

DIVISION 060 - CLAIMS ADMINISTRATION

9/10/15 at 9 a.m.

L&I, Room F Advisory committee meeting, OAR 436-060, Claims Administration

ISSUES DOCUMENT

Attendees:

Larry Bishop, Sedgwick CMS
Sue Cline-Quinones, City of Portland
Jennifer Flood, Ombudsman for Injured Workers
Mark Hopkins, EC Company
Carmen Jones, Legacy Health Systems
Jerry Keene, Oregon Workers' Compensation Institute
Julie Masters, SAIF Corporation
Sydney Montanaro, Swanson Thomas Coon & Newton
John Powell, Liberty Insurance
Barb Reich, Asante Work Health
Dan Schmelling, SAIF Corporation
Keith Semple, Oregon Trial Lawyers
Dean Spradley, Farmers Insurance
Sean Warren, SAIF Corporation

WCD Attendees:

Barbara Belcher
Fred Bruyns
Sally Coen
Cara Filsinger
Mary Lou Garcia
Michelle Miranda
Troy Painter
Mary Schwabe

Note: Issues 15-20 deferred

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?

Speaker & Committee Comments
Time

05:00 Issue #4
Fred Bruyns

07:11 Good idea to move towards more electronic communications because that is the
Julie Masters way things are going. To the extent the rules allow that or facilitate that is a
good thing from SAIF's perspective.

- 07:41
Dean Spradley
I would agree with that also. The only concern I would have is the signature is also dual authorization for medical records. Carriers often use that to request medical records or other carriers will give us records we are entitled to but without a signature on the 827
- 08:07
Fred Bruyns
I think this particular rule is talking about what you are reporting to us, the department, as opposed to what the medical provider or employer would send to you. Although, that is certainly pertinent as well. The signature issue is something we wrestle with sometimes as well because we ask for documents too.
- 08:28
Jerry Keene
I'm just curious on how many people are modifying the 1502 and getting approval, because I've never seen one.
- 08:32
Fred Bruyns
I think the 801 is the one that we meant. We occasionally get a request where they might want to add some information that might help, like their health and safety program, in terms of providing data for it and we've generally said yes so long as there isn't data removed. Of course the form is so crowded the question is where they are going to put it.
- 08:54
Jerry Keene
What I'm trying to get at is one of the things we train to is the current 1502 and how to fill one out in a basic claims situation, and if we have to start anticipating questions on how come my form looks different than yours.
- 09:05
Fred Bruyns
I don't recall any of those being modified.
- 09:10
Julie Masters
Maybe it's beyond the scope of this conversation, but you mentioned you get paper from SAIF Corporation and everybody else for many different things. Apparently, up till now the department hasn't had the capability to receive those documents in another form. Is that still true?
- 09:44
Fred Bruyns
Well as you know there is a pilot project that's gone on for some time with SAIF Corporation. It's not a secret. You send imaged documents to us, not for reconsideration but for just the 801, 1502, and maybe the 1503. But there is no prohibition on doing that obviously or we couldn't have done it with SAIF Corporation. So we can accept images if we set it up with a trading partner. It does involve setting up a secure file transfer protocol account. There is some work that goes into it on both sides. I think that we developed a memorandum of understanding with SAIF Corporation to do that. It's something that could probably be done with other insurance companies. We haven't had anyone else approach us. It was the volume and in fact you had to print it to paper so that you could send it to us, and ultimately we scan it and turn it back into an imaged document. It is very inefficient, and we recognize that.

10:47 Julie Masters *SAIF's imaging system is going to be replaced in the foreseeable future – something better and more PDF. Also the lack of the ability to sift through the data. More electronic exchange of documents is coming soon. I think everybody would agree generally it's a sustainable thing.*

11:31 Fred Bruyns *It's important for us to hear so we can pass it on to our administrator. As many of you already know we do proof of coverage electronically. It's an electronic data interchange process. We do medical data that way. Claim's is the last one that is still a highly paper intensive process for us, and therefore by extension to the people that report to us. So we appreciate the input on that.*

11:56 Keith Semple *I think the claimants that file feel the same way in terms of increasing the ability to transfer documents. One of the great things for us about electronic transfers is the paper trail as opposed to having to send things certified or return receipt to show that we can prove it was actually received to prove that we met our deadlines. That can be a huge concern when things get lost on a desk or something, so we would absolutely support moves in this direction.*

12:31 Fred Bruyns *There are really two types of transfers we are talking about. One is just giving us images, basically just photographs of the documents that we see in paper form, and there's pure electronic transfer data – a stream of data that comes into the department and is entered into a data base without any human intervention. Those are two things that we are looking at. We are doing it to some extent.*

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.

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?

***Speaker &
Time*** ***Committee Comments***

14:33
Jerry Keene *I think if you try to write a rule that said what parts of the 1502 to fill out for each of the different kinds of situations where you had to do a supplemental, you would end with a rule that would be more confusing then helpful. I think that if a 1502 is incomplete the department hasn't been shy about getting back and saying we need this.*

14:52
Fred Bruyns *We don't necessarily have a rule that says we need this, but you're right, it would be more involved.*

15:05
Jerry Keene *I would recommended against putting more words into the rule, because you can anticipate some situation that may arise and you go back and amend the rule; in this situation do this and in that situation do that. I don't think it would be a very workable rule. It's better to let the department identify the missing parts in the 1502. Maybe this would be more appropriate as an industry bulletin or something like that for how the department is going to interpret this particular rule.*

15:40
Dan
Schmelling *I think we should look at amending the rule and say this is when you should file the initial report, this is when you should file a subsequent report or reopening of a claim, and these are the instances where it might not be an initial report, but these are the other instances where you must file a 1502. That might be the example on the first page after you have already reported the initial acceptance of the claim so that it's clear. You can kind of read through and say okay for initial report here is what I need to do. For a subsequent reopening here's what I need to do. For any other issue that requires a 1502, the details of how to fill out the form are on the form itself.*

16:59
Fred Bruyns *So kind of the triggering points or when to do it?*

17:02
Dan
Schmelling *That seems to be the when that's in the rule, so put the how on the instructions. But make it clear when you need to file.*

17:15
Jerry Keene *Do you mean under what circumstances or what time frame?*

- 17:20
Dan Schmelling
Under what circumstances but the timeframe should be there. In all instances it is 14 days now.
- 17:42
Jerry Keene
Provided an example of some of the things cannot be anticipated in the rule.
- 17:54
Dan Schmelling
The triggering mechanism of when to file could be in the rule.
- 18:58
Jerry Keene
I'm reinforcing that discussion by Keith's suggestion that we try and do it by bulletin 237 then try to do it in rule. The bulletin could give examples.
- 19:33
Keith Semple
Bulletin can be more easily amended.
- 19:58
Fred Bruyns
060-0010(13)(g) could cause 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 1st, first payment is issued on May 10th, and the 1502 is filed timely for claim acceptance on May 15th and reports the first payment, this rule appears to require an "additional" 1502, due by May 24th, to report the first payment (again).
- 20:52
Jerry Keene
The thing that is being described here is could be fixed by the rule by just saying file 1502 within 14 days of the first time that any of these things happen after claim acceptance. The list already takes care of what you're talking about. If you had an acceptance and a first payment of time loss that happened before, then that first report of acceptance is going to include the time loss that has been paid. If time loss is first paid long after it's accepted as a non-disabling claim, then the current rule already says within 14 days of first time loss, even though it was previously reported as accepted. If you just add the words... "after claim acceptance" you'll probably get rid of all the confusion that you're describing in this example.
- 21:39
Julie Masters
Well I think some additional instructive language that explains after claim acceptance within 14 days of these things; date of first payment of temporary disability if not previously reported or something like that.

22:14
Fred Bruyns *WCD staff have 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 they had to file both forms. They should not file a 1502 in these instances, but the rule could be clarified.*

22:48
Jerry Keene *Back when this originally came about I was the one that raised the issue about please don't just make own motion reopening another box on the 1502 because it's already confusing enough. It's a department form not a board form. There would be jurisdictional issues. That is why there is a separate 3501 and I think that is actually anticipated and solved a lot of problems. I would very much in support of in clarifying in the rule again don't file a 1502 if what you are reporting is an own motion reopening – whether it's voluntary or board ordered.*

23:31
Julie Masters *I agree it's a simple fix.*

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 1st, first payment is issued on May 10th, and the 1502 is filed timely for claim acceptance on May 15th and reports the first payment, this rule appears to require an “additional” 1502, due by May 24th, 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.

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

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

***Speaker & Committee comments
Time***

23:50 *Should the policy number be a mandatory data item for Form 1502 submissions?*
Fred Bruyns

24:52 *I think the problems identified here are real ones that often the last person to know what the right name of the insurer is or the policy number is the claims examiner; it's just not part of what they get. Usually everything is keyed to the claim number. If you could revise your system so the claim number got you where you need to go that would be a more reliable and easily available number for the claims examiners than the other two pieces of information. Especially in situations with large deductibles where everyone treats the employer as a self-insured employer because it's all their money and they got all the say so. It's really an insured program with a massive deductible. The claim number would cut through all that.*
Jerry Keene

25:30 *The insurance company representative – would that ...?*
Fred Bruyns

25:35 *It sure would make things easier in my opinion from a processing standpoint.*
Dean Spradley

25:49 *Claim numbers are already on the form.*
Cara Filsinger

25:53 *How does it help with wrong insurer information?*
Keith Semple

25:55 *It doesn't help. We receive employer policy information and then we receive claim information from the processor and we need to match the two.*
Sally Coen

26:12 *So the policy number is a shared field on both records whereas the claim number is not. Not that it's not something we use, we do appreciate the claim number. We are looking for something to tie the employer and insurer together.*
Fred Bruyns

26:31 *The claim number gives us the hint that the insurer is wrong because the claim number isn't matching the normal configuration.*
Jennifer Flood

- 26:39
Sean Warren
I don't know about other carriers, but I know it's not that big of a deal to get a policy number and add it on there. I do think it would be just a little more time and more cost because it's programming. Especially because of the move towards electronic for pulling the policy number.
- 27:11
Julie Masters
How about just asking for the name of the insurer?
- 27:20
Jerry Keene
One insurer may go by four different names. Look on the 801.
- 27:26
Keith Semple
I have a huge problem with that because how do we know who the insurer is for us to do our job? Even the employer doesn't know who their insurer is. I can't comprehend how the people processing the claim could not know the insurer they are processing the claim for. That's a problem and it needs to be fixed.
- 27:47
Jerry Keene
The way it's fixed is the state leverages it through the processing company. Everybody has to identify their person in Oregon that's in charge of their processing. That is where it goes. Doing business with different names in different states – hopefully that's helpful information.
- 28:03
Julie Masters
So that insurer, processor, or service company, as they are now called, maybe add an element in there for "name of processor."
- 28:05
Discussion on policy numbers.
- 34:04
Julie Masters
I just had a comment about the title of rule 10 reporting requirements. I looked at it for a while I was trying to figure out what that meant. I was looking through these rules for what title might direct me to it. As we are talking about all these sub-sections, I'm thinking that what ties them together is they're about claims reporting. At first I thought about reporting to the director. I thought this isn't the right title. I'm just looking for a little more clarity in some of these titles.
- 34:41
Fred Bruyns
You thought claims reporting might be more on point?
- 34:43
Julie Masters
I think so, but you folks who are vetted in this rule everyday I would suggest that you look at it a little more to see if that's really what it's all about.

- 34:55
Dan Schmelling *I think that because most of us here dealt with division 60 for so long, we kind of know where it is. When I go to division 9 and 10, not going there very often, and I see this description e.g. “the requirements for an IME”, I find it a lot easier to get to that section of the rule in the 9’s and 10’s because of the descriptors. It’s telling me what I’m looking at. Whereas if you look at division 60, reporting requirements for a 1502, you can go straight there. Listing out descriptors that the layperson would know what that means. That might mean a complete overhaul of division 60 on how it’s titled versus really what the rule says.*
- 36:03
Jerry Keene *When I teach this I focus first on this rule – it’s about reporting. It’s all about reporting. If it said reporting injuries and claims, it would make it a little more bland. That word is helpful to most of the claims examiners and how they’re trained on where all the report stuff is.*
- 36:30
Fred Bruyns *Dan, by descriptors do you the sub-headings in division 9 and 10 that are actually sections, but actually show up in the table of contents, so you can read the table of contents and get there or electronically you can just click it and hop there through the hyperlink?*
- 36:48
Dan Schmelling *I just search using “ctrl F” anymore. A person going in and looking through the index When I use the board rules I do the same thing. Theirs kind of lays out, like claims disposition agreements, what you are looking for and in what section; whereas, division 60 I know where things are so I just go there, but for a new claims adjuster.*

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.

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?

**Speaker &
Time**

Committee comments

38:30
Fred Bruyins

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?

39:00
Julie
Masters

Personally it sounds like a division 30 rule to me. It's about sending a letter prior to closing your claim, and notifying about the time-loss. It seems like part of the claim closure process. You wouldn't be getting ready to close the claim, unless you, I mean, you wouldn't be sending this letter unless you're getting ready to close the claim and you're thinking about do I have sufficient information to close the claim.

39:29
Jerry Keene

Can I suggest one thing that has to issue before closure in all cases is an undated notice of acceptance. It's at the point where the insurer is going back over, and the purpose of the updated notice of acceptance is to let everyone be on notice prior to closure of what conditions are going to be rated. The worker can challenge that if they want to one last time, and it's a recap of everything the insurer considers to be accepted. It would be a logical point in time, if not even a logical document to also include the time-loss information because this is the last point in time the worker has to challenge that. The notice of closure is a challenge. I would say add it to the documentation part of closure and even add it to an existing document so you don't have one more piece of paper in the notice of closure package.

40:23
Keith Semple

In practice I've seen an updated notice of acceptance at closure issued with the closure, but I've never seen it as a matter of process. With the claimant doesn't have so much concern about where the rules are located, but I would agree with Julie that it makes more sense to put these closure requirements in the section addressing closure. One thing that we are having growing concern about is the job description used to close a claim with work disability. A lot of times the worker has no idea about what is going to be stated in regards to the base functional capacity component. This comparison is by far the biggest factor in the worker's compensation. The worker typically doesn't even know what the employer is going to say about how heavy their work was, and they may want to contest that. We would like to see a requirement that the employer provide that information of work disabilities anticipated with sufficient time that the worker could challenge that and request something formal as to what they did on the job. This is becoming a huge factor because there've been recent decisions that say the claimant's affidavit after the claim closure isn't by itself sufficient to prove what the job required in terms of lifting requirements. Provided example about health care workers transferring 200lb patients but their work base capacity was rated at medium that resulted in dispute.

- 42:19
Fred Bruyns *Would that be something we would place in the division 30 rules?*
- 42:24
Keith Semple *I don't care where it's placed. It is just a major problem and it creates a problem with due process for the worker because they don't have that full range of testimony and cross examination that you would have at a hearing.*
- 42:42
Jerry Keene *I was trying to find the rule because I know somewhere in the rule there is a requirement that there be an accurate description of a job at injury in the insurer's file before it closes at least a disabling claim. I think this also has to be provided to the worker.*
- 42:59
Julie Masters *Although that is true, there's a caveat that if it doesn't clearly look like the worker is released to regular work then you have to go through that process and send that to the worker. Adding a whole bunch of process to the claim closure is impractical. You were suggesting notifying before you close the claim?*
- 43:39
Keith Semple *Well no, but at least provide a description of the job that says this worker was only required to lift 50lbs. I'm not sure what the mechanism really is for us to say hey it's time for you to put the job description in front of us before you close the claim. I'm not sure if there are any repercussions even though it's something that is required in the rule, even if it's not done. I'd have to take a closer look at that rule and see exactly what it requires. As a practical matter, the worker needs a little bit more information to make an informed decision about do we have a fight about this or not. I would say that this is the most litigated piece on reconsideration other than I just want an arbiter exam.*
- 44:52
Fred Bruyns *So you need more information and more time?*
- 44:54
Keith Semple *Well we need a sufficient amount of time to say I've taken a look at this and I disagree. Once you disagree with it the job analysis process is triggered, then a formal job analysis is done to hash out the differences. The worker's not really clear there is a disagreement. Sometimes the job description is placed in file long before closure, and it's on the worker and their counsel to see if that is a dispute, but at the extent that it's not it should definitely be provided prior to claim closure.*
- 45:39
Jerry Keene *It is absolutely critical. What the rule requires you to provide is an accurate description of the physical requirements of the worker's job held at the time of injury which has been provided by certified mail to the worker and the worker's legal representative, if any, before closing the claim or at the time the claim is closed. The rule is specific.*

- 46:11
Julie Masters *You see that's the case with a vast majority of the claims. Happily, most people are not seriously injured. Obtaining that information from the employer is an arduous process because they don't know how much stuff weighs. I'm kind of agreeing with both of you, but hope there continues to be the out – if the worker is released to regular work you don't have to go through this whole process. I would not want to see that happen in every claim. There are thousands of them.*
- 47:37
Keith Semple *Just to be clear, we wouldn't be proposing a rule where this "has to be done" in every single claim. Just the ones you don't have a release to regular work, and anticipating that you will have to pay some work disability. I guess what I would like to see it be a requirement for claim closure. If it hasn't been done and you end up with work disability that there be a mechanism for the closure to be rescinded.*
- 48:26
Fred Bruyns *Jerry do you know what rule that is?*
- 48:28
Jerry Keene *Rule 30-0020.*
- 48:36
Julie Masters *Getting back to the discussion about the wage letter, just seems like division 30-0020 is kind of a checklist of what you have to do before you close a claim. Originally when work disability was created the department kept those separate because we don't want wage disputes being litigated through recon, so maybe that's why they are separate. In terms of notices that need to go out at claim closure (inaudible).*
- 49:18
Dan Schmelling *I mean that was just kind of a suggestion. Don't create a new letter that needs to be sent out, because we already have to send out an explanation that has to change the average weekly wage. It's already there, so most of the time if you're changing the average weekly wage you've already met the requirement that one prior to closure. So there's that argument of should you provide that information at the time of making the payment and let the worker know we are issuing you a time-loss check and this is the basis for it, versus doing it at closure when there might not have been any time loss for six months and it's not fresh in the workers mind, which could impact if there is work disability. At what point does the worker really need that information?*
- 50:51
Fred Bruyns *Question on timeframe*

51:00 Dan Schmelling *That's where I think timeframe is, you calculate the average weekly wage immediately if you have the payroll, it would be 2 weeks, 2 months, 2 years later, when you finally get the payroll and it's right at that point in time. You try to come up with a timeframe of when, it would have to be based on when average weekly wage was calculated or finalized versus some arbitrary point in the claim. So maybe it's when you calculated an average weekly wage is when you send out something to the worker saying this is the basis for your time-loss rate.*

51:53 Jerry Keene *I would still think that a timeframe would be helpful because prior to closure; first of all, workers are getting information every time there is a change in time-loss rate. They are getting a contemporaneous notice. They can file a request for an expedited hearing or they can wait until closing. So they get it one more time as part of the closure documentation. Subsequently, they are going to need it prior to closure because that is when it's going to matter most. That packet is huge and confusing.*

52:33 Keith Semple *This probably very rarely happens, but to the extent that there's a change between the most recent notification and what is used at claim closure, we would want sufficient time to be able to challenge that change. When there is a change at the very last minute when the claim is being closed, that is where a timeframe would be concerned.*

53:59 Jerry Keene *The claimant's attorney will now be keeping closer track of time-loss issues during the open claims because now it's a basis for an assessed fee. If they just catch it as part of the closure they don't get to present it as compensation.*

54:28 Julie Masters *Comment on title of rule 0005.*

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?

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?

**Speaker &
Time**

Committee comments

- 57:59
Julie Masters *Having the idea of date stamp on a paper document is the way a lot of business is conducted now, but not all of it. In the future it's going to be more of a matter of a data element, like a metadata element that is not actually on a piece of paper. Data will be exchanged using methods other than paper, but instead as pictures of paper. If the rule could reflect the way things are going in the future so you don't have to redo it again later, that would be better. Other than that, we would support a rule that allows the earliest date stamp to be the one that's used with division 009 & 010.*
- 59:12
Fred Bruyns *I don't think anyone necessarily wants a scanned date. The received date is what's wanted.*
- 59:24
Julie Masters *Yeah, we are still doing that where it punches little holes in the bottom of the paper.*
- 59:43
Keith Semple *It would be nice since there are often different stamps, making it difficult to figure out which one is the "date stamp." How would this be standardized or is this even possible? As we are moving towards electronic, maybe it'll be easier to designate where that date stamp needs to be. Needs to be labeled date of receipt as oppose to just a bunch of different dates all over the paper. That would be really helpful.*
- 01:00:28
Fred Bruyns *Are some of them superimposed – one on top of the other? I guess it would naturally happen if a fax had a banner across the top, and then someone applies an electronic date stamp over the top of that.*
- 01:00:41
Keith Semple *I may be a little less concerned about the fax stamp then knowing exactly which one is the date stamp.*
- 01:01:06
Fred Bruyns *What about adopting some of the some of the elements or ORS chapter 84? Do you think that is necessary or appropriate?*
- 01:01:20
Julie Masters *What is chapter 84?*
- 01:01:26
Fred Bruyns *Uniform Electronics Transactions Act. Provided definition.*
- 01:02:05
Dan Schmelling *Would it be better to put it in 001 to apply to all administrative rules versus putting it in 060 and then it's not in 009 or 010? Just look at it globally for every thing to have consistency throughout the rules.*

01:02:27 *That's a good point. There are a number of things that could be more
Fred Bruyns comprehensive.*

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”).

**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)?

Time & Speaker ***Committee comments***

01:04:57 *It's been a long time since I heard about anyone having trouble getting records from another insurer/employer in a responsibility dispute.*
Jerry Keene

01:05:08 *I have heard about trying to get old claims, and the company destroyed them. So having timeframes seems like a reasonable thing to do.*
Julie Masters

01:05:29 *The timeframe for responding to the workers is 14 days. The timeframe for getting out diagnostic studies is 14 days. That's a discovery time frame (from receipt though).*
Jerry Keene

01:05:46 *Does 14 days sound like a good timeframe?*
Fred Bruyns

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.

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.”

<i>Time & Speaker</i>	<i>Committee comments</i>
01:07:04 Julie Masters	<i>Discussed recent board cases that may be applicable.</i>
01:09:03 Jerry Keene	<i>I'll echo that Fred, during the advisory committee meetings on those rules urged that the department was being premature applying such a broad interpretation of what was going on in Brown. I think that urging for caution and wait. This is workers comp and rules get interpreted and refined. I think that was borne out by the board decisions now, and also by the supreme court spending so much time on the arguments waiting for Brown. Now we urge the department to hear our plea for "wait" to hear final word from supreme court before you change the rules.</i>
01:10:03 Fred Bruyins	<i>Do you have any sense of when the decision is going to be issued?</i>
01:10:11 Jerry Keene	<i>On average the supreme court issues decisions in workers comp cases within a year, unless it's attorney fee cases and they take longer. There have only been three or four situations where the supreme court allowed review by an employer in the last 15-20 years. In those cases the decisions came out more quickly.</i>
01:10:54 Keith Semple	<i>I would echo that. Many other rules have been changed. The department has evidently reached a conclusion that Brown is the law. We expect a favorable decision in that case. Obviously a lot of these cases take a long time. For now the decision stands and I see SAIF has adjusted their practices based on the new department rules to ask the attending physician what is – these are the conditions we've accepted, are there others that are related to the compensable injury or whatever language. We would encourage the department to adopt this rule and make all the rules consistent until if and when the law changes.</i>

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.

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?

**Speaker &
Time** **Committee comments**

1:14:45
Jerry
Keene

The statute said is that the department shall measure things by the date of mailing by regular mail unless otherwise provided by law – was the result of a situation where the department had prior to that been using mailing dates. With the shorter time frames like the 14 days, it meant substantively the time for doing something was much shorter for the more distant people because it took longer for the mail to get there. There were inequities and inconsistencies. When it was actually suggested to go to mailing date, someone from the department said we can't do that because we will have to go to certified mail for everything to prove mailing date, and that is why it says by regular mail. The department adjusted. The point about workers' timeframes being from date of mailing which also resulted in a lot of back and forth, the distinctions drawn from the past is usually the insurer timeframes are 14 days, 7 days, 10 days. The worker to request a hearing is 60 days, 30 days. The difference of the amount makes such a big difference for them but allow for certainty when responding to something on the insurer's part – the fact that something was mailed on Friday with a three day weekend would shorten the time for reacting.

01:16:25
Keith
Semple

For the claimants bar, we would like to see more parity in this in terms that the insurer's dates were from date of receipt and the workers deadlines run from date of mailing. This is a growing problem as insurers have distributed mail centers across the country, and mail is not as fast as it used to be as they have closed many post offices. So we have regularly five to seven or even more days between when a check is issued and when the worker receives it or a closing argument is submitted and it takes five days to receive it but you have only seven days to respond. That's not an issue for the division, but it's an issue of parity in terms of what's gauged as the mailing date versus what's gauged from the received date. This is a concern for workers, and I guess I would like to see the rule have parity for both parties. We would like to see the timeframe be gauged the same on both sides.

01:17:31
Jerry
Keene

Insurers are regulated with marking when they receive stuff, but there's no rule for a worker to document when they receive stuff – testimony and affidavits. It was deemed given two months, a date of mailing a post mark from the post office, was the more practical way to be consistent. The parity consideration kind of vanished when we talked about two months as apposed to 14 days.

01:18:12 Keith Semple *Just to respond to that, of course the insurer says that they received something and they date stamped it. We can't prove that the insurer received it when they just say they didn't get it. We are in the position of having to start sending return receipt in the same way the insurers are starting to be in that position. That's a huge expense for the worker and their counsel in a lot of places where we have to prove the date runs from the date of receipt. I have to prove receipt and I can't rely on the insurer just got it and date stamped it. I agree, we don't want it to come down to testimony. It should be the same on both sides.*

01:19:14 Julie Masters *I would just add SAIF is in support of the rule the division has suggested in the agenda.*

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.

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?

Speaker & Time *Committee comments*

01:23:28 Julie Masters *Don't know we need to put it in the rule.*

01:23:45 Jennifer Flood *I believe adding it to the rule clears up what the intention is.*

01:23:51 Fred Bruyns *I guess the meaning was contested at some point.*

01:23:57 Keith Semple *So that it's clear no one has to repeat that same line of argument or accidentally repeats that line of argument.*

01:24:08 *Don't say "and/or"*
Jerry Keene

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.

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?

Speaker & Time ***Committee comments***

01:27:11 *My only thought was that maybe instead of saying there can be no modification*
Jerry Keene *after notice of closure is after notice of closure has become final.*

01:27:27 *Maybe after a claim has been classified as disabling, it can't be classified as*
Keith Semple *nondisabling.*

01:27:40 *Was there maybe certain circumstances where this was done in error?*
Fred Bruyns

Committee *Yes.*

01:27:46 *Would there be an opportunity to fix it? But not after some point in time, I guess*
Fred Bruyns *that's the issue?*

01:27:58 *There is an opportunity to correct now before it becomes final, I believe.*
Jerry Keene

01:28:12 Julie Masters *The way it is written now is clear enough to me. Occasionally I get a call asking about a reclass. In reclassification you get to correct it if you did it wrong. I also had a call where they said they reclassified the claim, closed the claim, but now I found out from new wage information (I don't know what the facts were) but it should be a nondisabling claim. I think I told that adjuster technically you could rescind that notice of closure if it hasn't been appealed and reclassify to nondisabling, but I advised them not to do it because I didn't think would (inaudible).*

01:29:06 Jennifer Flood *Presented example.*

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.

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?

**Speaker &
Time** **Committee comments**

01:32:00 *Rule 0019 was created because previously all the divisions relating under the 3 day waiting period were sprinkled through several other areas. Actually, I testified asking to have them all put in one area so I can find them. That is the purpose of 0019, it would be consistent to at least add a reference here even if you keep it in another place. I have another issue about 0019 if I can raise it? 0019 says that the 3 day waiting period doesn't apply if the worker is hospitalized as an inpatient, or has 14 solid days of temporary total disability. In the case of those two exceptions they'll go back and pay for the three day waiting period. Then it says, but for the first day if the worker leaves for the first half of their shift and doesn't return that this is the first day of the waiting period, but if they leave and come back then it is or is not the first day of the waiting period depending on whether they're paid. Also, if they come back and only pay them half a day or no days depending on...if you look at the rule you'll see where I'm going and how confusing it is. I would like to know what the insurers would have to say, I don't know if it's causing any problems with your computer, but it's sure difficult to teach. To just say if the three day waiting period does not apply, so you are paying from day one, then just pay day one regardless of if the worker left, came back, or was paid for part of the day. It seems to me that is only one situation where the insurer confuses that or does it wrong and it's going to cost enough administratively and legally to undo all or whatever savings there are from not paying some workers for half a day in that period. I would just say from a point of view that usually is not the source for such things, that if the worker is not going to be subject to the three day waiting period then let's just eliminate the three day waiting period and don't get into the rules about how you count the first day for purposes of lost time – just say it's lost time.*

01:34:25 *We did have an issue about the not completing the work shift, even if there is no loss of wages. We discovered that there's a statute that authorizes it to be worded that way. As far as paying the first day, if they're in the hospital for 14 days or they're off for 14 days... do we already do that?*

01:34:59 *I think we look at it just half day. It adds a little bit of cost to the claim, but it would be easier just to say you don't have to determine at what point if it's a half shift or nothing, always just pay first shift. Some workers are going to get paid by their employers and receive time-loss, some will not receive a full days pay but receive a full day of time-loss.*

01:35:33 *I agree that if we take out the half day it will simplify it.*
Dean
Spradley

01:35:48 *You are assuming that the three day waiting period doesn't apply. It doesn't apply if they have been hospitalized as an inpatient or there've been 14 consecutive days of time loss. Both of those rare enough and serious enough that I don't think as a policy matter possibly paying them for an extra half day is going to matter. It is going to happen in those extreme situations anyways.*

01:36:13 *We agree with what is being said here.*
Keith
Semple

Note: **Issues 15-20 were deferred. Next issue discussed is issue 21.**

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.

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?

**Speaker &
Time**

Committee comments

01:39:12
Keith Semple

For the claimants bar, we think the use of paid leave time to make the worker whole is a fine idea to the extent that workers have a collective bargaining agreement or some other incentive for employment that is a benefit to them that allows them to collect either short term disability benefits that they've paid for without reimbursing those for comp payments or forces the employer to pay some ongoing payments without respect to the fact that they are getting work comp payments. Those are promises made: those are premiums paid. We don't see a reason those should be offset or viewed as double dipping. I understand that may be a perception, but it's already a deal that's been agreed upon beforehand. There is a broader issue here. Vacation that a worker has taken prior to the injury is counted towards their average weekly wage. When they have to take vacation for whatever reason during their claim (assuming their claim is denied), and they are forced to use vacation or sick time to make up the difference, then the claim is finally accepted, workers' compensation doesn't have to pay any of that back to them. They lose their vacation, and it's like oops your vacation is just gone. If you can pay your employer back dollar for dollar, then you have a wage loss and you can get compensation. The way that works out in reality is the workers are losing weeks or perhaps all their vacation or sick time for the year, and getting no compensation for the fact the insurer made the wrong decision about the claim and denied it. There is a real issue with this offset rule. It is not necessarily what you are asking about, but it is extremely unfair to injured workers to lose benefits associated with their job. It lets the insurer off the hook for something that eventually was their responsibility.

01:41:54
Jennifer Flood

Example of worker making up difference using accrued paid vacation, and insurers reducing payment based on the amount of vacation being paid.

01:43:22
Dan
Schmelling

As a practice SAIF tries to determine as best we can what is being paid for actual work being performed, and what is being paid to bring the worker to whole. So if you have an employer that offers them to come back to modified work at 20 hours a week, we're looking at those wages for those 20 hours, or sick leave associated with that 20 hours when we are doing our TPD calculation. Then if the employer says to the worker you can cash in an additional 10 hours of vacation to supplement both the wages you are earning in modified work, your workers' compensation TPD payments, and additional payments by the employer. To the extent that we are able, we try to identify that so those side agreements can happen more often.

01:44:30
Jennifer Flood

I think this is what it's trying to get at by saying wages only be considered for wages that you earn, not prior accrued leave.

- 01:44:46
Carmen Jones *We do the same thing that you do at SAIF. We allow people to take vacation when they're on modified work. But shouldn't be paying time-loss to them with scheduled vacation when it just happens to fall during the middle of the work comp time. I think that's part of the issue too. That sick time or vacation time should be considered as regular wages.*
- 01:45:17
Dan Schmelling *It really gets to what's the intent of the pay. Is the intent that it's being paid for actual work performed or the availability of work, and the worker saying no I don't want to work because I'm sick. Okay, now we're going to offset that versus we are going to let you with the side agreement cash out some of your accrued leave so your net pay isn't 66 2/3% of your gross pay, and you will be getting a full paycheck. It's the ability of the employer to distinguish between the two, if the employer isn't able to, and says these are the post injury wages for this time period, we're going to offset the full amount. If this is what they said they earned for work performed, then that is what we are going to prorate. You don't want to know about the little extra as a practice.*
- 01:46:16
Sue Cline-Quinones *I agree Dan. We kind of pay a supplemental pay based on their sick hours to equal their net take home pay. We consider that a benefit and we don't count that as wages earned. It's just an added benefit of being a City of Portland employee. With Legacy, I agree because some people already have their trip to Hawaii planned and I am going to count that preplanned vacation or that choice to take vacation over modified duties as income. We just document it.*
- 01:47:28
Unknown *We do the same thing. We allow them to use additional annual paid leave if they want. We don't count that either.*
- 01:47:37
Jennifer Flood *If modified job being offered and performed is just half time, and the worker has that Hawaiian vacation planned, are you saying you believe the insurer shouldn't have to pay for the other half?*
- 01:47:59
Unknown *We only offset (inaudible) ... what would have been available if they worked modified instead of vacation.*
- 01:48:17
Jerry Keene *I think that if we are going to go this route, first of all to make the worker whole is subject to all sorts of subjective determinations. It sounds like they're happening now in the industry. What's more important is these are subjective determinations that right now are being made by the insurer based on it's perception of what is going on, not by just excepting what the employers agreement with the worker is or intent is. You got to take a look at the circumstances and taking what they tell you into account, but you're making a determination whether to count is as a benefit.*

- 01:48:52
Dan Schmelling
We're looking at it case by case and asking the employer what's the worker working or what's the availability of work – report those wages to us.
- 01:49:02
Jerry Keene
The point is that it's the workers' comp insurer making these determinations about the intent of things that are being paid by the employer. That's the way it's happening now and I suspect that is probably the way it should be. I would urge that the rule allow this to happen without creating any new requirements. That there be an agreement on it or make it the basis of a request for hearing. Allow insurers the flexibility to go at the intent – intent of the compensation versus benefit meets the intent of the statute. Then wait to see if that surfaces problems that need to be addressed. This suggested change in the rule would make it legal.
- 01:50:02
Dan Schmelling
I think where the problem comes up is the insurers that are not asking and just taking that working day whole and taking the full amount
- 01:50:17
Jerry Keene
I agree, I think it's a great practice.
- 01:50:22
Dan Schmelling
I'd hate for those folks to then create a new administrative rule that for those folks that are trying to look to the intent (inaudible) and still allow the worker and employer the flexibility of their employment agreement that's not subject to work comp – how they're allowed to cash out their time. I would hate for an administrative rule to muddy that up.
- 01:50:52
Jerry Keene
I agree, and also to be clear what is being talked about here are benefits versus wage agreements that are being paid by the insurer – private short term disability plans, premium pay that's contractual and separate. I would not want there to be any confusion over (inaudible) the worker taking unemployment during this time, which is clear in the rule. This might get muddied up if the phrase is too broad.
- 01:51:18
Fred Bruyns
Is the current rule wording an obstacle?
- 01:51:39
Jerry Keene
Yes. Vacation and sick would have to be taken out and somehow modified subject to making adjustments.

01:51:51
Keith Semple *I guess I'm kind of hearing a consensus as far as the policy goes. If the worker is using up their benefits to be made whole, and they are not being offered work and they're not receiving comp payments, I don't see why their benefits that they're using while they're denied should be treated any differently. Again, I'm concerned more about the situation where the worker is receiving nothing from the employer and is using their benefits. We're talking about a little piece where they are being made whole from 2/3-100%, and it's a bigger concern when they're losing 100% and they're not able to get any compensation for that. I would say the unemployment benefits that same way. They're depleting their unemployment account while the claim is denied and they're off work and the insurer's not paying them. Then they go back and say well we don't have to pay unless you can repay unemployment dollar for dollar. What worker can ever do that? So the insurer just doesn't have to pay time-loss – we denied that claim, that was overturned, so that was improper, so guess what since we denied your claim all we have to pay is the attorney fee.*

01:53:13
Phone /
unknown *Is that actually how it's being done?*

01:53:32
Keith Semple *Yes. The vast majority of insurers will say did you collect on any unemployment, did you use any vacation time, did you use any sick time?*

01:53:42
Jennifer Flood *Are there any wages that we can use to reduce the benefit that we are going to have to pay?*

01:53:46
Keith Semple *The current rule clearly states that those are offsetable wages. That's a problem. If some insurers are paying the time-loss anyway, I say great, but if it's not required than the vast majority are not going to do it. I see this issue come up frequently when I have denied claims and the worker's not getting any other income.*

01:54:30
Julie Masters *I guess I question your statement about what worker can pay it back when they would get a large lump sum to cover the back pay time-loss that they could use to pay back their vacation.*

01:54:34
Keith Semple *In practice, I have always been told by insurers that they have to pay the money back to either the employer or the unemployment. If it was the other way around, again there's not problem with that. If it were able to be done the way you just described that would solve the problem, but that's not how the rule reads or is applied.*

01:55:13
Dan Schmelling
It's temporary partial disability that we are talking about going back. Yes, the insurer is going to ask about what wages, sick leave, vacation, and unemployment, but you're saying I'm capable of modified work and you're receiving unemployment though. Yes, we would say we are going to take all that into account retroactively for that time period that we are looking at paying, and use the TPD calculations to say this is the difference we owe you. If it's temporary total, there shouldn't be unemployment because they have to say I'm able to do modified work.

01:55:57
Jennifer Flood
Just going to throw this out, with FMLA and OFLA and now the new sick pay, this issue is not going to get better. There are those employers don't understand the mission of those programs, and there are some employers that say when you're on OFLA or FEMLA you have to use up your leave accrual. They get a little confused when we say its workers comp and they don't need to be using their leave except for that makeup part that's in 0240. Workers are having to use up their vacation pay on one hand and end up being entitled to benefits, but they don't get their benefits because they were forced to use up their vacation.

01:57:21
Fred Bruyns
That was a really good discussion.

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.

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?

<i>Speaker & Time</i>	<i>Committee comments</i>
01:58:43 Dan Schmelling	<i>If the question is just limited to does PTO equal vacation and sick than I would say yes it should be including but not limited to ... as words change over the years you don't have to keep going back to the rule and saying does this new aggregate type of benefit equal vacation. We should be able to offset it regardless of what it's labeled.</i>
01:59:43 Phone / unknown	<i>Jury duty pay (inaudible)</i>
01:59:54 Jennifer Flood	<i>Those workers who are released to modified work and earning full wage, more than what their average wage was at time of injury, and they decide to take a two week vacation, then this vacation time should be able to be offset. The workers comp insurer shouldn't have to pay time-loss benefits for this two weeks that they're off.</i>
02:00:26 Keith Semple	<i>Claimants bar would have to agree with that. That gets into the challenge that we talked about last time. The bona fide job offer and whether an informal agreement between the employer and the worker can be treated the same way. That kind of demonstrates the value of a bona fide job offer.</i>
02:01:09 Fred Bruyns	<i>As opposed to just a verbal agreement?</i>
02:01:10 Keith Semple	<i>It makes it more challenging if the agreement is verbal.</i>

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?

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)?

**Speaker &
Time**

Committee comments

02:03:10
Jerry Keene

I think that is consistent with the way time loss works now. Nobody here pays supplemental disability that comes out of the Workers' Benefit Fund. This is a fiscal decision for the benefit fund, rather than the stakeholders.

02:03:45
Keith Semple

As much as we would love to see supplemental wages be paid based on a secondary job at the time of aggravation, it's not really consistent with the way time loss is normally paid. I imagine the Workers' Benefit Fund would have a couple things to say about that.

02:04:04
Jerry Keene

There's a significant exception in vocational rehab. There's only one situation where wage at aggravation matters and that's in vocational rehab. I don't think you should expand that situation.

02:04:35
Keith Semple

One thing that comes up for claimants and their attorneys is the requirement that they give notice of a second job extremely early in a claim. I believe it's within the first 30 days, I could be wrong about that because it doesn't come up very often. It's a very tight deadline, and it often starts before the worker may even be disabled from the job at injury. A worker is not going to be thinking about reporting a second job and providing information. They may not even have a disabling claim yet. This may not happen until a year into the claim. We would like to see that deadline for them to provide notice of a second job at least run from the date of being disabled from the job at injury, if not we would prefer it being from disabled from the secondary employment because that's when it comes up in the person's mind.

02:05:43
Dan Schmelling
I would disagree. I think it's a two-part disagreement. One, to protect the worker. The wages are set at date of injury for the injury claim. If the claim becomes disabling and they are no longer working for the secondary employer, it's their obligation to get those wages from the secondary employer. They should be getting them at that point in time that the injury occurred. For us to make that decision, at some other point it's a two prong decision in determining eligibility, whether benefits are due at that point in time. It might be a nondisabling claim, and we're still determining eligibility for supplemental disability calculating an average weekly wage and saying there's no supplemental disability due at this time; it might be due two years later, but that determination needs to be made at the time of injury, not two years later. The way SAIF looks at it is, we make a lot of determinations where we say you're eligible, here's your average weekly wage, but your benefit is zero because it's nondisabling. They are not missing any time from their secondary employer, so we're not paying it. We still have an obligation to do that. The worker should have an obligation to let us know timely so they can get those payroll records from their employer at that point in time and not two years later when we have a responsibility then to make a determination. We are going to the worker asking for wage information and they say we don't know what our payroll was and maybe the employer is no longer even in business.

02:07:34
Jerry Keene
What does the statute say?

02:07:37
Julie Masters
They have within 30 days. It doesn't say, at least in the subsection, that they have to give us all their wages, but they do have to notify of the secondary job.

02:07:58
Jerry Keene
Part of that to, isn't it possible for a worker to have a nondisabling claim if they are at the employer at injury and still be entitled to supplemental disability?.

02:08:05
Jennifer Flood
Isn't there a requirement of the insurer providing, I mean if the worker misses the box on the 801 form, if 30 days passes they're out the door, or is there a notification that has to take place?

02:08:28
Sydney Montanaro
There is notification that triggers having to submit the wage documents.

02:08:49
Jerry Keene
I'm just going off vague recollection, but a lot of these were discussed when supplemental disability was first created. There was a lot of discussion about who bears the burden and if insurers were going to make this available in the system. Funded by workers and employers, not by insurers – the Workers' Benefit Fund It was part of the worker's obligation to service the situation so that everyone would know what was being dealt with. But the 801 form should be clear to the worker.

02:09:22 *I wonder if it could be more clear? It doesn't come up that often, but I have seen
Sydney it come up where people just miss it.*
Montanaro

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.

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?

***Speaker &
Time***

Committee comments

02:11:40 *Make it clear to whom, I don't know a single worker who's ever read this rule.*
Jerry Keene

02:11:45 *Is the concern about making sure they know it's the 60 days or also the
Jennifer Flood concern that it's a clear to the worker about the consequences of not
responding and what impact it's going to have? I read it that the DOJ is
saying you need to make it clear that the consequences of not timely providing
the required information is going to impact your temporary disability rating.*

02:12:11 *That was the issue because the insurer may know and be following their
Mary Schwabe requirement but the worker may not understand that. We wouldn't have gotten
this from DOJ unless an issue was presented.*

02:12:46 *I think what's not clear that it's the worker's duty to get the verifiable
Julie Masters documentation to the insurer. Maybe that is what the problem is? Because it's
written in a passive voice.*

02:13:20 *Consequences need to be made clear to the worker; that's fair notice and you
Jerry Keene are right the rule does not say that.*

02:13:46 *Jennifer Flood* That's my issue here is the worker not understanding the consequences of not responding. We have a better response from workers if they know the impact of not responding.

02:14:19 *Julie Masters* It does say or the worker will be found ineligible.

02:14:20 *Keith Semple* But it doesn't say anything about providing notice?

02:14:51 *Jennifer Flood* It mean's something to all of us because we work with it. But if I'm a worker and I'm told to send verifiable documentation or you won't be eligible, eligible for what?

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.

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?

Speaker & Time ***Committee comments***

02:17:39 *Dan Schmelling* Under 0019 it talks about supplemental disabilities under an occupational disease claim. The eligibility is based on the date of injury. The date of injury and date of disability might not be the same. Worker might be eligible on the date of injury, but on the date of disability they might not be working the secondary job. Need some clarity here ...

02:19:33 *Julie Masters* The way that this rule is currently worded is consistent with the statute. So that's what this rule doesn't capture, is that day of first treatment. If it's sooner than the day of disability it's going to be the date of injury for disease.

02:20:22 *Dan Schmelling* We went back to the date of injury for the secondary employer and used those average weekly wages; otherwise we would have made the worker eligible and said your secondary rate is zero.

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).

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?

*Speaker & Committee comments
Time*

02:23:48 *Why don't you just say "if any" after the words temporary disability. It's what everybody does anyway.*
Jerry
Keene

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

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.

*Speaker & Committee Comments
Time*

02:25:40 *I believe this is just the Schleiss case, not Brown, which isn't on appeal.*
Cara
Filsinger
02:26:15 *I think the reference should be to Brown.*
Keith Semple
02:26:24 *We'll check into it.*
Fred Bruyns

02:26:40 I would refer back to the input on the Brown decision.
Keith Semple

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))?

***Speaker & Committee Comments
Time***

02:28:50 I’ve always thought the court opinions on this were inconsistent with the statute and that the temporary disability from the end of the training program to the time of closure, if there is no permanent disability being paid, was procedural, particularly where you have statute saying training program, time-loss may not be paid for more than 16, 18 or 21 months, it keeps changing, but certainly SAIF would support this change.
Julie Master

02:29:43 We would be against this change. This case law goes back quite a while saying that this is substantive. I guess you can continue interpreting it that way. It kind of incentivizes the claims closing a claim quickly after a training program as well.
Sydney Montanaro

02:30:00 I think it might be for the fact that workers can demand closure given that it is so comparable and analogous to the other situation where the substantive entitlement stops, that it’s just convolution of information that causes the continuation of payments. I don’t know why it should be different here.
Jerry Keene

2:30:46 Going back to the standpoint I think it’s 3 month and not 6 months. When we are trying to close the ATP, we go back to the attending physician and get confirmation that the person remains medically stationary, sometimes two to three years after they last treated the worker. It can be difficult to get that information but we’re required to get it. Then we are required to pay time-loss beyond the end of the ATP, and it’s considered substantive and not procedural to where we can’t claim back that as an overpayment.
Dan Schmelling

02:31:42 It seems like it should remain substantive until a decision that they are medically stationary.
Sydney Montanaro

02:31:49 *In many cases you are reopening the ATP, not because of a worsening, but*
Dan *because it's vocational training. If there hasn't been an aggravation to have it*
Schmelling *treated throughout, why should we even have to get a declaration of medically*
stationary and just close it administratively following ATP, because it's not
reopened for a medical worsening but for vocational training. The rules can be
modified to say this is procedural for time-loss.

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.

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?

Speaker & Committee comments
Time

02:33:40 *Provided example. It should be recognized that IMEs are a processing*
Jerry Keene *mechanism and should all be in the 060s. It is a processing mechanism from*
beginning to end. Having them split just confuses people about their nature,
because it's not a medical treatment or service as defined.

02:34:36 *I'm supportive of making things easier to find, so if you find a rule of medical*
Julie Masters *examination, independent medical examination, you think you're capturing all*
the regulation on that, and then you find out later you have to go look at a whole
other section to find out if you did the correct action or not; this is a problem
that crops up in these rules.

02:35:15 *Sounds like there is consensus these shouldn't be split or housed in two different divisions of the rules.*
Fred Bruyns

02:35:31 *It's hard for you to do that because you would have to open two sections to change things at the same time.*
Julie Masters

02:35:44 *I don't know that we will, or we can. We will really have to take the advice you provide and take it back and consider it. We can always have duplication for a little while until we get rid of it.*
Fred Bruyns

02:35:51 *Duplication is better than not finding it.*
Julie Masters

02:35:55 *I have no understanding at all of why the difference between medical services and medical billings was enough to warrant of putting them in different divisions. ... Why doesn't time-loss have it's own division in the rules. It should. It would be easier to deal with. The time-loss stuff is just as distinct as vocational rehabilitation. I would suggest that you draw the line down, because the 060s are getting so big, it would allow you to just open the part you need to change without reopening on all. It just seems clear that time-loss should be in its own section of the rules. At first it will be difficult separating them, but it will be worth the effort.*
Jerry Keene

02:37:28 *That makes sense. Make it easier to deal with.*
Keith Semple

02:37:46 *I haven't had a chance to think through it, but on the surface it sounds like a good idea.*
Julie Masters

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.