

Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR chapter 436, divisions 010 and 060
Implementation of House Bill 3114

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Aug. 25, 2015, 9 a.m. to Noon, Room F (basement), Labor and Industries Building, Salem, Oregon Teleconference dial in: 213-787-0529 Access code: 9221262#
Facilitator:	Fred Bruyns, Workers' Compensation Division
9:00 to 9:10	Welcome and introductions; meeting objectives
9:10 to 10:30	Request for new issues – discussion of new issues Discussion of issues on file
10:30 to 10:45	Break
10:45 to 11:45	Discussion of issues continued
11:45 to 11:55	Summing up – next steps Thank you!

Attachments:

[Issues document](#)

[House Bill 3114](#)

[Related rules \(current\)](#)

**DIVISION 010 – MEDICAL SERVICES
RULEMAKING FOR HB 3114, EFFECTIVE JANUARY 1, 2016**

ISSUE: OAR 436-010-0270, and possibly other Division 010 rules

Issue: Does this rule addressing insurers' required notices to an injured worker and other parties regarding medical services need to be amended to implement provisions of HB 3114? If not, are there any other Division 010 rules that should be amended to implement this new law?

Background: Under current law, a worker must provide the employer notice of a work-related injury within 90 days of the accident. Certain exceptions allow that notice up to one year after the accident if the employer had knowledge of the injury or death, the worker died within 180 day of the accident, or the worker or beneficiaries establish good cause for not providing notice within 90 days. Where a worker provides timely notice of a workers' compensation claim and also has a health insurance plan, HB 4104 in 2014 addressed the medical services the health insurer is required to provide during the 60-day period the workers' compensation insurer is determining whether to accept or deny the claim. That bill also addressed the insurers' respective responsibilities for medical service costs after either claim acceptance or denial by the workers' compensation insurer.

HB 3114, effective January 1, 2016, addresses the situation where a worker has not filed a workers' compensation claim but has submitted a related claim to the health benefit plan and the plan rejects that claim as work-related. In this instance, the new law gives the worker 90 days from the date of the health plan's denial to then file a workers' compensation claim. The "clock" starts from the health benefit plan's action, creating an additional exception to the usual notice requirements in ORS 656.265. If the worker does file a workers' compensation claim and the insurer denies it, HB 3114 requires the workers' compensation insurer to notify the health benefit plan of the denial. The health benefit plan is then required to process the claim for payment subject to its plan's terms and conditions.

None of the division's administrative rules address the timeframes for providing notice of a work-related injury or death, because the statute (ORS 656.265) is so specific. It seems, then, that the additional exception provided by HB 3114 – after the denial of a claim first filed with the health benefit plan – will be similarly clear in the revised law. In the Division 060 (Claims Processing) rules, OAR 436-060-0140(11) already requires a workers' compensation insurer to send notices to the worker's health insurer(s) when compensability of any portion of a claim for medical services is denied. These notices must be sent to the health insurer when sent to the worker, within 14 days of receiving bills from medical providers not previously notified of the denial, or within 60 days of the date when claim compensability has been finally determined or claim disposition made. Thus, for the cases that HB 3114 addresses, if a worker files a workers' compensation claim within 90 days of the health insurer's denial and the workers' compensation insurer subsequently denies the claim, it is already required to provide the health benefit plan the denial notices required under HB 3114.

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However, the division is interested in hearing from insurers, self-insured employers, service companies, worker representatives, health insurers, and other parties about whether:

- The current rule, 010-0270, is sufficient as written (because of the existing Division 060 rule requiring denial notices be sent to the health benefit plan), or if it should be amended to address HB 3114 provisions; or
- There are any other Division 010 rules that should be amended to address HB 3114's provisions.

Note: Division 060 (Claims Processing) rules, and specifically OAR 436-060-0140, are also being opened for rulemaking to determine if amendments are needed to address HB 3114's provisions.

Alternatives:

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Discussion/Recommendations:

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Fiscal Impacts, including cost of compliance for small business:

**DIVISION 060 – CLAIMS PROCESSING
RULEMAKING FOR HB 3114, EFFECTIVE JANUARY 1, 2016**

ISSUE: OAR 436-060-0140, and possibly other Division 060 rules

Issue: Does this rule regarding insurers' provision of claim denial notices to the worker's health insurer(s) need to be amended to implement provisions of HB 3114? If not, are there any other Division 060 rules that should be amended to implement this new law?

Background: Under current law, a worker must provide the employer notice of a work-related injury within 90 days of the accident. Certain exceptions allow that notice up to one year after the accident if the employer had knowledge of the injury or death, the worker died within 180 day of the accident, or the worker or beneficiaries establish good cause for not providing notice within 90 days. Where a worker provides timely notice of a workers' compensation claim and also has a health insurance plan, HB 4104 in 2014 addressed the medical services the health insurer is required to provide during the 60-day period the workers' compensation insurer is determining whether to accept or deny the claim. That bill also addressed the insurers' respective responsibilities for medical service costs after either claim acceptance or denial by the workers' compensation insurer.

HB 3114, effective January 1, 2016, addresses the situation where a worker has not filed a workers' compensation claim but has submitted a related claim to the health benefit plan and the plan rejects that claim as work-related. In this instance, the new law gives the worker 90 days from the date of the health plan's denial to then file a workers' compensation claim. The "clock" starts from the health benefit plan's action, creating an additional exception to the usual notice requirements in ORS 656.265. If the worker does file a workers' compensation claim and the insurer denies it, HB 3114 requires the workers' compensation insurer to notify the health benefit plan of the denial. The health benefit plan is then required to process the claim for payment subject to its plan's terms and conditions.

None of the division's administrative rules address the timeframes for providing notice of a work-related injury or death, because the statute (ORS 656.265) is so specific and the Division 060 rules focus primarily on the claims processing requirements once notice of a claim has been provided. It seems, then, that the additional exception provided by HB 3114 – after the denial of a claim first filed with the health benefit plan – will be similarly clear in the revised law. It also doesn't appear that OAR 436-060-0140(11) needs to be amended, because this rule already requires a workers' compensation insurer to send notices to the worker's health insurer(s) when compensability of any portion of a claim for medical services is denied. These notices must be sent to the health insurer when sent to the worker, within 14 days of receiving bills from medical providers not previously notified of the denial, or within 60 days of the date when claim compensability has been finally determined or claim disposition made. Thus, for the cases that HB 3114 addresses, if a worker files a workers' compensation claim within 90 days of the health insurer's denial and the workers' compensation insurer subsequently denies the claim, it is already required to provide the health benefit plan the denial notices required under HB 3114.

However, the division is interested in hearing from insurers, self-insured employers, service companies, worker representatives, health insurers, and other parties about whether:

- The current rule, 060-0140(11), is sufficient as written or should be amended to address HB 3114 provisions; or
- There are any other Division 060 rules that should be amended to address HB 3114's provisions.

Note: Division 010 (Medical Services) rules, and specifically OAR 436-010-0270, are also being opened for rulemaking to determine if amendments are needed to address HB 3114's provisions.

Alternatives:

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Discussion/Recommendations:

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Fiscal Impacts, including cost of compliance for small business:

Enrolled
House Bill 3114

Sponsored by COMMITTEE ON BUSINESS AND LABOR

CHAPTER

AN ACT

Relating to payment of claims made by injured workers; amending ORS 656.265.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 656.265 is amended to read:

656.265. (1)(a) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a [*dependent*] **beneficiary** of the worker to the employer, but not later than 90 days after the accident. The employer shall acknowledge forthwith receipt of such notice.

(b) Notwithstanding paragraph (a) of this subsection, if an injured worker has not submitted a claim under this chapter but has submitted a claim to a health benefit plan that provides benefits to the worker, and the health benefit plan rejects the claim as being work related, the injured worker may file a claim under this section within 90 days from the date the health benefit plan rejects the claim. If a claim filed under this section is denied, the workers' compensation insurer or self-insured employer shall inform the health benefit plan of the denial and the health benefit plan shall process the claim for payment in accordance with the terms, conditions and benefits of the plan.

(2) The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A report or statement secured from a worker, or from the doctor of the worker and signed by the worker, concerning an accident which may involve a compensable injury shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement.

(3) Notice shall be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may be given to the Director of the Department of Consumer and Business Services and referred to the insurer or self-insured employer.

(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

- (a) The employer had knowledge of the injury or death;
- (b) The worker died within 180 days after the date of the accident; or
- (c) The worker or beneficiaries of the worker establish that the worker had good cause for failure to give notice within 90 days after the accident.

(5) The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death.

(6) The director shall promulgate and prescribe uniform forms to be used by workers in reporting their injuries to their employers. These forms shall be supplied by all employers to injured

workers upon request of the injured worker or some other person on behalf of the worker. The failure of the worker to use a specified form shall not, in itself, defeat the claim of the worker if the worker has complied with the requirement that the claim be presented in writing.

Passed by House April 17, 2015

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate May 26, 2015

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Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2015

Approved:

.....M,....., 2015

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2015

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Jeanne P. Atkins, Secretary of State

Related rules (current)

436-010-0270 Insurer's Rights and Duties

(1) Insurers must notify the injured worker in writing, immediately following receipt of notice or knowledge of a claim, of the manner in which they may receive medical services for compensable injuries.

(2) Insurers may obtain relevant medical records, using a computer-generated equivalent of Form 2476 (Release of Information), with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(3) The insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim. In claims which have been denied, the insurer shall notify the medical service provider and MCO, if any, within ten days of any change of status of the claim.

(4) Upon request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner within 14 days.

(5) When an insurer receives a written request for pre-authorization of diagnostic studies from a provider the insurer must respond in writing to the provider's request within seven days of receipt of the provider's request. If the insurer fails to respond within seven days of receiving a written request, penalties under OAR 436-010-0340 may be imposed.

(6) In disabling and non-disabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers must notify the injured worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(7) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer will be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician or authorized nurse practitioner.

(8) Insurers must reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(e), 656.325, and 656.327.

(a) Reimbursement by the insurer to the worker for transportation costs to visit his or her attending physician may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician of the same specialty who is in a geographically closer medical community in relationship to the worker's home. If a worker seeks medical services from an authorized nurse practitioner, reimbursement by the insurer to the worker for transportation costs to visit his or her authorized nurse practitioner may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate nurse practitioner of the same specialty who is in a geographically closer medical community in relationship to the worker's home. All medical practitioners within a metropolitan area are considered part of the same medical community and therefore are not considered geographically closer than any other physician in that metropolitan medical community for purposes of travel

reimbursement.

(b) A worker who relocates within the State of Oregon may continue treating with the established attending physician or authorized nurse practitioner and be reimbursed transportation costs.

(c) Prior to limiting reimbursement under subsection (8)(a) of this rule, the insurer must provide the worker a written explanation and a list of providers who can timely provide similar medical services within a reasonable traveling distance for the worker. The insurer must inform the worker that medical services may continue with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited as described.

(d) When the director decides travel reimbursement disputes the determination will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

436-060-0140 Acceptance or Denial of a Claim

(1) The insurer is required to conduct a "reasonable" investigation based on all available information in ascertaining whether to deny a claim. A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(2) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(3) The insurer must give the claimant written notice of acceptance or denial of a claim within:

(a) 90 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical condition claim for claims with a date of injury prior to January 1, 2002; or

(b) 60 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of a form 827 signed by the worker or the worker's representative and the worker's attending physician indicating an aggravation claim or written notice of a new medical or omitted condition claim for claims with a date of injury on or after January 1, 2002; or

(c) 90 days after the employer's notice or knowledge of the claim if the worker challenges the location of an independent medical examination under OAR 436-010-0265 and the challenge is upheld, regardless of the date of injury.

(4) The director may assess a penalty against any insurer delinquent in accepting or denying a claim beyond the days required in (3) in excess of 10 percent of their total volume of reported disabling claims during any quarter.

(5) A notice of acceptance must comply with ORS 656.262(6)(b) and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438. It must include a current mailing date, be addressed to the worker, be copied to the worker's representative, if any, and the worker's attending physician, and describe to the worker:

(a) What conditions are compensable;

Related rules (current)

Related rules (current)

(b) Whether the claim is disabling or nondisabling;

(c) The Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) The employment reinstatement rights and responsibilities under ORS chapter 659A;

(e) Assistance available to employers from the Reemployment Assistance Program under ORS 656.622;

(f) That claim related expenses paid by the worker must be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses. The worker must be advised of the two year time limitation to request reimbursement as provided in OAR 436-009-0025(1) and that reimbursement of expenses may be subject to a maximum established rate;

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(6) On fatal claims, the notice must be addressed "to the estate of" the worker and the requirements in (5)(a) through (h) shall not be included.

(7) The first acceptance issued on the claim must contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance must contain all accepted conditions at the time of the notice. When an insurer closes a claim, it must issue an "Updated Notice of Acceptance at Closure" under OAR 436-030-0015. Additionally, when reopening a claim, the notice of acceptance must specify the condition(s) for which the claim is being reopened. Under ORS 656.262(6)(b)(F) the insurer must modify acceptance from time to time as medical or other information changes. An insurer must issue a "Modified Notice of Acceptance" (MNOA) when they:

(a) Accept a new or omitted condition: on a nondisabling claim, while a disabling claim is open or after claim closure;

(b) Accept an aggravation claim;

(c) Change the disabling status of the claim; or

(d) Amend a notice of acceptance, including correcting a clerical error.

(8) Notwithstanding OAR 436-060-0140(7)(d), to correct an omission or error in an "Updated Notice of Acceptance at Closure"(UNOA), under OAR 436-030-0015(1)(c)(D), the insurer must add the word "Corrected" to the UNOA.

(9) When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267.

(10) A notice of denial must comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438, and must:

(a) Specify the factual and legal reasons for the denial, including the worker's right to request a Worker Requested Medical

Examination and a specific statement indicating if the denial was based in whole or part on an independent medical examination, under ORS 656.325, and one of the following statements, as appropriate:

(A) "Your attending physician agreed with the independent medical examination report"; or

(B) "Your attending physician did not agree with the independent medical examination report"; or

(C) "Your attending physician has not commented on the independent medical examination report"; and

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283.

(c) If the denial is under ORS 656.262(15), it must inform the worker that a hearing may occur sooner if the worker requests an expedited hearing under ORS 656.291.

(d) If paragraph (10)(a)(B) above applies, the denial notice must also include the division's Web site address and toll free Infoline number for the worker's use in obtaining a brochure about the Worker Requested Medical Examination.

(11) The insurer must send notice of the denial to each provider of medical services and health insurance when compensability of any portion of a claim for medical services is denied when any of the following applies:

(a) The denial is sent to the worker;

(b) Within 14 days of receipt of any billings from medical providers not previously notified of the denial. The notice must advise the medical provider of the status of the denial; or

(c) Within 60 days of the date when compensability of the claim has been finally determined or when disposition of the claim has been made. The notification must include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(12) The insurer must pay compensation due under ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer must report to the division payments of compensation made by the employer as if the insurer had made the payment.

(13) Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include the costs of medical benefits or burial.

Related rules (current)