missing information may include payment for final services, worker mileage, and tuition costs (some institutions provide the education invoice at the end of the quarter/semester/training period).

To ensure that the form may be complete at the time of submission, SAIF suggests that that insurers continue to have 30 days from the end of eligibility to file form 2800.

**7. OAR436-120-0433**

(14)(c) Adds justification for extending a training plan to include the capacity for the worker's income to increase to 100 percent or more of the workers' adjusted weekly wage with time as a result of the training. Existing rules require proving a 10% wage increase to qualify for more than a 16 month training program. While adding language that speaks to the capacity of increased earnings over time potentially increases the approval of extended training plans, determining wage increases over time is problematic for the insurer. Employee wage increases are determined by worker performance, financial capacity of the employer, and overall economic factors over which the insurer cannot predict and has little control.

SAIF suggests the department retain the current rule.

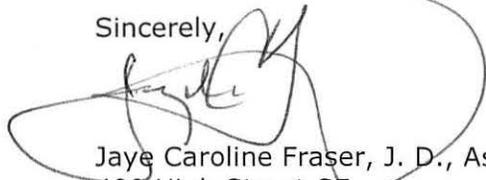
**8. OAR436-120-0445**

(4). Increases the number of allowable months for formal training from 16 to 18.

The proposed rule conflicts with ORS 656.340(12), (14)(a), and (14)(c), which state that training is limited to 16 months. To maintain consistency with the statute, SAIF suggests keeping the current rule.

Once again, SAIF appreciates the opportunity to provide input into these administrative rules. We are hopeful that our input will be of assistance. As always, SAIF is available to answer any questions you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Jaye Fraser", is written over a large, light-colored circular scribble or stamp.

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**BRUYNS Fred H \* DCBS**

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**From:** Bob Livingston <LivingstonB@comcast.net>  
**Sent:** Friday, October 28, 2016 1:42 PM  
**To:** BRUYNS Fred H \* DCBS  
**Subject:** proposed change to OAR 436-060-0025

Dear Mr. Bruyns:

On behalf of the Oregon State Fire Fighters Council who represent career fire fighters throughout our great state, we are concerned with the proposed rule change as it relates to time loss benefits and would request that you hold the record open for additional comment. If I understand correctly this proposal, the agency is seeking a different calculation that factors in the last 52 weeks of an injured workers employment rather than their current salary. As written, this may have unintended consequences in protecting the earned benefits of employees - particularly employees who may be eligible for regular step increases or that may realize an increase in pay for a variety of reasons.

In my attempt to gather information regarding this change, it is also my understanding that perhaps MLAC was not made aware of this change and while this type of change may not rise to the level of discussion of MLAC, it does serve as a way to ensure the various stakeholders are aware of changes that may impact employee benefits - particularly when calculating time loss benefits. Further, it is my understanding that this rule was made to make it easier to calculate benefits. We are not sure that this should be the reasoning behind a rule change - particularly when it comes to ensuring the benefits of an injured worker. In fact, it has and should be the goal of the agency to ensure that an injured worker receives accurate and timely benefits. Additionally, as you may be aware, recent law changes have made it clear that when it comes to ensuring proper payment of workers when it comes to their wages, employers must ensure that this information is readily available on a workers paycheck, and many employers are having to make changes to paycheck stubs in order to comply with this law. It appears that this new rule may be inconsistent with this law which was intended to make sure that employers and employees alike understand important information that is essential in ensuring wages are clearly understood and accurately accounted for. Again, this new rule as written appears to create confusion along with the propensity to reduce the benefits rightly owed by many workers.

In closing, due to the importance of this rule change and the impact that it may have on injured workers time loss benefits, we would respectfully request that the agency at a minimum hold the record open longer for a better understanding by stakeholders, and in the absence of this action, would oppose the proposed rule as drafted. Thanks for your attention to this matter and please do not hesitate to contact me if you are in need of additional information regarding this matter.

Respectfully,

Bob Livingston  
President  
Oregon State Fire Fighters Council  
[BobL@osffc.org](mailto:BobL@osffc.org)  
503.508.7192 cell  
503.540.0648 office



**BRUYNS Fred H \* DCBS**

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**From:** Chris Frost <cfrost@tcnf.legal>  
**Sent:** Friday, October 28, 2016 5:05 PM  
**To:** BRUYNS Fred H \* DCBS  
**Cc:** Arthur Towers; Chris Moore; Keith Semple  
**Subject:** OTLA oppose rule change for time-loss calculation

Please accept this email as OTLA's comment regarding a rule change proposed that will lower time-loss benefits for those injured workers who had a rate increase in the 52 weeks before injury.

OTLA opposes the proposed change to OAR 436-060-0025, calculation of time-loss that will average worker's wages rather than multiply the current rate by the hours worked. This change will lower time-rates for all injured workers who had a wage rate increase at any time in the 52 weeks prior to the date of injury. Given that many workers find it difficult to live on their time-loss benefits while recovering from injuries, we oppose this rule change that will negatively impact these workers.

We understand this change was made to simplify calculating TL benefits, but it isn't clear why the current formula would be so much more difficult.

Finally, ORS 656.202 requires benefits be determined on the date of injury. It is hard to see how a wage increase can be ignored, and time-loss be based on the previous wage that is no longer applicable.

As always, we appreciate the work WCD does to address rule changes. We also see many positive changes proposed. Simplifying the extended gap rule is one such change that will likely help both insurers and workers figure out proper benefits.

Chris Frost  
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