

# Agenda

## Rulemaking Advisory Committee

Workers' Compensation Division Rules  
OAR chapter 436, division 060, Claims Administration

<b>Type of meeting:</b>	Rulemaking advisory committee
<b>Date, time, &amp; place:</b>	Aug. 27, 2015, 9:00 a.m. to Noon Sept. 10, 2015, 9:00 a.m. to Noon Sept. 21, 2015, 9:00 a.m. to Noon and <i>ADDED</i> 1:00 p.m. to 4:00 p.m. All meetings: Room F (basement), Labor and Industries Building, Salem, Oregon Dial-in information: 213-787-0529   Access code: 9221262#
<b>Facilitators:</b>	Fred Bruyns, Workers' Compensation Division
<b>9:00 to 9:15</b>	Welcome and introductions; meeting objectives
<b>9:15 to 10:30</b>	Request for new issues – discussion of new issues Discussion of issues on file
<b>10:30 to 10:45</b>	Break
<b>10:45 to 11:45</b>	Discussion of issues continued
<b>11:45 to 11:55</b>	Summing up – next steps  Thank you!

### Attachments:

- [Issues document](#)
- [Form 1502](#)
- [Form 3283](#)
- [Form 3501](#)

**DIVISION 060 - CLAIMS ADMINISTRATION  
ISSUES DOCUMENT  
AUGUST 19, 2015**

**ISSUE #1 – OAR 436-060-0009 – “Access to Department of Consumer and Business Services Workers’ Compensation Claim File Records”**

**Issue:** Should this rule referring to DCBS rules regarding public records requests and fees include a hyperlink to OAR 440-005?

**Background:** During the 2010 revision of OAR 440-005 (“Access of Public Records, Fees for Record Search and Copies of Public Records”), the DCBS director’s office and WCD Rules Coordinator reviewed 060-0009 for potential overlap or conflict. While that matter was resolved, this rule was flagged for review during the next comprehensive revision of Division 060. This rule section addresses accessing worker records. 060-0009(2), though, more generally addresses fees and the first copies provided free to allowed requestors. It would be helpful to users referencing this rule to include the hyperlink to the department’s rules:

[http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_440/440\\_005.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_440/440_005.html)

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #2 – OAR 436-060-0010(1) – “Reporting Requirements”**

**Issue:** Should this rule be amended to state the employer must provide both Form 801 and Form 3283 (“A Guide for Workers Hurt on the Job”) at the time the worker reports an injury, or is this sufficiently addressed in 060-0015(4)?

**Background:** Section 060-0010 addresses claim reporting requirements, with (1) requiring the employer to provide an injured worker Form 801 immediately upon request, to use for filing their claim. 060-0015 addresses required provision of notices and information, with (4) stating that insurers must provide Form 3283 to their insured employers, who must then provide it to their workers when they file a claim. That rule also allows the content of Form 3283 to be printed on the back of Form 801. A stakeholder suggested that provision of Form 3283 also be addressed in 060-0010(1). If this change is made, should 060-0015(4) also reference 060-0010(1)?

**Alternatives:**

- If this change is made, the agency committee noted that the rule could state “...the employer must provide a copy of...Form 440-801...to the worker immediately upon request and Form 440-3283, under OAR 436-060-0015(4)...”
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #3 – OAR 436-060-0010(4) – “Reporting Requirements”**

**Issue:** Does this rule need to be amended to further clarify what constitutes “first aid?”

**Background:** First aid following work incidents or claims, and what is required or allowed in these situations, is sometimes confusing for insurers and employers. WCD periodically gets complaints about and investigates employer-retained services that provide first aid. The division doesn’t have a concern with employers using first aid services as long as the employers or services don’t provide medical treatment or restrict the worker’s right to travel to or see their own provider or to file a claim. This is now addressed in ORS 656.260(21)(b).

**Alternatives:**

- One insurer suggested amending language addressing who may provide first aid by shifting from “a person who does not require a license” to one who is “not qualified to be an attending physician or authorized nurse practitioner...”
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #4 – OAR 436-060-0010(7) – “Reporting Requirements”**

**Issue:** Should this rule’s prohibition on computer-printed forms, faxing claim documents, or electronic filing absent the director’s authorization be deleted, so as to allow more flexibility in reporting? If so, should the rule instead address parameters for alterations made in a computer-printed form?

**Background:** For example, current rules require Form 827 to be signed and a copy of the Notice of Acceptance to be filed with the director. Separately, Form 1502 has a signature/certification field (though there isn’t any requirement for that in the rules). The division has accepted faxed reports and documents for several years, based on a prior bulletin allowing the

practice. The division has also received numerous requests for approval of computer-printed forms, some with additional questions the insurer wanted to include. These have generally been approved. WCD's concern would be if an insurer wanted to report data currently contained in required forms or copies of notices without the documents themselves, before electronic claims reporting is implemented. As long as an insurer or service company submits electronic images of forms or letters they currently send by mail, in compliance with 060-0010(10), (11), and (12), there doesn't appear to be a problem. At a minimum, the rule may need to state that insurers/service companies can't alter a form so as to make it unrecognizable or eliminate required data. Or, it may be that the rule need only be amended to delete references to faxing documents since the director's authorization isn't needed for that.

**Alternatives:**

- Amend the rule to state that insurers or service companies cannot alter a required form so as to make it unrecognizable or eliminate required data.
- Delete references to faxing documents.
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #5 – OAR 436-060-0010(10), (12) and (13) – “Reporting Requirements”**

**Issue:** Do these rules need to be amended to align with Bulletin 237 and Form 1502?

**Background:** The bulletin and form reflect that there can be multiple circumstances requiring a “first report” – new claim, new or omitted condition, aggravation, reopening for vocational training, or post-litigation. An insurer identified that these rules don't clarify these situations or what needs to be reported in each instance. WCD staff also identified the following specific examples that may demonstrate the need for these rules to be clarified:

1. 060-0010(12) describes *what* to report on the 1502 for the initial accept/deny decision, but 060-0010(13) describes only *when* to file subsequent reports. It doesn't describe what to report on the form like (12) does. Maybe some of the subparagraphs under (12) should also be under (13). The back of the form describes what to report for (13), but the rule doesn't.
2. 060-0010(13)(g) could cause a confusion about in the timing of reporting. It requires insurers to file an “additional” report when the first payment is issued, but the first payment is often issued long before the accept/deny decision, and WCD doesn't require a 1502 before acceptance/denial. Also, if the first payment is reported on the initial report, this rule could be read to require filing another 1502. For example, if the claim is accepted on May 1<sup>st</sup>, first payment is issued on May 10<sup>th</sup>, and the 1502 is filed timely for claim acceptance on May 15<sup>th</sup> and reports the first payment, this rule appears to require an “additional” 1502, due by May 24<sup>th</sup>, to report the first payment (again).

3. WCD staff I've had questions from claims examiners about 060-0010(13)(a): the rule says *any* reopening but should not include Board's Own Motion (BOM). This conflicts with (15) and the back of the form, which both require filing Form 3501 instead of a 1502. Claims processors have expressed confusion about whether or not they had to file both forms. They should not file a 1502 in these instances, but the rule could be clarified.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #6 – OAR 436-060-0010(11) – “Reporting Requirements”**

**Issue:** Should the policy number be a mandatory data item for Form 1502 submissions?

**Background:** Form 1502 has a field for policy number, but many insurers don't complete that field before submitting the form. Its absence creates additional workload for WCD staff, and the problem is exacerbated when claims processors include the wrong insurer's name on the form. Completion of the policy number field isn't mandatory based on (11), although the instructions on the back of the form say to include it. If the policy number is required on all 1502s, this will likely eliminate most “wrong insurer” issues. However, do claims processors always have access to policy numbers? What would self-insured employers enter on the form? A check-box indicating self-insured status could be a problem since some insurers or service companies sometimes think an employer is self-insured when they're actually covered under a large deductible policy.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #7 – OAR 436-060-0015(8) – “Required Notice and Information”**

**Issue:** Would this requirement for the insurer to send the worker a notice prior to claim closure that documents the wage upon which benefits were based be better placed in 060-0025, which

addresses wages and temporary disability rates? Separately, should the rule provide a time frame for sending the notice?

**Background:** WCD staff note that it is often difficult to find this particular requirement and it might be more easily found in 060-0025 which addresses wages and temporary disability rates. On the other hand, this pre-closure letter is a required notice which is the topic this section (060-0015) addresses. (Note: 436-060-0030(12) and 436-060-0150(10)(c) also address notices of changes in compensation rates and benefit amounts.) Regardless of its location, the rule’s “prior to closure” language is vague and might benefit from a specific timeframe. If so, what should that timeframe be?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #8 – OAR 436-060-0017(2) – “Release of Claim Documents”**

**Issue:** Should the requirement for insurers to date stamp documents upon receipt be updated by adopting ORS Chapter 84 provisions that allow e-record processes for recording receipt? If so, how should insurers demonstrate receipt of document images?

**Background:** Date stamps must include the month/day/year of receipt and name of the company, unless the document already contains that information, as in faxes, email, and other electronic communication. Many insurers and service companies no longer get their mail directly. Instead, it goes to processing centers where the “received” date is the date the document is scanned in the system. However, sometimes the scanned date isn’t always the same as the received date; this could create situations where it appears a worker didn’t submit something timely, possibly losing their rights to compensation or a potential remedy. WCD staff handling disputes also noted that there are a lot of things driven by the receipt date, such as treatment plans and surgery responses. The division’s auditing standards allow for using an electronic scan date to designate receipt, and where there is a difference in the two days, auditors use the earliest date. When there are differences in the received and scanned dates, WCD Sanctions staff also use the earliest date.

“Date stamp” was recently defined in Division 009 rules and the same definition is in the proposed Division 010 rules: “Date stamp means to stamp or display the initial receipt date and the recipient’s name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.” It may be best for 060-0017 to be amended to be consistent with the newer “date stamp” rules in Divisions 009 and 010. An insurer also suggested that the more general ORS Chapter 84 provisions could be referenced (for example, see 84.043 - “Time

and Place of Sending and Receipt”, 84.019 – “Legal Recognition of Electronic Records,” and 84.037 – “Admissibility in Evidence”).

**Alternatives:**

- Amend this rule to be consistent with the “date stamp” definitions in the Division 009 and 010 rules.
- Amend the rule to reference ORS Chapter 84 provisions (see 84.043 - “Time and Place of Sending and Receipt”, 84.019 – “Legal Recognition of Electronic Records,” and 84.037 – “Admissibility in Evidence”).
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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #9 – OAR 436-060-0017 – “Release of Claim Documents”  
and  
OAR 436-060-0180 – “Designation and Responsibility of a Paying Agent”**

**Issue:** Should these rules be amended to provide for easier and faster discovery (provision of records and information)?

**Background:** OAR 436-060-0017 requires insurers to furnish document copies, without cost, to the worker, beneficiary, or worker’s attorney. Except for responsibility processing under 060-0180, a request by anyone other than the worker or beneficiary must be accompanied by a worker-signed attorney retention agreement or medical release. The insurer must provide the requested records within 14 days of receiving the request, or 30 days for archived records. If the claim is lost or has been destroyed, the insurer must notify the requester in 14 days and reconstruct and mail the file within 30 days of its prior notice. OAR 436-060-0180(4), however, only states that insurers identified in a responsibility dispute “must, upon request, share claim related medical reports and other information without charge...to expedite claim processing.” No timeframe is provided.

Although 060-0017 is more specific in addressing providing records to workers and attorneys while the only rule that addresses insurer-to-insurer records transactions is in 060-0180, an attorney raised this issue about both rules. However, since he specifically noted the problems created when carriers are investigating claim responsibility and can’t obtain timely information from other insurers, the agency committee suggested that perhaps the issue is actually whether a time frame requirement should be added to 060-0180. It would be helpful to hear from the stakeholders about whether either rule needs revision.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #10 – OAR 436-060-0018(2) – “Nondisabling/Disabling Classification”**

**Issue:** This rule addressing claim reclassification upon the receipt of information that “any condition already accepted” meets the disabling criteria should be amended to require reclassification upon the receipt of information concerning “any condition related to the compensable injury.”

**Background:** Recent rulemaking in Division 030 and 035 rules incorporating changes based on the *Schleiss v. SAIF (364 Or.637 (2013))* and *Brown v. SAIF (262 OR App 640 (2014))* cases identified that this rule should also be rephrased to address conditions due to the compensable injury. Such a change shouldn’t affect reclassification processing much from a practical standpoint since, except in very rare cases, disabling status is triggered by time loss.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #11 – OAR 436-060-0018(5)(b) - “Nondisabling/Disabling Classification”**

**Issue:** Should this rule be amended to allow an insurer 14 days from its receipt of a worker’s request for claim reclassification to respond to the request?

**Background:** The current rule requires the insurer’s response in a shorter period - within 14 days of the worker’s request, the date of the letter. A service company representative suggested that other rule timeframes generally count the time period for an action to occur from when the party or the division receives something, not when it was sent. The agency committee noted, however, that workers’ timeframes to take actions (such as requesting a hearing) run from the mailing dates of denials, Notices of Closure, or other documents. The option of tying the insurer’s timeframe to the postmark date on a worker’s request is also problematic since insurers’ mail scanning centers don’t retain the postmarks once processed.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #12 – OAR 436-060-0018(10) - “Nondisabling/Disabling Classification”**

**Issue:** Should this rule be revised to clarify that the director may assess both penalties under OAR 436-060-0200 and attorney fees under ORS 656.386(3), for an insurer’s or self-insured employer’s failure to respond timely to a worker’s request for claim reclassification?

**Background:** The rule currently says that WCD may impose penalties “or” attorney fees for untimely classification responses. A self-insured employer interpreted this as meaning the division can only impose one or the other sanction. The Hearings Division’s August 10, 2012 Proposed and Final Order for Jason K. Nolan (*Jason K. Nolan*, 17 CCHR 199 (2012)) summarized the division’s position that “or” means “and” “such that, under OAR 436-060-0018(10), “penalties or attorney fees or both may be assessed.” The division alternately asserted “that because the face of the rule is unclear, the rulemaking history...should be considered,” contending that it shows the rule “allows injured workers an additional avenue of recourse, not an alternative to imposing civil penalties.” The Administrative Law Judge (ALJ) concluded the rulemaking history indicated WCD interpreted ORS 656.386(3) to authorize a civil penalty and an attorney fee, and that WCD’s interpretation of its rule is reasonable. Nevertheless, the division believes the rule can more clearly express the intended, possible consequences by amending the rule to say that the division may assess penalties, attorney fees, or both.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #13 – OAR 436-060-0018(11) and (12) - “Nondisabling/Disabling Classification”**

**Issue:** Should 060-0018(11) specify that a Notice of Acceptance cannot be modified to reflect a change in claim status to “nondisabling” after the Notice of Closure has been issued? More generally, should the “Notwithstanding (12),” language in (11) be deleted and (12) be amended to clarify reclassification criteria for nondisabling claims?

**Background:** The division has long held that once a claim has been classified as “disabling,” it remains a non-disabling claim even if there are new conditions that are nondisabling. After review by its Policy staff, WCD issued an industry notice on December 29, 2000 titled “New and Omitted Medical Condition Reopening Claim Processing by Insurers.” It stated: “ORS 656.262(7) (c) states that an Updated Notice of Acceptance issued at claim closure must specify which conditions are compensable and that ‘if a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.’ The Workers' Compensation Division determines this to mean that once a claim has been classified as disabling and the insurer later accepts a new condition, it is immaterial whether the newly accepted condition is disabling or non-disabling. Any disabling claim may contain a mix of disabling and nondisabling conditions, but the work-related injury claim remains a disabling claim.”

A former WCD manager raised the question of whether 060-0018(11) needs to specifically prohibit modifying claim status in a Notice of Acceptance issued after closure, and whether (12) could more clearly address criteria for “correcting” claims that were improperly classed as disabling. The “Notwithstanding (12)” in 060-0018(11) appears to clearly signal that (12) is an exception so it isn’t apparent that deleting that phrase would help in clarifying either (11) or (12). The agency committee is interested in hearing whether stakeholders have concerns about either rule.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #14 – OAR 436-060-0019 – “Determining and Paying the Three Day Waiting Period”**

**Issue:** Should the language in OAR 436-060-0025(6) regarding which date should be used for the date of injury be deleted from that rule and moved to this rule addressing the three day waiting period?

**Background:** Both WCD staff and claims processors sometimes have trouble locating the rule. 060-0025(6) states that when a working shift extends into another calendar day, the date of injury shall be the day used by the employer for payroll purposes. That rule section addresses weekly wage and rate of temporary disability calculations. The rule itself is intended to tell processors how to treat wages and count dates for initial disability for situations with unusual shift times; it addresses claims processing and isn’t making a compensability or legal determination about when an injury actually occurred. For example, if the employer’s payroll function calls a shift that covers Sunday-Monday, “Monday,” then Monday is the first day used for the three-day

waiting period. If the shift is considered for payroll purposes to be “Sunday,” then the first date of the three-day waiting period is Sunday. It may be that this rule has application in both 060-0025 and 060-0019, but is more germane to the three day waiting period determination in the latter rule. However, because the entire 060-0025 “average weekly wage” rule is going to be reviewed during this rulemaking, the agency committee suggests deferring recommendations about the rule’s appropriate location pending the larger discussion with the stakeholder’s committee.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #15 – OAR 436-060-0020(1) – “Payment of Temporary Total Disability Compensation,”**

**OAR 436-060-0025(1) and (2) – “Rate of Temporary Disability Compensation,” and**

**OAR 436-060-0150(6) – “Timely Payment of Compensation”**

**Issue:** Do one or more of these rules need to be amended to clarify that self-insured employers do not need to seek prior approval from WCD to pay time loss on their usual payroll schedule (where the pay dates exceed the 14-day requirement)?

**Background:** 060-0020(1) says an employer may pay compensation with the approval of the insurer, though the insurer’s responsibility to determine what compensation is due is not waived. Rules 060-0025(1) and (2) say an employer shall not continue to pay wages in lieu of statutory temporary total disability (TTD) payments due. While ORS 656.018 says the employer isn’t precluded from supplementing TTD, they must separately identify benefits from other payments and not make payroll deductions from those benefits. Section (2) also says that a self-insured employer may continue to pay the same wage with normal deductions at the same pay interval that the worker was receiving at the time of the injury. These rules address the “what” gets paid (wage vs. compensation) and not the timing aspect addressed in 060-0150(6), which requires timely payments every 14 days.

Those rules, however, don’t specifically address a self-insured employer paying time loss on their payroll schedule. Some self-insureds have requested permission from WCD to do so, with one even requesting approval annually. 060-0025(2) says that a self-insured employer may continue the same wage at the same pay interval; that is different than paying time loss on the payroll schedule. Based on 060-0020, time loss must be paid on the time loss schedule unless the employer gets permission to pay it on a payroll schedule. Since a self-insured employer is both the insurer and employer, it doesn’t seem that they need to ask WCD for approval to do this. This

is the basis for the suggestion to clarify the rules above to state that self-insureds don't require division approval in these cases.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #16 – OAR 436-060-0025(2) – “Rate of Temporary Disability Compensation”**

**Issue:** Should this rule define “wage continuation?”

**Background:** Claims processors, workers, and their attorneys periodically ask WCD how self-insured employers should “calculate” the wage continuation this rule allows in lieu of temporary disability. WCD sometimes see claims where the wage a self-insured employer paid “drops back” to a base salary rate that doesn't include the worker's usual overtime or other types of pay at the time of injury. If, for example, police officers or fire fighters work a lot of overtime but the wages “continued” in lieu of compensation are their base wages, that doesn't seem consistent with the intent of 060-0025(2) regarding what they were usually earning on the date of injury. Because WCD also sees some problems in interpreting how the sentences in this rule work together, discussion with the stakeholder committee would be helpful in determining what clarifying changes should be made to the rule.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #17 – OAR 436-060-0025 – “Rate of Temporary Disability Compensation”**

**Issue:** Should insurers and self-insured employers include paid leave (sick leave, vacation leave, personal business days, etc.) when determining a worker's wage based on a 52-week average?

**Background:** OAR 436-060-0025 attempts to address many situations and factors when determining the average weekly wage used as the basis for temporary disability benefits. However, the rule does not specifically address the inclusion or exclusion of paid leave. ORS

656.005(29) defines wages as the money rate at which services rendered are recompensed; it is understandable that paid leave might be considered part of that money rate. However, in addressing “payroll” in (22), the same statute refers to a record of wages payable that does not include vacation pay, one type of paid leave. This latter statute is consistent with rules established by the National Council on Compensation Insurance, where gross wages subject to premium assessment exclude vacation pay but include sick pay and holiday pay. Evolving benefits practices where employers no longer delineate between vacation and sick leave but provide workers a combined number of days to use, complicates the current question.

Another rule regarding temporary partial disability, 060-0030(10), advises that “post-injury wages” include sick or vacation leave payments. It seems contradictory to say that leave included in post-injury earnings wouldn’t also be included when calculating the average weekly wage; it would seem it would either be included in both, or neither. Given the 2015 Legislative’s discussions about mandating leave, this question can be expected as more employees have leave. For situations where a worker’s wage must be determined based on a 52-week period, this rule should provide clarity about how various types of paid leave should be treated.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #18 – OAR 436-060-0025(5)(c) – “Rate of Temporary Disability Compensation”**

**Issue:** Should this rule be amended to be consistent with 2013 case law finding that subsistence and travel pay are to be considered wages?

**Background:** The current rule defines these types of costs as reimbursed expenses that are not to be considered part of the wage. However, in *SAIF CORPORATION and Pioneer Waterproofing Co. Inc., v. Jeffery P. SPARKS* (258 Or App 227 (2013)), the Court of Appeals ruled that for purposes of determining claimant’s temporary total disability benefits under ORS 656.210(1) and [citing this rule] OAR 436-060-0025(5)(c), a worker’s subsistence and travel pay are considered wages when determining the average weekly wage (AWW). WCD staff note that in this case, the worker was being paid a flat amount of money for travel that wasn’t designated as expenses being “reimbursed” or a per diem. The court did note in its opinion that it was not making a finding that the amounts in question were “per diem” amounts; however, that is how WCD has previously categorized these types of payments. It would be helpful to discuss whether the Court’s decision invalidated this rule or applied more narrowly to the case’s circumstances.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #19 – OAR 436-060-0025(5)(f) – “Rate of Temporary Disability Compensation”**

**Issue:** Should the last sentence (“One-half day or more will be considered a full day when determining the number of days worked per week”) be deleted from this rule?

**Background:** This sentence doesn’t seem to be related to the rest of this rule addressing when to include overtime earnings in the average weekly wage calculation. It isn’t clear if it relates to calculating average wages based on counting days or how to count a worker’s scheduled days off. The statute for a daily worker says daily wages are multiplied by the number of days worked per week. This rule seems to say if the employee works 3 ½ days you’d multiply the daily wage by four, but doing so would throw the wage off. Do claims processors rely on this rule?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #20 – OAR 436-060-0025(5)(m) – “Rate of Temporary Disability Compensation”**

**Issue:** Should this rule be expanded to address other situations where the combination of long work shifts and cyclic work may adversely affect a worker’s compensation rate?

**Background:** The rule says “For workers with cyclic schedules insurers must average the wages of the entire cycle...” Intended to even out the “ups and downs,” the rule was implemented to address situations where nurses were getting over-compensated when they worked “one week on, one week off.” For the week worked, their compensation rate was very high. However, WCD received input that nurses who often work long shifts sometimes do not receive 66 2/3 of their average wage when time is lost for a portion of the work cycle. For example, in partial weeks, some get more compensation and some get less, because the rule also says “For purposes of temporary disability payments, the cycle shall be considered to have no scheduled days off.” It makes all seven-day-per-week workers, so if they are only missing four days, they get four sevenths of their comp rate but if they were scheduled to work three days, they would only get three sevenths for the three days they missed for the entire week. The larger issue is addressing

situations where workers aren't compensated for what they "lost" when their hours and shifts vary. However, this can also go the other way, with some workers being overcompensated in similar circumstances. Can this be resolved by rule or does it require a statutory change?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #21 – OAR 436-060-0030(10) – “Payment of Temporary Partial Disability Compensation”**

**Issue:** Should this rule allow the use of paid leave time to “make the worker whole” when temporary partial disability is calculated only on actual wages earned?

**Background:** Currently, paid leave time is defined as post-injury wages for purposes of calculating temporary partial disability. Some large employers (hospitals and school districts, for example), have employment policies allowing the use of paid leave time to supplement temporary disability. In other cases, self-insured employers have union contracts with provisions addressing paid leave even if the employee is off work due to a work injury. The rule doesn't consider these situations, which are similar to when a short-term disability policy is going to pay benefits and doesn't have a provision carving out, or offsetting, workers' compensation benefits. Some employers perceive this as “double-dipping.” WCD sees situations where the employer pays just a little extra wages to bring the worker's income up to what it was before, while others have a policy of allowing the worker to use some sick leave to get the extra money. But based on rule, that sick leave has to be offset against temporary partial disability. And regardless of whether the employer has a specific policy or contract provision addressing this, ORS 656.240 allows it with the worker's consent. However, this is contrary to what the rule requires.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #22 – OAR 436-060-0030(10) – “Payment of Temporary Partial Disability Compensation”**

**Issue:** Should this rule clarify that time provided for vacation or to cover illness or personal business is considered “post-injury wages” even where the leave type is not labeled as such or individually tracked?

**Background:** This rule states that post-injury wages include sick or vacation leave payments. More employers are now aggregating vacation, sick, and personal leave days into a single “paid time off” (PTO) account which employees may use as needed without indicating the specific purpose. If a worker has a nondisabling claim and has to go to physical therapy three days per week, is gone for two hours for each of those appointments, and uses sick leave to get paid for that time because they won’t get time loss, is that sick leave considered post-injury wages?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #23 – OAR 436-060-0035(1)(c) – “Supplemental Disability for Workers with Multiple Jobs at the Time of Injury”**

**Issue:** Should the definition in (1)(c) be amended to clarify that secondary jobs at aggravation do not affect the rate previously determined at the time of injury that includes (the combined wages due to) supplemental disability (SDB)?

**Background:** This rule currently defines secondary jobs as other jobs held by the worker in Oregon subject employment at the time of injury. A worker with multiple jobs at the time of injury may not have the same jobs, or the same number of jobs, at aggravation. The rule may be more helpful to claims processors if it specifically states that the determination for SDB is made at the time of injury, not at aggravation, regardless of subsequent changes in employment. [The only consideration will be time lost from either or both jobs.] For workers eligible to receive SDB at injury the temporary total (TTD) rate at aggravation will still include the SDB portion even if the worker no longer has a second job. Conversely, if a worker only had one job at the time of injury but holds multiple jobs at aggravation, the wages at injury will be used.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #24 – OAR 436-060-0035(4) - “Supplemental Disability for Workers with Multiple Jobs at the Time of Injury”**

**Issue:** Should this rule be amended to clarify that the insurer’s initial notice must inform the worker that the verifiable documentation regarding secondary jobs must be received within 60 days?

**Background:** While (3)(b) already addresses the 60-day timeframe requirement the insurer must cite in its notice to the worker, the Department of Justice advised WCD that also referencing it in this rule will make it clear that the consequences of the worker not timely providing the required information is that the insurer will calculate the temporary disability rate based only on the job at injury.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #25 – OAR 436-060-0035(6) - “Supplemental Disability for Workers with Multiple Jobs at the Time of Injury”**

**Issue:** Should this rule be amended to state the additional condition for the worker’s eligibility for supplemental disability benefits of providing timely verifiable documentation of wages from a secondary job?

**Background:** Consistent with the suggested change in Issue #25, the Department of Justice (DOJ) advised WCD to add “the worker timely provides verifiable documentation of wages from a secondary job” to the current list of conditions in (6). This fourth condition is required by 656.210(2)(b)(B) and DOJ raised the issue after a worker’s attorney argued the point at a hearing. WCD suggests this fourth condition be listed as (c), with the current (c) renumbered to a new (d).

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #26 – OAR 436-060-0040(2) – “Payment of Permanent Partial Disability Compensation”**

**Issue:** Should this rule be amended to clarify that permanent partial disability must continue to be paid even when temporary disability is not due?

**Background:** The rule can either be reworded (“whether temporary disability is due or not” or something similar) or a new (3) can be added.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #27 – OAR 436-060-0040(2) – “Payment of Permanent Partial Disability Compensation”**

**Issue:** Should this rule be amended to address aggravation of conditions due to the compensable injury, in lieu of the current reference to aggravation of “accepted conditions?”

**Background:** Division analysis and recent rulemaking in Division 030 and 035 rules to incorporate changes based on the *Schleiss v. SAIF (364 Or.637 (2013))* case identified that this rule should also be rephrased to address conditions due to the compensable injury.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #28 – OAR 436-060-0040(4) - “Payment of Permanent Partial Disability Compensation”**

**Issue:** Should this rule be modified or deleted, given the Court of Appeals ruling in *Liberty NW v. Jose L. Olvera-Chavez* (267 Or App 55 (2014))?

**Background:** This rule currently provides that insurers must stop temporary disability payments and resume any suspended award payment when a training program is completed or ends, unless the worker is not medically stationary. If no award payments remain, the rule requires that temporary disability must continue until claim closure. Relying on this rule, the November 2014 decision concluded that the temporary disability due from the end of training to closure is substantive in nature because the rule requires it to be paid. Internal input is that this temporary disability should be considered procedural, in that it is similar to that due from medically stationary status to closure. The Court issued a subsequent decision that increases the amount of information an insurer must obtain before issuing a post-training closure. The division issued rules in August requiring the insurer to get recent closing medical information in these cases, even if will not affect the new closure; “recent” is defined as within the last six months. In combination, the court decisions make the post-training temporary disability due a larger issue than in the past, and it is suggested that the committees should consider modifying or deleting the rule.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #29 – OAR 436-060-0095 – “Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice”**

**Issue:** Should the sanction provisions related to independent medical examinations (IMEs) in Division 010 (“Medical Services”) rules be moved to these rules?

**Background:** This issue was raised by a Sanctions representative in 2008. A WCD manager asked in 2010 that it be considered during the next comprehensive review of Division 060.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #30 – OAR 436-060-0135(9) – “Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker”**

**Issue:** Should this rule be amended to delete the requirement that, after WCD has issued its suspension order, the worker and insurer must notify the division when the worker cooperates with the investigation [4<sup>th</sup> sentence]?

**Background:** In practice, this appears to be an unnecessary reporting burden. If WCD doesn't use the information, there shouldn't be a reporting requirement. A suspension order is “self-lifting” once the worker cooperates. It is the division's expectation that an insurer will resume paying benefits if the worker cooperates. Where that doesn't occur, the worker may request a 656.262(11) penalty for unreasonable delay in paying compensation.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #31 - OAR 436-060-0140(11)(c) – “Acceptance or Denial of a Claim”**

**Issue:** Should this rule be amended to require that a copy of the claim disposition agreement be provided to the medical providers?

**Background:** The notice requirements in the rule already require that the notice of denial sent to each medical services provider and the health insurer include the “results of the proceedings ...and the amount of any settlement.” The Board rule 438-009-0010(2)(g) requires the specific amount that each medical provider will receive to be in the disposition agreement. Neither rule requires a copy of the agreement to be provided, though the notification requirement can be satisfied in this manner. Many insurers do send copies to the provider(s), but requiring this method to communicate the information about what the providers will be paid may be unnecessarily prescriptive.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #32 – OAR 436-060-0140(12) – “Acceptance or Denial of a Claim”**

**Issue:** The intent of the second portion of this rule regarding the employer’s ability to pay interim compensation is unclear.

**Background:** Since OAR 436-060-0020(1) already addresses the employer’s ability to pay compensation with the insurer’s approval, under ORS 656.262(13), it isn’t clear how this rule relates to the former rule. The first part of the rule addresses the insurer’s payment of interim compensation until the claim is denied, so does the remainder of the rule say the employer may pay interim compensation, but only on claims that are ultimately denied? That seems unlikely since the employer won’t know beforehand the claim will be denied because the insurer is obligated to conduct a reasonable investigation before making the acceptance/denial decision. Does this rule unnecessarily duplicate 060-0020(1), or is it intending to distinguish a particular circumstance that should be clarified?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #33 – OAR 436-060-0147(6)(a) – “Worker Requested Medical Examination”**

**Issue:** Is this rule addressing the timeframe for receiving a worker’s response to a division-provided list of physicians for a Worker Requested Medical Examination (WRME) consistent with statutory and other rule provisions addressing timeframes?

**Background:** ORS 656.726(4)(a), in addressing the director’s authority to make rules, provides that “unless otherwise specified by law, all reports, claims or other documents shall be deemed timely provided to the director... *if mailed* by regular mail or delivered *within the time required* by law.” [emphasis added] This means that the division must honor postmark dates and WCD’s programs do so. Input suggested that this rule, however, may be in conflict with .726(4)(a) by requiring that the worker’s or representative’s response be received by the director within ten business days of the division providing the list. If the worker mails a response on the 10<sup>th</sup> business day, it will be deemed untimely. Other administrative rules, such as Division 030 rules for requesting reconsideration of claim closures, use language that address mailing or delivering a request within the required timeframe. On the other hand, in promulgating this rule, the director “otherwise” specified a different timeliness standard and the rule may be appropriate

as written. Even if this is the case, the committee may want to discuss if there is a reason for using a different timeliness standard for a worker’s “deselection” response.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #34 – OAR 436-060-0147(10) - “Worker Requested Medical Examination”**

**Issue:** Should this rule be amended to provide the physician performing the Worker Requested Medical Examination (WRME) additional time to complete and send the report to the worker, worker’s representative, and insurer? If so, what should that timeframe be?

**Background:** The current rule provides the WRME physician five working days after completing the exam to address the original independent medical examination’s (IME)and worker’s/representative’s questions and send the report to the parties indicated above. A physician who performs both IMEs and WRMEs commented that five working days is too short a period to complete a thorough report, and as a result, he declined to perform a WRME. WCD staff note that many division rules provide for a 14-day timeframe, as does 060-0147(8) in addressing timeframes for the insurer to provide the worker’s records to the WRME physician. If this timeframe is extended, 14 days may be an option.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #35 – OAR 436-060-0147(12) - “Worker Requested Medical Examination”**

**Issue:** Should this rule regarding the insurer’s payment for a WRME that the worker failed to attend be amended to be consistent with OAR 436-009-0010(13)?

**Background:** The Division 009 rule states that if the worker fails to attend a WRME without providing the WRME physician at least 24 hours notice, the provider must be paid 50% of the exam or test fee. This Division 060 rule simply says the provider must be paid for the missed

exam, which may imply the full amount. It doesn't appear there was ever any discussion regarding the Division 060 rules that the insurer wouldn't be responsible for the entire fee. The only question at the time the rule was amended in 2004 was whether the worker would be responsible for paying for additional exams. The rule was amended then based on WCD's conclusion that it didn't have authority to require the worker to pay for anything. It may not be necessary for 060-0147 to specify a rate because Div. 009 rules address it, but it might make sense to have the two rules agree. If so, a simple cross-reference to the Division 009 rule may be all that is needed.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #36 – OAR 436-060-0147- “Worker Requested Medical Examination”**

**Issue:** Should this rule addressing Worker Requested Medical Examinations (WRMEs) be amended to 1) require the insurer to ask the attending physician to respond to an IME report, and 2) to provide that no response from the attending physician means “do not concur?”

**Background:** A worker's attorney expressed the concern that because insurers are not required to ask attending physicians to respond to IME reports, it is more difficult for a worker to satisfy the third requirement for requesting a WRME (identifying one or more IME reports with which the attending physician (AP) or authorized nurse practitioner has disagreed). The attorney noted that if no one asks the AP about concurrence and the insurer closes the claim based on the IME findings, the worker won't be eligible for a WRME. This may create an incentive for insurers not to ask APs about concurrence, and also shifts costs to the worker's attorney if the attorney must ask the AP about concurrence. Further input was that WCD misinterprets ORS 656.325 by viewing “does not concur” as requiring the affirmative action of a response from the AP stating the lack of agreement.

WCD previously acknowledged that while there is no requirement for the insurer to solicit a response from the AP, the AP is not prevented from providing their input on the IME, nor is the worker or their attorney prevented from asking the AP to send a response to the insurer. While the division noted the issue of who should pay for an AP's review of an AP report if requested by someone other than the insurer might best be clarified by statute, WCD agreed to raise the topic in rulemaking to obtain stakeholder input. WCD also noted that because it is difficult to prove that silence equates with a particular opinion one way or the other, and there might be a number of reasons an AP might not comment on an IME, it has determined the better approach to be to require a response documenting the lack of agreement. This approach has been consistent with how the division regulates other areas where an AP's response is needed to

trigger an action. For example, Division 030 rules state that concurrence cannot be presumed in the absence of an AP's a response regarding a closing report.

Separately, if any of the suggested changes are made, would they more appropriately be made to the Division 010 rules governing IMEs since the input addresses actions that precede a WRME?

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #37 – OAR 436-060-0150 [and possibly other rules] – “Timely Payment of Compensation”**

**Issue:** Should Division 060 address how to count days for purposes of determining timeliness?

**Background:** An insurer representative raised this issue.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #38 – OAR 436-060-0150(1) and possibly (5) – “Timely Payment of Compensation”**

**Issue:** Should this rule be amended to require that time loss checks be delivered to the worker by the 14<sup>th</sup> day, not merely be in the mail?

**Background:** A worker's attorney raised this issue during prior Division 050 rulemaking, pointing out that claims processing requirements shouldn't only address the location from where time loss checks are issued.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #39 – OAR 436-060-0150(3) – “Timely Payment of Compensation” [see Issue #49]**

**Issue:** Should this rule addressing timely payment of temporary disability benefits be amended to delete the reference to quarterly penalties issued for performance falling below the 90% standard?

**Background:** The rule’s current language was related to the former Quarterly Claims Processing Performance (QCPP) penalties issued by the Audit Unit for certain claims processing actions, including timely first payments. WCD does not issue quarterly penalties for timely first payment anymore. Instead, timeliness of first payments is reviewed in the Annual Audits. To accurately reflect what now occurs, “during any quarter” could be changed to “during any year.” However, given the director’s general penalty authority, it may be better to simply delete “during any quarter” and not specify an alternative penalty timeframe.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #40 – OAR 436-060-0150(6) – “Timely Payment of Compensation”**

**Issue:** Should the first sentence be reworded to improve readability and enhance understanding of the requirement for timely payments?

**Background:** One “plain language” suggestion for rewording the first sentence is “Temporary disability payments must be paid every 14 days and each payment must pay a period to within seven days of the date of the payment.” This could also be two sentences. Advisory committee members may have other suggested language.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #41 – OAR 436-060-0150(9) – “Timely Payment of Compensation”**

**Issue:** Should this rule be amended to clarify what is required, and allowed, in making monthly payments of permanent disability and fatal benefits?

**Background:** In addressing past questions and complaints about the timing of monthly payments, WCD managers and the Injured Worker Ombudsman identified the need to clarify this rule. A similar recommendation was made in the division’s Regulatory Redesign review of this issue. One suggestion is to specify that payments are to be made “in a regular and predictable monthly sequence” or “on a regular and predictable schedule.” Another suggestion is that “payment dates” in the second sentence be amended to “payment days or date” to allow an insurer to make payments, for example, on the first Monday of each month or last business day of the month; in these cases, the actual “date” could change quite a bit from month to month. While providing this option, the primary goal is to ensure the recipient can count on regular, predictable payments.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #42 – OAR 436-060-0150(14) – “Timely Payment of Compensation”**

**Issue:** Should this rule, addressing the required Oregon compensation for a worker with a claim in another state for the same injury or disease as a claim filed in Oregon, be amended to be more consistent with ORS 656.126 requirements?

**Background:** The rule’s current language requires the insurer to pay any unpaid compensation due, up to the amount required under Oregon law, within 14 days of receiving written documentation of underpaid compensation. This suggests that the insurer can assume that if the worker is receiving benefits under another law, it doesn’t have to pay compensation unless the worker provides documentation of an underpayment. This doesn’t seem to be the intent of the “offset” (credit) allowed by 656.126(6), nor does the statute indicate that the burden is on the worker to flag the issue.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #43 – OAR 436-060-0153 – “Electronic Payment of Compensation”**

**Issue:** Should the worker consent requirements for electronic compensation payments be revised to be consistent with the newer laws affecting wage payments, effective January 1, 2014?

**Background:** HB 2683 (2013 Legislative Session) allowed employers, on or after January 1, 2014, to pay wages through direct deposit. Another provision of that law states that employers shall pay an employee’s wages by check upon written or oral request of the employee. This establishes direct deposit as the default for payroll, with the worker having to “opt out.” The current rule for compensation payments requires the worker to “opt in” for direct deposit of benefits by the insurer. A large self-insured employer asked if this rule will be changed to be consistent with the wage payment requirements, especially given payroll and payment systems “in the real world.” While HB 2683 applied to wages and not worker’s compensation payments, under ORS 656.262(4)(b) and 060-0025(2), a self-insured employer is allowed to pay wage continuation in lieu of temporary disability payments. Even where they do not do so, compensation payments are often issued through the same payroll system and it may create complications to have different “opt in/opt out” standards for the two types of electronic payments. [Note: If this rule is amended as suggested, WCD will notify the Insurance Division since it uses current WCD rule language in its electronic payment rules.]

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #44 – OAR 436-060-0155(4) – “Penalty to Worker for Untimely Processing”**

**Issue:** Should the timeframe in this rule, for the insurer to respond to the director regarding additional amounts that may be due the worker as a penalty, be the same as the timeframe in 060-0400(3) and other rules?

**Background:** This rule provides the insurer 21 days from the mailing date of the division’s inquiry to respond to WCD. However, a similar rule re: penalties and attorney fees requested for

failure to pay amounts due on a disputed claims settlement (060-0400) allows the insurer only 14 days to respond to the division’s inquiry letter. The latter timeframe is the standard used in most rules.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #45 – OAR 436-060-0155(4) – “Penalty to Worker for Untimely Processing”**

**Issue:** Should the provision for a \$50 penalty against the insurer for failure to copy the worker or attorney with the response sent to the division in an ORS 656.262(11) inquiry be retained?

**Background:** Staff questioned the purpose and efficacy of this penalty in late 2007. It was also reviewed during WCD’s subsequent Regulatory Redesign reviews. In those discussions, team members noted that Sanctions staff usually just contacted the insurer and directed them to copy the parties. Several team members thought the small dollar amount was unlikely to change insurer behavior and that such penalty orders cost WCD more to issue than would be received. However, the team concluded that we couldn’t evaluate its effect when the penalties were so rarely assessed, that many insurers do try to avoid any penalty (regardless of the amount), and that there was no harm in leaving the rule language in place, if warranted. Staff recently indicated, as before, that very few of these penalties have been issued in the years since the last review, for the same reasons as before.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #46 – OAR 436-060-0155(11) - “Penalty to Worker for Untimely Processing”**

**Issue:** Should this rule specify that stipulations approved by the Hearings Division will not be “counted” as a timely processing violation as it applies to the Appendix B civil penalty matrix?

**Background:** The division’s long-standing practice, in counting previous delayed compensation violations, has been to include all Hearings Division orders and stipulations and WCD orders and stipulations re: a penalty under ORS 656.262(11) in a given claim. However, in excluding agreements not involving stipulations approved by the division, the rule may appear to limit WCD to counting only stipulations approved by the division. On that basis, an insurer’s attorney provided input that the rule should similarly exclude stipulations approved by the Hearings Division. The rule has been effective since August 1994; no testimony on the proposed rule was provided (or, recorded) and it isn’t clear now why WCD made this change. It’s possible that the division wanted to reinforce, for disputes in WCD’s jurisdiction, the section (9) requirement that stipulations be submitted to the division for approval if they are to be “acknowledged.” If (9), (10), and (11) are read together, it appears that the intent was that (11) apply only to stipulations/agreements resolving matters under review by WCD.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #47 – OAR 436-060-0180(3) – “Designation and Responsibility for a Paying Agent”**

**Issue:** Should this rule addressing the designation and responsibility of a paying agent be amended to include voluntary reopening of Board’s Own Motion (BOM) claims by insurers?

**Background:** The current rule states that Own Motion claims are subject to this rule’s provisions “with the consent of the Workers’ Compensation Board...” Since insurers can voluntarily reopen BOM claims, it appears this rule needs to be updated to address the insurer’s self-initiated processing as well. The insurer still needs to report the reopening to the Board, but in those instances they are not obtaining the Board’s “consent.”

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #48 – OAR 436-060-0190(4) or? – “Monetary Adjustments Among Parties and Department of Consumer and Business Services”**

**Issue:** Should this rule address what an insurer must do to request reimbursement, of sums the designated responsible carrier won't pay, from the Consumer and Business Fund?

**Background:** When all litigation on the issue of responsibility is final, the insurer ultimately found responsible must reimburse nonresponsible insurers for compensation previously paid. This rule further specifies that the division will direct any necessary monetary adjustments between the parties that are not voluntarily resolved. In a situation where a nonresponsible insurer does not receive full reimbursement from the responsible insurer, the rule does not specify what a nonresponsible insurer must do to request assistance from the Consumer and Business Fund in obtaining the unpaid amounts. In the occasional instances where an insurer has had difficulty in getting reimbursed by another insurer, WCD has received questions about what the insurer must do to have the division intervene. The rule would be more helpful if it addressed that missing step before the existing language that says the division will direct any necessary adjustments. The rule could specify that the responsible insurer may notify the division when its attempts to resolve the reimbursement matter have been unsuccessful and describe what supporting documentation must be provided.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #49 – OAR 436-060-0200(11) – “Assessment of Civil Penalties” [see Issue #39]**

**Issue:** Should this rule be reworded to eliminate references to quarterly review of insurer performance data by WCD and the subsequent issuance of civil penalties based on Appendix C?

**Background:** The rule's current language references the past review of data and resulting Quarterly Claims Processing Performance (QCPP) penalties by the Audit Unit for certain claims processing actions, including timely reporting of claims to the division. WCD does not issue QCPP penalties anymore. Instead, timely reporting is reviewed in the division's Annual Audits. If this rule is reworded, Appendix C should also be deleted (see “Housekeeping Issues,” #16).

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #50 – OAR 436-060-0500(4) – “Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury”**

**Issue:** Should this rule be amended to address the division’s recovery of previously reimbursed supplemental disability in situations other than periodic audits, and for additional reasons?

**Background:** This rule currently addresses periodic audits by the division to validate the amounts reimbursed to an insurer processing a claim with supplemental disability (SDB). The rule specifies that repayment to the division will be required for payments exceeding statutory amounts due (except for “reasonable overpayments”), compensation paid as a result of untimely or inaccurate processing, or undocumented compensation payments. However, WCD sometimes identifies reimbursed amounts at other times that should have been disallowed. The Department of Justice recommended in 2010 that this rule address the division’s ability to recover overpayments outside of audit situations. WCD also identified the need to address other SDB overpayment situations including the division’s ability to direct insurers to remit a proportionate share of any overpayment recovery due to third-party recoveries, etc. If this is added to the rule as another example, it may be best to reword the list of situations to use “including, but not limited to” language.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #51 – OAR 436-060-0500(6) – “Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury”**

**Issue:** Should this rule be amended to clarify the director’s prior approval of dispositions or settlements that include amounts for supplemental disability?

**Background:** The current rule states that Claim Dispositions or Stipulated Settlements aren’t eligible for reimbursement of SDB from the Worker Benefit Fund (WBF) without “the prior written approval of the director.” There has been some confusion regarding WCD’s “pre-approval” of settlements that may be eligible for reimbursement from one of the WBF programs (Reopened Claims, SDB, Retroactive, Preferred Worker, etc.), since it is the Workers’

Compensation Board (WCB) that actually approves settlements. As a result, the division identified the need to rewrite this rule to better convey that WCD must review and confirm the settlement (whether the full or a partial amount) meets the criteria for reimbursement under the SDB program before the settlement is approved by the WCB. Further, WCD sometimes gets requests for prior approval of settlements that include proposed waivers of past SDB overpayments. The division has declined the last several such requests and recommends that this rule be amended to state that WCD won't approve settlements that waive overpayments involving prior WBF reimbursements.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #52 – OAR 436-060 - Multiple**

**Issue:** Division 060 rules should be reviewed to identify language and terms that hamper an insurer's ability to implement paperless processes for claims-related information.

**Background:** SAIF made this suggestion regarding all of WCD's administrative rules.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**ISSUE #53 – OAR 436-060**

**Issue:** Should these rules define or limit the types of medical and claim information that may be given to the worker's employer? Should such information be limited to that which assists with return-to-work activities?

**Background:** This issue was raised in the September 2009 internal advisory committee considering changes to Forms 801 and 827. ORS 656.360 states insurers and their assigned claims agents must maintain the confidentiality of workers' medical and vocational claim records. These records may not be disclosed to persons other than the worker unless the worker

or beneficiary consents; doing so is reasonably necessary to manage, defend or adjust claims, suits, or actions or perform other required functions; to detect or prevent criminal activity or fraud, or nondisclosure; or as otherwise required or permitted by law.

**Alternatives:**

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**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

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**“HOUSEKEEPING” CHANGES**

1. **436-060-0009(4)(d)** – The placing of the apostrophe in “of the workers’ claim record” should be corrected.
2. **436-060-0015(3)** – The name of Form 3283 should be revised to “A Guide for Workers Recently Hurt on the Job.”
3. **436-060-0019(3)** – The first sentence’s reference to “the initial work day” should be revised to conform with on-line dictionaries that suggest “workday” is correct.
4. **436-060-0030** – Should the “Stat. Implemented” cite at the end of the rule include ORS 656.268 (in addition to 656.325(5))? The rule provides examples of commuting requirements under 656.268(4)(c)(B).
5. **436-060-0035(6)(a)** – This rule should be revised to “The worker was employed at [the]a secondary job...” since a worker may have more than one secondary job.
6. **436-060-0095(6)(a)** – This rule requires the insurer to send the worker a form for requesting reimbursement with its medical examination appointment notice. WCD does not require the insurer to use Form 3921, published in Bulletin 112 (“Reimbursement for Worker’s Travel, Food, and Lodging”). Would referencing the form as an option in the rule be helpful?
7. **436-060-0105(1)** – Input on this rule asked if “insanitary” is a typographical error. The rule references ORS 656.325(2) which addresses “insanitary or injurious practices.” Since the dictionary includes both “insanitary” and “unsanitary” as appropriate spellings for a practice that isn’t sanitary, it doesn’t appear the rule needs to be revised.

8. **436-060-0135(4)** – This rule states that an insurer’s notice to a worker regarding an investigatory interview must advise the worker of the date, time and place of the interview and/or any other reasonable investigation requirements. For several years, WCD has been replacing “and/or” usage in administrative rules with “or.” Should the same change be made in this rule?
9. **436-060-0137(2)(a)** - Should this rule delete the reference to “a form and format as prescribed by the director?” WCD does not proscribe a particular form for requesting additional vocational evaluations. Separately, the division has not had such a request in many years.
10. **436-060-0140(10)(d)** – This rule references the division’s toll free Infoline number. Should we provide the specific phone number? WCD has a number of toll-free numbers.
11. **436-060-0150(7)(f)** – This rule, regarding the end of a training program and any previous awards remaining unpaid, references 060-0040(2) but should reference 060-0040(4).
12. **436-060-0170(1)** – The language “unless authority is granted by an Administrative Law Judge or the Workers’ Compensation Board” should be deleted, as this older wording is no longer correct.
13. **436-060-0180(12)** – This rule states that the designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015(9) unless relieved of the responsibility by an Administrative Law Judge’s order. This cite should be updated to 030-0015(12).
14. **436-060-0200(9)** – This rule should delete the reference to ORS 656.335 as one of the statutes being enforced, and its citation at the end of the rule as an implemented statute, because this statute was repealed in 1995.
15. **436-060-0500(2)(e)** - The current rule requires an insurer requesting reimbursement of the supplemental disability benefits it has paid to include the primary and secondary employers’ WCD “registration” numbers. Given the July 2009 shift from guaranty contracts to the policy-based proof-of-coverage system, this rule should require the respective employers’ **policy** numbers.
16. **OAR 436-060-0500(4)** – The current rule references the division’s periodic audits of the physical file of any insurer responsible for processing a claim for which the division has reimbursed supplemental disability benefits paid, to validate the amount reimbursed. Almost all insurers now use electronic files, so this rule’s wording should be updated.
17. **Appendix C** – This matrix for assessing civil penalties for violations of 060-0200 (quarterly performance in timely claim filing, acceptance/denial, first payment, and notice of closure) should be deleted since WCD does not issue these penalties any longer.

Insert insurer name, third-party administrator name (if applicable), and the mailing address and phone number of the location responsible for processing the claim.

# INSURER'S REPORT

		WCD file no.:				
Worker's legal name: First _____ MI _____ Last _____		Date of injury (month-day-year): _____				
Address: _____		Social Security no.: _____				
City: _____ State: _____ ZIP: _____		Insurer's claim no.: _____				
Insured policy holder name as it appears on policy: _____		Policy no.: _____				
Covered employer's legal name, if different from above: _____						
Covered employer's address: _____ City: _____ State: _____ ZIP: _____						
<b>1</b>	<b>Status of claim</b> at the time of filing this report. <i>Check one in each column.</i>	<input type="checkbox"/> (A) Accepted <input type="checkbox"/> (X) Denied <input type="checkbox"/> (X) Partially denied	<input type="checkbox"/> (D) Disabling <input type="checkbox"/> (N) Nondisabling <input type="checkbox"/> (Y) Fatality Date of death: _____	<input type="checkbox"/> (Y) Occupational disease <input type="checkbox"/> (N) Injury	<input type="checkbox"/> (O) Original injury <input type="checkbox"/> (R) Aggravation	<b>Mo. - Day - Yr.</b>
		<b>2 Reason for filing this form</b> (At least one reason must be checked.)  <i>Complete on all reports.</i>  Attach forms 801 and 827 if not previously sent.				
<b>3</b>	<b>Weekly TTD rate</b> based on paid-through date.	\$ _____	Paid from (this open period): _____	Paid through: _____	<b>OR</b>	<input type="checkbox"/> No compensation due. (Skip to #6; explain below).
		<b>4 Weekly wage</b> <i>Complete on first reports and wage changes.</i>				
<b>5</b>	<b>Was first payment of compensation paid timely?</b> <i>Complete only on first reports.</i>	<input type="checkbox"/> Yes If payment was made, provide date of first payment.	<b>OR</b>	<input type="checkbox"/> Salary continued (self-insured employer).	<input type="checkbox"/> No compensation due. (Explain below.)	
		<input type="checkbox"/> No		<b>6 Was claim accepted or denied timely?</b> <i>Complete on acceptance or denial of claim only.</i>		FOR WCD USE ONLY
<b>7</b>	<b>Is worker enrolled in an MCO?</b> <i>Complete unless enrollment has been previously reported.</i>	<input type="checkbox"/> Yes If "Yes," provide date of enrollment.	MCO no.: _____			
		<input type="checkbox"/> No				
<b>Explanations:</b>					<b>FOR WCD USE ONLY</b>	
I certify this information is true and correct and that all dates required are accurate.						
<b>X</b> _____ <i>Insurer's representative</i> Phone no. of representative _____ Date mailed to WCD _____						

# General instructions for completing and filing Form 1502

## **Header:**

Provide the actual name of the insurance company or self-insured employer responsible for the claim, the third-party administrator (if applicable), and claims processing address and phone number.

## **Claim identifiers:**

Provide the claimant's name, address, Social Security number (SSN), date of injury, and claim number. The SSN is required under OAR 436-060.

## **Insured policy holder:**

Provide name of insured entity that purchased the coverage as it appears on the insurance policy.

## **Covered employer's legal name:**

Provide the legal name of the employer as it appears on the insurance policy (not doing business as name).

## **Policy number:**

Provide the policy number as it appears on the insurance policy.

## **Section 1: Status of claim**

Report the status of the claim at the time of filing the 1502 with the division by checking only one item in each of the four columns.

"Original Injury":

- (a) a claim that has not been closed by a Notice of Closure; or
- (b) a claim that has been closed by a Notice of Closure, but reopened for a new or omitted medical condition or for vocational assistance only.

"Aggravation":

- (a) the actual worsening of the worker's compensable condition(s) on a claim that has been closed by a Notice of Closure; or
- (b) reclassification of a non-disabling claim as disabling at least one year after original acceptance.

## **Section 2: Reason for filing this form**

*(Complete on all reports- at least one reason must be checked.)*

Check at least one reason for filing the 1502. Associated dates must be reported in the spaces provided. The following are the most common reasons for filing the 1502:

### **(F) First report of claim**

File 1502 within 14 days of the insurer's initial decision to either accept or deny the claim (defined in OAR 436-060-0010(10)). The 1502 should be attached directly behind the 801; attach the 827, if available, behind the 1502. To report a disabling aggravation of a previously nondisabling claim, check reasons "F," "R," and "S."

### **(T) First report of new condition reopening**

File 1502 within 14 days of reopening a claim made under ORS 656.267. Use Form 1503 (instead of the 1502) to report claims that can be closed within 14 days of the first to occur: acceptance of the new or omitted condition; or the insurer's knowledge that interim temporary disability compensation is due and payable. If the new or omitted condition claim is made after the worker's aggravation rights under ORS 656.273 have expired, file Form 3501 (instead of the 1502); see OAR 438-012-0030(4) and OAR 436-060-0010(13).

### **(R) First report of claim for aggravation**

File 1502 within 14 days of the insurer's decision to reopen or deny the claim under ORS 656.273. Report the date the insurer first received the claim for aggravation, i.e., the date of receipt of Form 827 (if the worker has selected the aggravation report option on the 827), along with written medical evidence supported by objective findings.

### **(V) First report of reopening for vocational training**

File 1502 within 14 days of reopening the claim for vocational training services under OAR 436-120. Report the first date the worker is actively engaged in training.

### **(L) First report since litigation ordered acceptance**

File 1502 within 14 days of the date a disabling claim is ordered accepted through litigation. Report the date the litigation order was signed by the approving authority.

### **(S) Change in acceptance or disability status**

File 1502 within 14 days of the status change. Describe the change in the "Explanations" section. Attach a copy of the notice

sent to the worker explaining the change.

### **(P) Notice of partial denial of accepted claim**

File 1502 within 14 days of the denial of a medical condition, treatment, etc., on an otherwise accepted claim. Attach a copy of the denial letter.

### **(C) Correction of wage, SSN, date employer first knew of claim, TTD rate, etc.**

File 1502 within 14 days of knowledge that previously reported data is incorrect. Describe the correction in the "Explanations" section.

### **(O) Other**

Check the "Other" filing reason when the above filing reasons do not apply. Examples of appropriate use of this filing reason:

- (1) to notify WCD that the claim was reopened in error, as reported on an earlier 1502, or
- (2) to report an amended denial. Describe the filing reason in the "Explanations" section.

### **(M) MCO enrollment after claim acceptance**

File 1502 within 14 days of enrollment unless enrollment was previously reported by Form 1502. Complete Section 7.

## **Section 3: Weekly TTD rate based on paid through date**

*(Complete unless previously reported.)*

Report the rate of temporary total disability based on the "Paid through" date reported on the 1502, unless there is no compensation due. Report the TTD rate even if the worker is receiving temporary partial disability.

**Do not include supplemental disability in the TTD rate; report only the rate related to the employer-at-injury.**

Report the beginning "Paid from" date since the most recent opening or reopening of the claim and the last "Paid through" date at the time of filing the 1502, unless there is no compensation due. Explain why "No compensation due" is checked (e.g., worker lost no time/wages from work).

## **Section 4: Weekly wage**

*(Complete if a "First Report" box is marked in Section 2 or if reporting a wage correction, unless "No compensation due" is checked in Section 3.)* Report:

- (a) the weekly wage at the time of injury; or
- (b) the weekly wage at the time there is medical verification that the worker is unable to work due to an occupational disease (ORS 656.210). If the weekly wage differs from 801 wage data, explain wage computation in "Explanations" section.

## **Section 5: Was first payment timely?**

*(Complete if a "First Report" box is marked in Section 2.)*

Check "Yes" or "No" and provide date of first payment OR check "Salary continued" (self-insured employer only – see ORS 656.262(4)(b) and OAR 436-060-0025) or "No compensation due," as applicable.

## **Section 6: Was claim accepted or denied timely?**

*(Complete upon acceptance or denial of original injury or aggravation claim. Check "Yes" or "No" based on current status reported.)*

Report if the claim was accepted or denied within 60 days after:

- (a) employer's notice or knowledge of the claim, if a new claim;
- (b) receipt of a claim for aggravation by the insurer in accordance with ORS 656.273; or
- (c) receipt of a new or omitted condition claim under ORS 656.267.

Note: Only an order issued under OAR 436-060-0135 may extend the 60-day period.

Attach a copy of the notice of acceptance or denial letter sent to the worker to the 1502.

## **Section 7: Enrolled in MCO?**

*(Complete unless enrollment has been previously reported.)*

If "Yes," provide date of enrollment and MCO number. Once enrollment is reported, completion of Section 7 on any subsequent 1502 is not required unless you enroll the worker in a different MCO.

## A Guide for Workers Recently Hurt on the Job

### How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

### How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

### Are there limitations to my medical treatment?

- **Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

### If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

### What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

#### **Ombudsman for Injured Workers:**

##### **An advocate for injured workers**

Toll-free: 800-927-1271

Email: [oiw.questions@state.or.us](mailto:oiw.questions@state.or.us)

#### **Workers' Compensation Resolution Section**

Toll-free: 800-452-0288

Email: [workcomp.questions@state.or.us](mailto:workcomp.questions@state.or.us)

**Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?** You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

Insurer name, address, and phone:

# Notice of Voluntary Reopening Own Motion Claim

Pursuant to ORS 656.278(5)

Worker:

Mailing date:  
WCD file no.:  
Date of injury:  
Insurer's claim no.:

**Your aggravation rights have expired under ORS 656.273. However, you may be eligible for additional disability benefits under ORS 656.278.**

## Your claim has been reopened for:

**A. "Post-aggravation rights" "worsened condition" claim. ORS 656.278(1)(a).**

List claim(s) or condition(s) that has/have been "determined to be compensable" under OAR 438-012-0001(3) that has/have worsened:

**B. "Post-aggravation rights" new or omitted medical condition claim. ORS 656.278(1)(b).**

List "post-aggravation rights" new or omitted medical condition(s) that has/have been "determined to be compensable" under OAR 438-012-0001(4). **A Modified Notice of Acceptance has been issued to the worker under ORS 656.262(7)(a), with copies to the worker's attorney, if any, and the Workers' Compensation Division. ORS 656.262(7)(a).**

**C. Pre-1966 "medical services" claim. ORS 656.278(1)(c). Pre-1966 claims involving "post-aggravation rights" "worsened conditions" or new or omitted medical conditions are included in boxes "A" and "B," respectively.**

List medical services for which claim was reopened.

### NOTICE TO WORKER

If a dispute arises out of a voluntary reopening of a claim under ORS 656.278(5), you or your attorney may file a written request for review by the State of Oregon Workers' Compensation Board. Send your request to: Own Motion Unit, Workers' Compensation Board, 2601 25<sup>th</sup> St. SE, Ste. 150, Salem, Oregon 97302-1280. You must send a copy of your request to the insurer or self-insured employer named at the top of this form. Within 14 days after notification from the Workers' Compensation Board that a review has been requested, the carrier shall submit to the Workers' Compensation Board and to you or your attorney, if any, legible copies of all the evidence that pertains to your compensable condition at the time of the voluntary reopening. The insurer also may submit written arguments at this time, with copies to you or your attorney, if any. Within 21 days of the date the insurer mails these written arguments, you must submit any additional evidence and written argument to the Workers' Compensation Board.

Authorized representative: (Please type name):

Distribution (one copy each to):

- Worker
- Worker's representative (if any)
- Workers' Compensation Division
- Insurer

By:

Signature

Date