

**DIVISION 060 - CLAIMS ADMINISTRATION**

**9/21/15 at 9 a.m.**

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

**ISSUES DOCUMENT**

<p><b>Attendees:</b></p> <p><b>Barb Reich, Asante Work Health</b> <b>Bryan Aalberg, Washington County</b> <b>Carmen Jones, Legacy Health Systems</b> <b>Dan Schmelling, SAIF Corporation</b> <b>David Runner, SAIF Corporation</b> <b>Dean Spradley, Farmers Insurance</b> <b>Doris Bain, Compro Inc.</b> <b>Dwayne Yoder, SAIF Corporation</b> <b>George Goodman, Cummins, Goodman, Denley &amp; Vickers P.C.</b> <b>Jennifer Flood, Ombudsman for Injured Workers</b> <b>Jordan Snyder, Special Districts</b> <b>Julie Masters, SAIF Corporation</b> <b>Julie Riddle, The Hartford</b> <b>Keith Semple, Oregon Trial Lawyers</b> <b>Larry Bishop, Sedgwick CMS</b> <b>Lori See, Trinity Health</b> <b>Mark Hopkins, EC Company</b> <b>Melissa Schnell, City of Portland</b> <b>Sara Stevenson, Washington County</b> <b>Spencer Aldrich, Law Offices of Kathryn Reynolds Morton</b> <b>Susan Wilson, Liberty Mutual Insurance</b> <b>Sydney Montanaro, Swanson Thomas Coon &amp; Newton</b></p>	<p><b>WCD Attendees:</b></p> <p><b>Barbara Belcher</b> <b>Cara Filsinger</b> <b>Edie Roster</b> <b>Fred Bruyns</b> <b>Karen Howard</b> <b>Mary Lou Garcia</b> <b>Mary Schwabe</b> <b>Michelle Miranda</b> <b>Sally Coen</b> <b>Troy Painter</b></p>
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*Meeting minutes have been entered below in italicized text. The following is not a transcript, and some comments have been paraphrased for brevity.*

**See meeting handout regarding OAR 436-060-0025 – “Rate of Temporary Disability” Requirements for determining Average Weekly Wage (AWW)**

***Time & Speaker***

***Committee comments***

*Fred Bruyns*

*There are two options for amending 060-0025: 1) further clarify how to handle varied employment and wage situations, or 2) substantially rewrite the rule to implement some other approach for determining the AWW. Regardless of the option chosen, the following needs to be considered...*

08:12  
Dwayne Yoder *In looking over things to consider we have two choices: clarify the rules or substantially rewrite the rules. Maybe it is time to rewrite the rules substantially. We came up with very simplistic, three-point approach, but there's a lot of "what ifs." It's a starting point. Just looking at regular employees, and obviously you are multiplying the daily wage by the days of the week. The workers with no work earnings, would go with premium, and everybody else would basically be from date of hire or 52 weeks would be divided to determine average weekly wage. Again, just trying to be very simple in how we calculate this.*

09:23  
Doris Bain *This probably isn't a favorite opinion, although consistent with the current rule, that process would not accommodate the fact of a job change or a rate change. Since we are trying to come up with a method to compensate them for their loss, I don't think that the straight 52 week method deals with that topic.*

10:07  
Keith Semple *There is still a question of earnings, and I would have to go back to the very beginning of the definitions. My recollection is most of the minutia deals with what is considered earnings and what is not considered earnings. I share the concerns about what happens if a person just got a raise before they were injured (why should they have to go back to their lower rate?), or extended gaps in employment (this doesn't discuss that at all) so they would be presumably averaged into a person's earnings which may not be appropriate in a lot of cases. As a more general proposition, we would disagree with a total rewrite or substantial rewrite of these rules. I know there some strange cases that have to be litigated, but it's not my perception that there is an overall real difficulty in applying these rules. Most frequent issues that I see litigated are intent at the time of hire, which is always going to be an issue of fact if there is a disagreement, if a gap is extended or not, which a lot of times is determined if there was an expectation that they go back after being on unemployment. The third is on the rate change – a lot of folks still do go back and average it and not use a change of rate in employment. Broadly, I don't see a ton of litigation in this realm.*

11:58  
Dean Spradley *In general I feel like it's difficult to apply the different scenarios, because sometimes they're not clear. I would be in support of a revision; however, I do feel like a simpler revision. You can still account for gaps and have those. Also, for wage increases, it would be easy to do. I think that the confusion lies at least when it's difficult to understand what type of worker they should be classified as. There're so many different ones: seasonal worker, cyclical workers, and a whole list of things that is a little over complicated. If you just use the average weekly wage method, accounted for wage increases and gaps, and simplified it but not try and classify every worker.*

13:02                    *That's kind of where we were coming from. You can look at gaps and anything  
Dwayne Yoder        over four weeks, you would exclude that. You take into account seasonal  
workers. Looking at some of those exceptions would be okay.*

13:25                    *The statute says you are to figure out the wage at the time of the injury. That's a  
George                    simple statement. We have made it awfully complicated. The wage at the time of  
Goodman                the injury and the hourly rate at the time the person got hurt and we have  
managed to take that and extrapolate that into all of these various scenarios of  
calculations. We want to be fair, we want to compensate people for their loss,  
but on the other hand the time-loss rate is 66 2/3 of the wages at injury. That's  
not fair. Very few workers actually have a third of their income being taken out  
of their check each week. We've already set an artificial limitation on what  
workers get. I agree that average weekly wage is a giant source of litigation  
generally; there are a number of claimants' attorneys raising it every time they  
pick up a case. Then you have to get wage records, which makes you dependent  
on employers to provide you information. The claims handlers are dependent on  
an unreliable source inherently. If you are trying to cut back on litigation why  
don't you just stick to what the statute says? I've always thought this is a silly  
system, it's wasteful and creates litigation, it's trying to do something that's  
impossible which is be fair in every situation, and you can't do it. If you want to  
avoid litigation stop creating rules that create lawyer fodder for the lawyers  
that want to make money.*

15:58                    *What do you do about the hour situation? Because some workers don't work a  
Doris Bain              40 hour week.*

16:06                    *Change the statute or follow it the statute which says pay the wage at the time  
George                    of injury. That to me is an hourly rate the person is making at the time they are  
Goodman                hurt. If somebody is going to end up making more because they are on time-  
loss, that's the way it goes. Change the statute. The statute is simple, the  
language is clear. There are going to be inequities both ways, but that's  
inherent to the system.*

16:33                    *That's kind of hard to say wage at injury, because a lot of times, I think that's  
Melissa                    where the litigation will increase. We have a lot of employees where wage at  
Schnell                    injury, based on union contract, is their hourly based rate plus .80 cents an  
hour or other stipulation, so if we start saying your base rate only, that will  
create horrendous litigation. We'll have a lot of union grievances.*

17:13                    *The rule says base rate, so you are following the rule.*  
George  
Goodman

- 17:18  
Melissa Schnell  
*It doesn't say base rate, it says wage at injury. So what is the wage at injury? Wage at injury potentially would include all the other extra wages.*
- 17:32  
George Goodman  
*I think you are absolutely right Melissa. CBAs are a whole different thing, and whether the CBA that allows for kickers and incentives and other things that come into play should affect what the statutory language says for wage at time of injury. It can say subject to CBA or it can say base rate in the rule. Either way it would be relatively simple. If you leave it to the employer to make the decision on what same wage means, then you will create litigation. If you want to make it simple define it in the rule.*
- 18:21  
David Runner  
*Just to clarify when you are talking about the wage at injury, you are just talking about the day of the injury? Doesn't matter whether the person is working part-time, full-time, over-time or whatever?*
- 18:35  
George Goodman  
*It says at the time of the injury. That should be relatively easy number to identify. For claims processing purposes I think easy is good.*
- 18:52  
Doris Bain  
*What if they were working over-time on their day of injury?*
- 18:57  
George Goodman  
*Then they are lucky aren't they.*
- 18:59  
Jennifer Flood  
*What if they're a salesman and they didn't sell any cars that day or they are paid on commission but didn't sell any cars that day?*
- 19:09  
George Goodman  
*They are getting commission only – that would be an interesting rule related issue. I thought car salesmen got minimum wage if they didn't sell any cars that day. I thought that is the law that they have to get minimum wage at least.*
- 19:55  
Keith Semple  
*If we want to read the rule and be literal about it, the time of injury could be the hour or minute that the worker was injured. The way I read the statute is that the director has been given authorization and been delegated authority to determine what that nebulous phrase means. At the time of injury does it mean the day of injury or minute of injury, or the year prior to the injury? I think the director appropriately exercises the authority to make that determination.*

- 20:40  
George  
Goodman *I disagree with that. You're saying that the department can say the time of injury goes back ten years. The statute for an occupational disease says that for purposes of occupational disease, at time of the injury will be the date upon which the worker first becomes disabled. The date, not 52 weeks prior to that date. So how can we get the date for purposes of an occupational disease, and is your rule even enforceable if someone wanted to litigate?*
- 21:49  
Fred Bruyins *We want to have all the ideas out even though we won't necessarily come to a conclusion or consensus this morning, but we would like everything put on the table so we can have it available to us. Encourage additional discussion.*
- 22:09  
George  
Goodman *For people on commission, why couldn't you treat them just like volunteers and assume a wage – created by the rule?*
- 22:48  
Melissa  
Schnell *I do agree with George. We need to make it simpler because there's a lot of industries and not just public entities that have very complex wage history. Part of the problem is that I think everyone has gotten confused, especially after the audit years ago. Auditors had good intention to pay appropriate time-loss, but then they found out they were doing it wrong. Some of us had been doing it wrong for 20 years and didn't know. Simpler version would be best. There's no way we can be fair to everyone.*
- 24:14  
Doris Bain *I do a lot of weekly wages for a lot of different employers and probably encounter every complexity that you are going to encounter. Sometimes I don't know what to do. I have friends that help me in that situation when I don't know what to do. Sometimes there isn't an easy answer. I have embraced the rules as they exist right now, studied them, and thought about them. I have tried to come up with some method that would be equitable for the worker and more simplistic for the examiners. My bottom line is when I pick up an average wage to do and I have certain pieces of information that often times are not available to me that would allow me to do an accurate calculation. I try to get that information, and if I can't I do my best job possible. I don't think that there is a way to simplify the ruling to be equitable to the injured workers. If I look at it and say do I have an average of gross hours or do I have an average of gross rate, and what kind of information is available to me. I very simplistically use one of those two calculations. My problems come in with questions like when did the pay period start, when did the pay period end, and other situations. I find the department to be rational and reasonable on how they overview. I don't see a way to simplify it at all.*

- 26:58  
Dean  
Spradley *Just for the record I feel it should be simplified. I feel that you can be fair to the worker and you can write language that allows the adjusters (which they do already) to make a fair decision and to determine what that average weekly wage is at the time of injury. I don't feel that if we simplified the rules that it would cause increased litigation. I think that it would be about the same. I think that they're a little too long and can be written more concisely. I realize there might still be disagreements, but they would have to be open-ended enough to allow someone to make a decision – if the injured worker still didn't agree with it, it can be litigated. But I don't think the litigation rate will go up.*
- 28:03  
Carmen Jones *I agree they need to be rewritten. If it helps, Washington is having the same issue. They are currently in committee trying to determine an easier way to do it and maybe that's something we need to look at.*
- 28:24  
Spencer  
Aldrich *I understood by what was said earlier about putting some type of language in the rule about how the gap is extended or not. That's something that oddly enough comes up in my practice. I agree with Keith that their always will be things that are factual or will have to be litigated. But this is something that I oddly see a lot of. I think that there might be an opportunity to look at perhaps pinning that down a little more, which might give a little more clarity, potentially reduce litigation, and give people a better idea of what is extended and what isn't.*
- 29:14  
Dwayne Yoder *I'm going to defer to Dan a little bit on this, but again it's just to simplify and maybe just looking at four weeks. Anything over four weeks is excluded. Discussed addressing seasonal workers.*
- 29:48  
Spencer  
Aldrich *Yeah I like that idea. I have some adjusters that see the word seasonal in a workers description and immediately just want to cut all the time short, and some look in more detail. It's something that takes the guess work out.*
- 30:27  
Melissa  
Schnell *I do think that we do it currently how most examiners do it. Currently if we have rules in more simplified order, because when you're reading through the rules double checking what you're doing, they kind of bounce all over the place. Then you have to go back and look again and that's part of what I do; I proof read average weekly wage determinations just about everyday. Then I look at it again and audit. We try to train a new person to calculate average weekly wage, I just go by history as I've done it for so long. I always send an email to WCD, and they are amazingly helpful. I think it would be beneficial if we kept it under the same basic mechanism.*

32:39 Fred Bruyns *I'll just let you decide if I have the right take-away from what I've heard. I heard two general approaches: SAIF Corporation gave to us the possibility of a definition of extended gaps and what to do about recent pay increases, and from George about folks staying on the wage at the time of injury and letting that be the focus. Melissa you said you would like to see a re-ordering of the rule to help streamline it in evident clear sequence.*

33:28 Keith Semple *There is also leaving it the same, and not making changes. That has been brought up by many of us.*

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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)?

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

36:41 Dan Schmelling *I think we discussed it at the first meeting, but my suggestions would be if you want to allow self-insureds to pay time-loss based on their own pay schedule that it should be opened up for insurers also. Allow insurers to pay TPD on the employer's payroll schedule that's regular and predictable. Maybe you need to look at it's own rule on the timeliness of ongoing time-loss payments and make it clear that self-insurers may do this based on their schedule and insurers may do this based on the employers regular and predictable schedule. Whether that is for TPD and TTD, or just for TPD for insurers, I think it would add a lot of benefit both to the employers that we insure and to the people administering those claims. We can match up what we're paying with how the employer is paying them, and I think audit would see more accurate payments down the road.*

37:50 Larry Bishop *Yes, I agree. I think it should be both benefits, and not matter if it's TPD or TTD. It's still predictable and based on what the worker is accustomed to receiving when they worked.*

38:05 Jennifer Flood *From the worker's perspective, it's confusing for them – they have all the bills – all this stuff is set up for when they get paid, so it makes sense to have benefits paid on same schedule. There are a lot of different case schedules, so is it going to be hit or miss or is it going to be predictable? Are some people going to be paid every week versus some differently, from the insurer's perspective? If you were given the ability to pay with the payroll would it be determined by each worker? Claim by claim or by employer?*

38:56 Dan Schmelling *Each employer has their own payroll cycle. Some pay twice monthly, some pay monthly, some pay every other Friday, I think from the insurers perspective the benefit of being able to match our time-loss schedule to their payroll schedule is just in obtaining those post injury wages for the TPD calculations. When you're trying to get the tail end of one pay period and the beginning of the next pay period, some employers can provide you that information and others can't. Some payroll is with the contact person while other information may be on the east coast. You can't get payroll dealing with one of our major accounts, where we are starting to see more penalties on payment of TPD simply because they can't provide us the payroll information on a bi-weekly basis. When we call up, with the shift differential, they can't give us the hours. They can give us an estimate, but their response is we can't run payroll until the end of the payroll period so we can give you an estimate. Then the worker is not getting accurate payment, we are incurring penalties on behalf of the employer, but if we're able to match that up – yeah so regular and predictable. So if you have an employer that says we run payroll when we run payroll, that's not regular and predictable. If you can look at their payroll records and they say we issue a check every other Friday and it's for this time period.*

40:34 Jennifer Flood *I guess I'm not thinking about it from the employer/insurer perspective. I'm thinking of it as explaining to a worker when they could expect to receive their disability check and having it kind of known from that perspective. Or would we have to call on each claim to say when is it scheduled to go? And, can you change mid-shift?*

41:06 Melissa Schnell *I think getting the first pay when you make the three point contact with the injured worker and explain your first benefit will be a little early, your second [payment] is going to match with your payroll record. From the employer ... it makes it a lot easier instead of ... having to call payroll everyday, because each employee has a different date that their benefit is due. So it's the initial contact and you have to have good communication with the employee.*

41:57 Jennifer Flood *I'm not opposed to the idea at all and that's why my questions are a little bit more on the details of how it's implemented. I just want to make sure that it's on the table as to how that is communicated and known, not just to the worker but to DCBS as well.*

42:15 Carmen Jones *We currently do that. We run it with payroll and exactly what you said with the three point contact explaining to employer that the first check is going to be off cycle most times and that the rest will go on cycle because we pay every other Friday. Once they know that it does run (inaudible) let's the employee know exactly when to expect their check and it's consistent for them.*

42:48 *I think it would be more consistent and easier for attorneys also representing the*  
*Keith workers to do the audits and calculations because we run into the same problems.*  
*Semple Having to figure out what was the last two hours of that pay period for TPD*  
*purposes. If we are doing what we should be doing, and we are auditing if not*  
*most but all of our claims as well on our end, we run into some of these same*  
*problems of checks falling in between cycles, and sometimes we need it daily*  
*which we may or may not be able to get. I think that this would probably be good*  
*for all involved.*

43:23 *I would agree with Keith. We get these TPD issues that don't end up being that big*  
*Spencer a deal but take up a lot of time to go through the numbers, and get all the*  
*Aldrich documentation in support of it. I would agree that I think simplicity in this area is*  
*achievable.*

43:55 *I would agree with the perspective that it shouldn't really matter if it's an insurer*  
*Keith or self-insured, and it really shouldn't matter in my view whether it's TTD or TPD.*  
*Semple I don't see any realistic distinctions on that would operate. If you were going to*  
*make this change I would propose or support the idea of making it a little more*  
*broad in terms of who can do this or what circumstance.*

**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.

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

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

**Speaker & Committee comments**

**Time**

45:29  
George Goodman  
*This is why I'm here today. I've got the experience over the last couple of years of dealing with this rule, and I think that the question should not be defining wage continuation, it should be defining the phrase "same wage." The phrase same wage is what's in 656.262(4)(b), not wage continuation. I don't know anywhere else that those two words are in the statute. I think that the way you phrased the question here is interesting, because your statement (inaudible). Speaks to the issue of the department sometimes being in a cloistered environment and not understanding practical reality. From my experience, practical reality is what's going on with wage continuation or salary continuation. Almost always self-insured employers who are subject to a collective bargaining agreement (CBA), and the union has bargained to get wage continuation while they're on a on the job injury that's been accepted. Discussion about same wage and base wage. The way to fix this is to define same wage in a meaningful way that acknowledges what is really going on in the real world when self-insured employers have decided to do a salary continuation or wage continuation program.*

52:19  
Keith Semple  
*I would agree with George in so far as this statement that this should be subject in any collective bargaining agreement. I think that offers clarity. I wouldn't go so far as to say the rule should define it for everybody at a base rate. If it's part of the collective bargaining agreement it's part of the deal, but not all workers are subject to those CBAs. It is a major concern for workers. I agree they are not contributing to social security, unemployment, PERS, and what ever other incentives an employer may offer. That is a problem that's inherent unfortunately for time-loss for an injured worker. I would love to see them get some sort of remuneration for those losses, but obviously that's a statutory issue to address.*

**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:**

**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?

***Speaker & Committee comments  
Time***

*55:33 Several people said yes.*

*55:39 Carmen Jones No. You don’t budget your employees for a full FTE even when you are going through a budget period. Someone may be 40 weeks but I’m not going to budget them for 40 weeks in a 52 weeks, because we always know there’s going to be some kind of variable absences. So to include that in is not accurate in what reality is for an average weekly wage. Because on average, at least not at Legacy, nobody works 365 days a year. There is always some sort of variance in time off. Not including that variance and throwing it all into the average weekly wage, you are not getting a truly accurate average weekly wage.*

*56:30 Melissa Schnell Normal is 2080 hours per year. I look at types of earnings. If they are taxed on their vacation leave and sick leave, that should be included in the average weekly wage calculation. If it’s nontaxable earnings or just a little benefit (e.g. discount on Trimet pass), but definitely taxable earnings should be included in average weekly wage.*

*01:03:17 Jennifer Flood It doesn’t really have to do with the rate of TPD, but it has to do with vacation pay and calculating the wage versus e.g. vacation for post injury wages. It doesn’t have to do with the actual rate, it has to do with what would we do with TPD. I don’t agree that all of that should be included as post-injury wages.*

*01:04:05 Fred Bruyns I would encourage everyone to look at that second paragraph on page 12.*

*01:04:46 Doris Bain I’m currently working on a temporary partial calculation. I received post-injury wages from the employer. Provided example of wages received. You have to gather information for what period is being paid in a specific check.*

*01:06:31 Jennifer Flood My concern is worker has only returned to temporary partial work. Never mind.*

*01:07:01 Barbara Belcher You need to consider each of those things. When they are making themselves whole by using vacation day, and consider it differently if they chose to take a two week vacation.*

01:07:29 *Example of using vacation time.*  
Melissa  
Schnell

01:08:02 *This conversation doesn't reflect the conversation we had at the last one.*  
Jennifer  
Flood

01:08:26 *One proposal is to include the wages at injury a calculation of all paid time that may or may not be available to the worker. When evaluating post-injury wages as they are potentially using that paid time, be it for a vacation they've chosen to go on or to make them whole from their injury, we would then have to be constantly recalculating that amount. We would have to include those paid time on both sides of the equation.*

01:09:17 *On the second part we do it on a case by case basis. If they offer us total time-loss and an employee wants to take extra pay, and take vacation, we would not put that in the temporary disability because the doctor authorized that. If they are released to modified work and they had a preplanned vacation, or decided they just don't feel like going to modified work and the doctor has not authorized it, or it's for sick or non-relatable reasons, we would include that in the TPD calculations. If it's a holiday we include that in the TPD. If it's total time-loss we do not include it.*

01:10:06 *I don't disagree with this proposal, I'm just for seeing an administrative nightmare on the part of Liberty in trying to figure out how we need to audit the employer, what their understanding of why a worker chose to use paid time off was or wasn't. I'm remembering the first discussion with Keith's proposal in anytime time-loss is cut-off would the employer supply through their insurer evidence of exactly why. This information can be difficult to gather.*

01:11:05 *This already happens. It happens everyday for the adjuster when they are calling up and asking for those post injury wages. They don't equal what modified work is available; they're asking why didn't the worker work their full modified shift. They may have voluntarily left early and said I don't want to work the rest of my modified shift. Work was available, we are going prorata based on the availability of work. It requires the employer to track what is happening. Let us mesh up the pay periods with the TPD periods. It would make it easier, because you would have accounting of the payroll period.*

01:12:30 *Are you suggesting that the normal claims examiner does this?*  
Doris Bain

01:12:37 *They'd better be doing that now. That is probably why audit is having a hard time auditing and there are penalty and fees out there. Our claims adjusters are making phone calls every two weeks, unless the information is emailed to them.*  
Dan Schmelling

01:13:13 *I can tell you they are not. What I see quite frequently is a TPD release. I'm not saying everyone does that, but I'm saying it's a common occurrence. I don't agree with that, but that isn't what I see.*  
Doris Bain

01:14:05 *I can see where that work load could be reduced on the adjuster. If we're able to mesh with the payroll schedule – Say you get paid once a month and if you can make those payments once a month, you are only having to call one time.*  
Jennifer Flood

01:14:39 *I haven't heard anything from an employer's perspective. There is a huge cost to employer. Software modification, payroll accounting systems, and programming to account for things that is outside of NCCI. Most payroll and operations systems are set up for NCCI, and anything outside of this has to be done manually. I don't know what that cost might be, but it's going to be significant for employers.*  
Mark Hopkins

01:15:43 *Asked for clarification on cost impact.*  
Fred Bruyns

01:15:51 *We have to manually calculate everything because we can't rely on our payroll system to do it for us. We operate in multiple states, we are a union company so we have multiple locals, everyone has their own deals, so we can put as much of that stuff in there that we can. Ultimately, you are going to have to spend a lot of time manually crunching numbers. That's something that right now we don't necessarily have to do because our accounting system can handle it. If we had to do something outside of that we would have to pay for people's time.*  
Mark Hopkins

01:16:36 *There's nothing in this rule that is requiring specific payroll reporting or payroll methodology; it's simply if that payroll is available you should use it. If gross wages are provided that's what you use. To the extent that we're able to determine what was paid as e.g. vacation, sick time, we should apply these rules, but if you're never able to determine that because it's just all gross wages reported then that's what you should use for the average weekly wage calculation. To the extent that we are able to determine, because it's all gross wages reported.*  
Dan Schmelling

01:17:20 *If I wasn't able to mirror my TPD and run it with my payroll, I would have those same issues. I think part of this connects to that whole issue to allowing (inaudible) insurers, self-insured to pay with payroll cycle of the employer. It all kind of interconnects together.*  
Carmen Jones

*Next issue discussed is issue #19.*

**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.

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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?

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

58:43            *I would agree with the proposed amendment.*  
*Keith*  
*Semple*

58:53            *Things like this with small employers it is difficult to get that information. From*  
*Dean*            *fiscal standpoint time from adjusters spent has an impact.*  
*Spradley*

59:35            *Payroll records we get quite often the per diem or travel pay is outside of the*  
*Dan*              *payroll for the employee. We are not seeing any tax taken out or deductions. Our*  
*Schmelling*    *question is this wages when it’s paid off to the side? We understand that Sparks*  
*exists, but when we get the payroll record, then if it’s taxed we will include it in the*  
*wages, if it’s not taxed we will exclude it unless there’s a request. We try to gather*  
*more information about it.*

*01:01:43 David Runner*     *The word reimbursed, looking at the dictionary, means expensed incurred. Those are for expense being submitted and there's a payment made on that. Technically speaking this would exclude per diem when there is not a particular method of accounting for expenses. This perhaps would be the focus of the change for the rule, some change in the definition of reimbursement that would include the sorts of things that Dan was talking about.*

*01:03:17*     *Returned back to issue 17.*

**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.

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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?

***Speaker & Committee comments***

***Time***

*01:19:15*     *No comments.*

**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?

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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?

<i>Speaker &amp; Time</i>	<i>Committee comments</i>
<i>01:21:26 Dan Schmelling</i>	<i>That portion of the administrative rule can be struck entirely. That’s the one part of the rules that tells you how to determine the scheduled work days where nothing else tells you how determine the scheduled work days. A worker that’s employed variably with different hours and shifts; the rules don’t tell you how many days a week the worker is, but you look at kind of what is regular and customary for that worker. This is the only rule that tells you for cyclical workers you make them a seven day a week worker, but what if they never work seven days a week? What about workers that have a flex shift? Inequities are built into this rule. The other option is to get rid of scheduled work days entirely. Make everyone a seven day worker across the board. You’re still going to have inequities, but you have them now.</i>
<i>01:24:18 Jennifer Flood</i>	<i>Provided a historical example.</i>
<i>01:25:20 Doris Bain</i>	<i>It also effects payment of benefits for supplemental disability.</i>
<i>01:25:33 Dan Schmelling</i>	<i>Great point. They’re a seven day a week worker also.</i>
<i>01:26:01 Fred Bruyns</i>	<i>Asked for more input.</i>
<i>01:26:07 Carmen Jones</i>	<i>We need to recognize that it will increase time loss claims.</i>
<i>01:26:29 Jennifer Flood</i>	<i>I don’t think that we are talking about calling it seven days and having that be the three day wait.</i>
<i>01:26:37 Carmen Jones</i>	<i>If you make everyone a seven day a week worker that is going to impact three day waiting period.</i>
<i>01:26:42 Jenifer Flood</i>	<i>No.</i>

- 01:26:50 *First wage loss would be when they left work early, but if there's no wage loss when calculating benefits there would be no TPD due.*  
Melissa Schnell
- 01:27:00 *I view that as two separate things. Determining three day wait versus scheduled days off.*  
Jennifer Flood
- 01:27:06 *I'm not talking about determining a three day wait. I'm talking about authorization for ten days you would pay ten days of time-loss, correct? What if there is a three day waiting period in that ten day authorization, you are going to pay seven days of time-loss, then there is the three day waiting period in a normal work week, they didn't really lose anytime in those seven days. It's going to cross over whether you like it or not.*  
Carmen Jones
- 01:27:28 *Once you calculate the three day wait, if the three day wait is perfected and the next day, the forth-sixth day is not scheduled, you still don't have a disabling claim even if you are looking at a seven day a week worker. They still need to get to that next shift where they are missing time from work to have a disabling claim. Then time-loss is due. You would have to go back and pay from the fourth day forward. So it may not create more time-loss claims – disabling claims. In that situation you might be paying more temporary partial or temporary disability, because you are paying for each calendar day and not just that one scheduled work day at the end of the ten days that they missed.*  
Dan Schmelling
- 01:28:31 *With the seven day work week workers, the inequities come on partial weeks and they can be positive or negative on both sides of it.*  
Jennifer Flood
- 01:29:08 *I did check with our underwriting, and the preliminary thought is that it shouldn't impact premium because you shouldn't be paying anymore time-loss because you are switching from a five day a week to a seven day a week worker. You are just paying a smaller amount each calendar day. Where you may see problems is where some construction companies can't bid on jobs if they have too many claims with more than 150 days of paid time-loss. If you go from a five day to a seven day a week worker for everyone, you are going to have more time-loss days reported.*  
Dan Schmelling
- 01:30:19 *We are in construction, and you are right. Those are issues. This can be of concern for a lot of construction people.*  
Mark Hopkins
- 01:30:37 *They don't look at the actual time-loss paid, but they look at the amount of time-loss paid.*  
Dan Schmelling

01:30:51 *They look at both. Those are calculated rates of severity. Generals and owners use those rates in ways that were never intended by the insurers or the state. That in essence is the construction company's report card, so we are going to be sensitive about this.*  
Mark Hopkins

01:31:26 *How has it worked in other jurisdictions where they do have it at a seven day week? How has that impacted you?*  
Melissa Schnell

01:31:52 *I don't know. We do very little work in California so I can't answer that question.*  
Mark Hopkins

01:32:01 *Would this water down TPD at all? Would there be an issue with calculating out the TPD if someone was to get released to that four hours a day. Assuming that they are hourly rates based on seven day a week ends up being lower, would there still be issues then?*  
Spencer Aldrich

01:32:26 *You are still looking at the time period. In that sense you're almost looking at calendar days, and what did they earn within that time period.*  
Dan Schmelling

01:32:56 *What if it's just a shorter period, like just a couple of days?*  
Julie Masters

01:33:00 *That's where you would have the inequity. It could be that you are paying at the end of a claim, paying two days of time-loss that were normally not scheduled work days. You would pay 2/7 of the time-loss rate for those two days because they were authorized. Conversely, you could have it where that is there one scheduled day – let's say they're a two day a week worker – and they would expect 50% of their time-loss rate. We're saying no, you are not going to get 50% of your time-loss rate, because of how we have set you up. It's the partial pay periods that are quirky.*  
Dan Schmelling

*Next issue discussed issue #30.*

**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:**

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

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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]?

<i>Speaker &amp; Time</i>	<i>Committee comments</i>
<i>01:38:20 Keith Semple</i>	<i>I think that it's important that the worker needs to be notified that whatever they've done constitutes cooperation in the insurer's eyes because it really scares and upsets an injured worker when their benefits may be suspended. That is a major concern for them.</i>
<i>01:38:42 Spencer Aldrich</i>	<i>I agree with Keith. Discussed example of suspension letter language to worker, and how the information being communicated by WCD is unclear.</i>
<i>01:39:38 Jennifer Flood</i>	<i>Is that possible two different things? With the appellate unit saying everything is suspended because of non-action at the department?</i>
<i>01:39:48 Spencer Aldrich</i>	<i>It was a letter saying the workers benefits were suspended because that didn't show up to two arbiter exams. It said the only way you can lift this is by cooperating with an arbiter exam or objecting within a certain timeframe. It wasn't an actual order, but a letter. That can create a lot of uncertainty in my review.</i>
<i>01:41:19 Fred Bruyns</i>	<i>That was something from the department. This rule actually says the worker and insurer must notify the division immediately when the worker cooperates. Something from the department would be an addition then that the department should provide in terms of providing some kind of closure?</i>
<i>01:41:39 Julie Masters</i>	<i>This is a little different process than what we are talking about. The department eventually does issue an order on reconsideration expressing whether or not the worker ever got the arbiter exam and if the benefits are suspended.</i>

01:41:52 *In this case the Order on Reconsideration did indicate it. It said the worker's  
Spencer benefits are suspended. My phone call to the department said that wasn't true.  
Aldrich*

01:42:10 *It sounds like WCD is not using the information. The rule could require a letter  
Julie Masters from the insurer to the worker saying that the worker has cooperated and now  
will receive benefits. There should be something.*

**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.

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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?

***Speaker & Committee comments  
Time***

01:43:53 *No.  
Julie  
Masters*

01:43:57 *I don't see as much reason to provide them a copy of the CDA as a copy of the  
Keith DCS to tell them they can expect such amount to be paid.  
Semple*

01:44:16 *Is there some reason why the worker can't provide that or the worker's attorney?  
Dan They're the ones dealing with the provider and if they have to pay a balance. They  
Schmelling have a copy of the finalized DCS.*

01:44:41 *Do we send a letter when we DCS the claim saying there's a denial final to  
Julie providers?  
Masters*

01:45:08 *Yes, it would go on the EOB with a check. If we are paying on the settlement it  
Dwayne comes with a check.  
Yoder*

01:45:25     *Can't compromise medical.*  
*Fred*  
*Bruyns*

01:45:31     *Speculating on a situation where you CDA claim, and that claim may be treated as closed for purposes of palliative and things like that. It seems like after a CDA the claim is treated as closed. The doctors do get a notice when claims have been closed, notifying them of palliative care requirements. That's the only thing I can think of how the provider would somehow be in need of information about a CDA.*

01:46:27     *CDA does not mean the claim is closed, because many claims are CDA's prior to closure. In my opinion, the requirements regarding when the worker is medically stationary, palliative care, and what not, those requirements are separate from the CDA.*

**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.

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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.

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

01:48:41     *Is the question even clear?*  
*Fred Bruyns*

*Committee*     *No.*

01:49:21     *It seems like it's a solution in search of a problem. To me the rule says the insurer pays interim comp unless the employer elects to pay. I think in general there's an option for the employer to pay the compensation instead of the insurer if that's the way they want to process the claim. I don't see a need for a change in this unless somebody else does?*

01:50:20     *Does it duplicate rule 0020? Maybe it's partially or completely unnecessary to have it here?*  
*Fred Bruyns*

01:50:29 *I don't think so. Rule 020 says the employer has the option to pay the  
Julie Masters compensation but this rule says the insurer must pay it – then there would be an  
inconsistency. I think it's consistent with 0020, but it could be written  
differently. The insurer or the employer under rule 0020 must pay compensation  
due.*

01:51:00 *Is it trying to say that someone has to pay it? It's either the insurer or the  
Dan employer.*  
*Schmelling*

01:51:21 *It sounds like it's not a source of concern for anyone?*  
*Fred Bruyns*

01:51:26 *I've never encountered it on behalf of claimants.*  
*Keith Semple*

**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?

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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?

#### *Speaker & Committee comments Time*

01:53:22 *Would agree that rule should be changed to reflect that mailing it by the required  
Keith date is sufficient.*  
*Semple*

01:53:33 *I don't have a concern either way, but I'm wondering if that ten days to receive  
Dan was because of the tight time frames between the WRME and if there's already a  
Schmelling hearing scheduled, that they wanted to make sure everything was done timely so  
that the WRME report was available for the hearing. This is why there is the must  
be received within ten days versus mailed within ten days. I don't know if that few  
days would make that big of a difference.*

01:54:03 *It's getting more and more difficult to get mail from one point to another. It's very  
Keith difficult to predict when something might be received on the worker's end.  
Semple*

01:54:48 *I think it's always good to be consistent with the statute.  
Jennifer  
Flood*

**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.

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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?

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

01:56:05 *I'm trying to recall the timeline for the elective surgery request: 7 days for the  
Keith doctor to respond. 28 days for the doctor to obtain and present the item.  
Semple*

01:56:31 *It does seem short. If it results in not getting the report in time for the hearing, you  
Julie would probably get a postponement for that.  
Masters*

01:56:45 *Unfortunately, that's just part of the practice. It happens all the time in that things  
Keith get postponed for last minute evidence, including WRME's, and the five days is an  
Semple extraordinarily tight timeframe for anything to happen.*

01:56:58 *Is the IME standard 7 days or is it 14?*

*Dan  
Schmelling*

01:57:02 *That's why I pulled out the elective surgery because I knew there was a time frame attached to how long the doctor has to perform the IME. I mean, 28 days seems reasonable. 14 days seems reasonable too, but 5 days is extremely short.*

*Keith  
Semple*

**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.

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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)?

*Speaker & Committee comments  
Time*

01:59:19 *Cross reference would be beneficial.*

*Dan  
Schmelling*

01:59:34 *I would agree. There should be consistency.*

*Julie  
Masters*

**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.

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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?”

***Speaker &  
Time***

***Committee comments***

02:02:26

Julie Masters

*First, there is a merging of two separate things. If there's an IME conducted in order to close the claim – first of all that would be the basis for a WRME. It's not causing a denial. It's causing a claim closure. If the IME is being relied on to close the claim, it's not going to be good unless the attending physician concurs with it in terms of the requirements for the attending physician having to be the one who decides the findings of the claim closure. If it's that kind of IME it shouldn't even be in the discussion. The other part is should an attending physician always be asked whether or not they concur with an IME that's being used to investigate a claim for compensation. It seems like the department reached the correct answer on that before, which is they get a copy of it, they can decide if they concur or not, the insurer can decide whether or not they want to ask for that concurrence, and the worker and worker's attorney is entitled to send a copy of the IME – do you concur... or a more complicated letter with questions. That's how they do their job.*

02:04:03

Fred Bruyns

*We did talk about this at the first meeting. I think maybe Keith had raised an issue that was related. I know we talked about the deficiencies of some denial letters. Not actually stating that the denial was based on an IME, or maybe everybody just sort of thinks or knows it was. We did check, and we do get cases where the denial letter is insufficient. If a denial letter is insufficient then sometimes WRME's are denied.*

02:04:35

Keith Semple

*I wouldn't support a rule that requires the insurer to go to the doctor and solicit that concurrence or non-concurrence, but I would support a rule that says they decide not to do that then the worker becomes eligible for a WRME. That gives the insurer the option to solicit concurrence or non-concurrence, but if they fail to do that and show that they obtained concurrence in it's entirety then the worker should be able to go for the WRME.*

02:05:09

Jennifer  
Flood

*The expense of getting that doctor's concurrence shouldn't fall on the worker.*

- 02:05:22  
Dan Schmelling *My only concern is it might be based on the defectiveness of the denial letter. If the insurer obtained an IME in the compensability portion of the claim, but didn't rely on the IME... they don't have to comment on the IME, because that's not the basis for their denial. In those situations it might be appropriate to say we haven't asked the attending physician to comment on the IME, but if that is viewed as deficient language in the denial letter, and the lack of concurrence allows the WRME, then there would be situations where WRME's are granted when we never were relying on the IME before the denial to begin with. It was a compensability issue.*
- 02:06:21  
Keith Semple *I would agree. It's very rare in my experience that the insurer will obtain an IME with no intention of depending on compensability and causal relationships.*
- 02:06:48  
Dan Schmelling *It would be nice if the insurers, every time they relied on an IME, put the required language in the denial letter.*
- 02:07:02  
Julie Masters *The board's rule requires that the language be in there: the denial was based on the IME, and if the carrier fails to put that language in there, then that's why there are penalties. I think I mentioned this at the last meeting. They didn't do their denial correctly. This issue that we are talking about here is any lack of concurrence – is that presumed to be a non-concurrence. I think that the department made the right call when they wrote these rules the first time. It was determined that the statute doesn't go so far as being suggested that any non-concurrence or any not commenting one way or the other equals does not concur as is required by the statute. From SAIF's perspective, we wouldn't want a rule said anytime that there is not a comment that means does not concur.*
- 02:08:28  
Keith Semple *I read it opposite. I read it requires a concurrence to get out of a WRME. Does not concur means to me, they do not comment, they do not concur. Concurring is an affirmative action. The rule says does not concur, but that doesn't really mean silence, does not concur, it means they have to affirmatively say I don't concur. That's just not how I read that language. Obviously the department has looked at this and made a different determination.*
- 02:08:58  
Fred Bruyns *This issue has come up again and again, and we said we would bring it to this committee. We appreciate your feedback.*
- 02:09:27  
Keith Semple *What about doctors that refuse to comment one way or the other? Should that qualify for a WRME just as a policy matter? Or not? Do we want to have the ability for a worker to have a WRME if their doctor won't comment? This situation arises too and I'd imagine we would have different thoughts on that.*

02:10:01 *Julie Masters* I would say the way the statute is phrased is susceptible to more than one reading. It seems like the sort of question that should be directed to the court. I think that the director initially took the position that was maybe err on the side of not causing a number of these to be conducted. It seems like a lot of times the worker don't even want one because the same doctors who do the WRME's sometimes have the same opinion that the IME has.

02:10:52 *Keith Semple* I think that there are different camps among the claimants bar about whether you want a WRME or not. Those folks that use these run into problems with some of the hoops you have to jump through, which can be very difficult to get through sometimes. Such as if the doctor is reluctant to make certain statements or comments.

02:11:20 *Jennifer Flood* This statute was put in place to allow a worker that right to a WRME. I would think that making sure the barriers to them obtaining it – as a system we have an obligation to knock down those barriers when the statue is saying they are entitled to something. You have represented and unrepresented workers. They may not be able to understand if they do or don't qualify for a WRME.

02:11:54 *Fred Bruyns* Maybe going back to their attending physician to ask. I don't know if they would know to do that or not.

02:12:07 *Keith Semple* I would agree with Jennifer on that. For an unrepresented worker to obtain a WRME, it would be an onerous obstacle for them to overcome.

02:12:23 *Julie Masters* I wanted to bring up a related issue, which is – I don't know if it says the insurer has to send the IME to the attending physician. I think maybe it does, but practically speaking as part of the contracts, the IME companies between SAIF and them, the IME company sends a copy of the report to the attending physician. We would want the rules to reflect that.

**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?

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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?

*Speaker & Committee comments  
Time*

02:14:18 *No. I don't think you should reiterate how to count. It's already in division 001? Dan Schmelling So maybe since division 0150 is an important rule that talks about timeliness, a cross-reference back saying if you don't know how to count days look in division 001. But to reiterate it, no.*

02:14:45 *I'd support a cross-reference but it is already in the rules. Keith Semple*

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

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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?

*Speaker & Committee comments  
Time*

*Committee No.*

02:15:46 *Some employees move out of state. We've had some seasonal employees that move back with their parents out of state. Melissa Schnell*

02:16:06 *It could be a problem. Luckily a lot of our workers elect to get their benefits on a card, and so they get them right away.*  
Julie  
Masters

02:16:22 *I think this is a challenging one. It's frustrating when checks are increasingly being mailed out of distribution centers that may be on the east coast. It's hard to tell a worker asking about their time-loss check that got issued 5 days ago when they might get it when it's coming from across the country. On the other hand, I can see that it being issued every 14 days they should be within one or two days in the mail, even being mailed from across the country. I also see that it is difficult to prove when something was received, without doing a return receipt on everything. Having direct deposit be an option would be a major benefit to everyone involved.*

**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.

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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?

*Speaker & Committee comments*  
*Time*

*No comments.*

**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.

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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?

***Speaker & Committee comments***

***Time***

02:19:34 *Make it clearer.*

*Dwayne  
Yoder*

02:19:43 *Does this sentence make it clearer?*

*Fred  
Bruyns*

02:19:49 *I still don't know what it means.*

*Julie  
Masters*

02:19:57 *I think the one thing is if we match payroll...*

*Melissa  
Schnell*

02:20:01 *This is a perfect spot if we could match payroll to have an A or B option. If you are not matching payroll you should continue to pay every 14 days with a week in arrears. This gives some predictability if you are not going to match payroll.*

*Dan  
Schmelling*

02:20:23 *I have a question about the must pay within seven days, because many don't.*

*Jennifer  
Flood*

02:20:42 *Are you saying write it in that it's a maximum lag of seven days?*

*Dan  
Schmelling*

02:20:48 *I think clarifying this language would help. It would probably help us all explain it to folks who aren't initiated into the system what seven days in arrears means.*

*Keith  
Semple* *This is the language I would use, this is more or less the same language that I'm using: to pay within seven days of the date that they issued the payment.*

02:21:13 *I heard Julie say that it's still unclear. We would welcome input on a better way to state this.*

*Fred  
Bruyns*

**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.

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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?

***Speaker & Committee comments  
Time***

*02:22:52 Dan Schmelling I agree with regular and predictable monthly schedule, and that could be where you could put the example including the last Friday or the last business day, including but not limited to so that you provide the example of what it is and then say it needs to be regular and predictable.*

*02:23:12 Jennifer Flood That’s kind of how I’ve approached it being regular and predictable. I’ve had some challenges with explaining this to widows. I guess what I’m saying is I would like it to be predictable but also flexible.*

*02:24:30 Committee Discussion on when payments are started.*

*02:25:25 Dan Schmelling Is the rule addressing a claim-to-claim basis or the insurer’s practice? On the one it seems to be payment of that claim but then it goes on to talk about for example if the insurer pays on the first Monday or the last business day. Are you saying that if we’re paying on a regular and predictable schedule on claim one, but claim two is a different regular and predictable schedule?*

*02:25:56 Jennifer Flood I’m saying claim by claim.*

*02:26:00 Sally Coen Correct me if I’m wrong, but when we audit that is one of our questions, “what is your usual schedule you normally pay.” We audit to this in addition to auditing time-loss. How closely did they follow to what they said their practice was?*

*02:26:18 Dan Schmelling So we say that our regular and predictable schedule is the last business day of the month, and we have one claim out there that we deviate from that but it’s on a regular and predictable schedule, should we be making an allowance for this claim?*

*02:26:34 Sally Coen We would probably ask the question about that one claim.*

*Committee Discussion on predictable schedules.*

02:27:57 *So the real issue is that the rule says no payment shall exceed one month, but we  
Dan don't know what one month is.  
Schmelling*

02:28:06 *If you are paying on the 12<sup>th</sup> ...  
Jennifer  
Flood*

02:28:09 *That sentence refers to the amount of payment that's included in the payment. I  
Sally Coen believe we've had this conversation before.*

02:28:27 *So we are just talking about the sequence: what is the monthly sequence. So you're  
Dan saying we need to apply the monthly sequence to a regular and predictable, which  
Schmelling I would support that versus something specific like the last business day. That way  
the insurer can determine what regular and predictable is and you can audit to.*

02:28:57 *The problem that adjusters have had in the past (inaudible).  
Jennifer  
Flood*

02:29:24 *What is your reasoning behind not being able to pay more than one month at a  
Dan time? What if the insurer forgets to pay, and then you say you can only pay in one  
Schmelling month increments versus let's catch them all up at once.*

02:30:00 *It used to say you have to pay it as it's earned. We deleted that. I'm wondering ...  
Sally Coen*

*Committee Discussion on how it could be worded and scheduled.*

**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.

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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?

***Speaker & Committee comments  
Time***

***Second audio recording advisory committee meeting, OAR 436-060, Claims Administration 9/21/15, starting at 9 a.m. L&I, Room F Afternoon portion of meeting.***

01:48      *So is the suggestion if the insurer is not able to state with certainty what the underpaid is they just have to go ahead and pay?*  
Dan  
Schmelling

01:59      *Read rule to committee.*  
Fred  
Bruyns

02:56      *It rarely happens now, but when we are aware of it we have an earnings questionnaire that we send to the worker. We put the burden on them to say this is how much I'm receiving in the other jurisdiction in time-loss benefits or whatever benefits they may be. We determine if that rate's larger then our rate would be, or if not we determine the difference we need to pay. Since we quite often don't know who the other insurer is or who's processing it, the worker is the person we rely on.*  
Dan  
Schmelling

03:40      *Again, we are not talking about two Oregon claims.*  
Jennifer  
Flood

03:45      *No. We get maybe one or two of these a year. We'll find out about another claim, but they're not for the same body part. So that kind of narrows it down.*  
Dan  
Schmelling

04:00      *Is there a problem with this?*  
Julie  
Masters

04:05      *The questions that we get in the performance section are from insurers saying "what do we do." There is no procedure outlined in the rules. ...*  
Sally Coen

04:19      *We appreciate the rules are not prescriptive and allow us to manage the claim appropriately.*  
Dan  
Schmelling

04:26      *I would say if the insurer doesn't have documentation from somebody regarding the amount, then they have to pay the full benefits.*  
Jennifer  
Flood

04:55            *By us saying we are letting the worker know, your lack of response or failure to respond is an assumption you are receiving a full benefit, and we are not going to pay a difference. Yes, it is putting the burden on the worker to tell us how much they are being paid.*  
Dan  
Schmelling

05:13            *I think that is an extremely helpful practice. Personally, I'd like to see that be universal. I don't know how you do that in the context of the statute, but that would help address this problem at least to my satisfaction. It is a very rare problem. Most of the time if the worker is represented you are going to get notice.*  
Keith  
Semple

05:39            *Maybe adding to the way this rule is phrased where it says under the statute – when Oregon compensation is more than the compensation under another law. Well that's a little vague, so if it said more than the compensation that was received under a law or compensation that was paid under another law, so it would be clearer that the worker has to actually get the money before this comes into play. It's not that the law says they got some money so then you don't pay them their Oregon entitlement. There has to be some evidence.*  
Julie  
Masters

06:26            *That we actually got it. Is there any other procedural matters we should spell out in the rule?*  
Fred  
Bruyns

06:32            *Before we move, still part of this rule, I have a bit of an issue I want to talk about – subsection (5) timely payment of temporary disability benefits, says they have to be 14 days from the date of any division order including but not limited to a reconsideration order that orders payment of temporary disability. The carrier or any party has 30 days to determine whether or not they are going to appeal that order. This rule says you're late paying the time-loss if you don't pay it in 14 days even though you have 30 days to decide whether or not you appeal it. I looked at it and understand it is a question of the way the department has interpreted the statute saying that temporary disability must be paid every 14 days, but I would argue that the procedural temporary disability award in the order on reconsideration isn't subject to that. It's not a procedural time-loss or it's a substantive time-loss. It's saying you missed a period and now you have to go back and pay it. In order to make that right of 30 days to appeal that, we shouldn't be held to this rule saying that we have to pay it within 14 days.*  
Julie  
Masters

08:17            *What if the reconsideration is rescinding the notice of closure?*  
Jennifer  
Flood

08:24            *Well it's the same thing. If the carrier decides they're going to appeal that then it stays the payment. It wouldn't stay payment of ongoing time-loss. In that case they would have to start paying current time-loss due even if they pay late. This just has to deal with prior periods of time-loss if it were increased.*  
Julie  
Masters

08:50            *The past periods due, you have 14 days to pay what could have been staid had you  
Dan                appealed the order, but anything from the date of the order rescinding the notice  
Schmelling        of closure forward we have to pay that within 14 days, we have to resume paying  
                         within 14, but what had been staid or what might now be due we stay for the 30  
                         days.*

09:29            *The date that litigation authorizing retroactive temporary disability becomes final,  
Julie                but it doesn't apply or specify it applies to a reconsideration order. Instead, it says  
Masters            any division order. I would suggest that be changed.*

10:03            *Any additional thoughts on the timeframe?  
Fred  
Bruyns*

**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.

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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?

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

12:10            *Seems to me that the default should be what the worker was getting before they  
Keith                were injured. I don't see any problem with direct deposit being the default. That is  
Semple            beneficial to the majority of the stakeholders in the system. Most importantly the  
                         injured workers. However, there certainly will be people that don't have a bank  
                         account or won't want to give out their financial information, but those folks can  
                         easily ask for a paper check.*

12:46 Dan Schmelling *From a practical standpoint this might be easier for the self-insured, especially self-insured, self-administered to apply because they are both paying the benefit and dealing with the payroll. However, for an insurer for 40-50 thousand policy holders, for us to have all the direct deposit information that we need for all of our clients, to have an opt-out of direct deposit would be impractical. ... Self-insured have the integration to do this from day one. We have an opt in now and we encourage direct deposit. We like the ReliaCard. To have a blanket opt out, I'm not sure that would be feasible or practical for most insurers with that many policy holders. For those self-insureds that could do that from day one – that have that integration of payroll and workers' comp, to give them the opportunity to have we can just do this from day one, as an insurer I don't care. They are getting their benefits timely and it's less disruptive to the worker.*

14:10 Fred Bruyns *So that wouldn't be opt in or opt out, it would be if it's practical then do it.*

14:50 Melissa Schnell *We wouldn't have a direct deposit if it didn't match our payroll dates. To be timely we would have to be off schedule.*

15:04 Mark Hopkins *How is it envisioned that the insurer would obtain the direct deposit information from the employer. I'm not sure how that happens.*

15:21 Dan Schmelling *We request it from the worker. We have a form sent out that provides us their checking/savings account or whatever account they want it deposited into. They need to give us permission and give us that information. We don't go to the employer to get it. We are an insurance carrier – that is why it might be different with a self-insured.*

15:43 Unknown *We go directly to the employee or the widow.*

**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.]

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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?

<i>Speaker &amp; Time</i>	<i>Committee comment</i>
<i>17:33 Keith Semple</i>	<i>We would support change in the rule to 14 days like most of the other rules are.</i>
<i>17:59 Jennifer Flood</i>	<i>Is 14 days reasonable for most?</i>
<i>18:04 Julie Masters</i>	<i>Just in general 14 day is short for stuff, but it is consistent across the rules.</i>
<i>18:41 Dan Schmelling</i>	<i>My only concern is it's: response and provides an adequate response. Now it says: provides an inadequate response. If we don't have the information and we respond within 14 days saying here's what we can provide and we tried to gather this other information but it's with the employer, is that going to be an inadequate response? And if it's outside of our control? 14 days to turn around and ask the employer for that information, get it, and then respond to the department, might be pretty tight.</i>
<i>19:19 Unknown</i>	<i>Is that why it's maybe 21 days?</i>
<i>19:25 Mary Lou Garcia</i>	<i>If you are responding that you don't have the information to adequately respond, then that is a response.</i>
<i>19:37 Dan Schmelling</i>	<i>The rule now that if an insurer fails to respond or provides an inadequate response...</i>
<i>19:51 Fred Bruyns</i>	<i>Should it be documents in your possession?</i>

19:53 *I'd be more comfortable with that.*  
Dan  
Schmelling

19:56 *Well no, because they are likely to need to go get some documents. I don't think it would be good for them to say I'll just send you what I have.*  
Jennifer Flood

20:09 *There's an obligation to follow up and obtain that information from the employer. To do this within 14 days to make it an adequate response is one thing, but 21 days gives us a little bit more time if it's going to be determined inadequate if we don't have that additional information that has been requested, and wasn't in our possession at the time of the request.*  
Dan  
Schmelling

20:35 *The statutory scheme already provides penalties for failure to provide discovery within 14 days. I don't know why this is distinctly different. You have to go get your records from your employers to get the discovery. I keep hearing all these things that the employers are not cooperating, but there are rules that require their cooperation. I guess I don't see that being an excuse that the employers are not following the regulation or the rules. I feel for the insurers that have clients that they aren't thrilled with, but rules are rules.*  
Keith Semple

21:11 *... Are they hitting the 21 days or do they come in earlier?*  
Jennifer Flood

21:20 *Earlier.*  
Mary Lou  
Garcia

21:21 *Well, it is like a civil penalty may occur – so we did it in 14 days and it may occur and they could do the assessment on whether or not it was reasonable. I agree with Keith, if the other ones are 14 days it seems to make more sense.*  
Jennifer Flood

21:58 *Discussed that this is analogous with the discovery rule.*  
Keith Semple

**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.

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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?

**Speaker & Committee comments**

**Time**

23:23 *It might be that you don't have to issue them because the rule is in place.*

Jennifer  
Flood

23:34 *It is self-evident that you need to copy the attorney on these types of responses when you are in a legal dispute. I don't see the rule being violated that often. To the extent that the rule provides some sort of recourse for someone who does violate this rule, I proposed we raise it up to \$500.00. This hardly ever occurs, but if we get one then the department can get some benefit out of it.*

Keith  
Semple

24:27 *If it comes up it's due to oversight and human error. Everybody makes mistakes. Having a rule saying there is an additional civil penalty makes it unreasonable, but human error is not unreasonable. We would prefer having it out and are not for raising it.*

Julie  
Masters

25:40 *I think raising it is a good idea. It's here for a reason. I don't think anyone has ever not copied me, but if there is an instance where you forget to copy an attorney and you get fined and it's meaningful, you are going to be more careful about it in the future. I think it is good to have some incentive there. Obviously, \$50.00 is low in this day and age, but I think raising it a little bit might be a good idea rather than getting rid of it.*

Sydney  
Montanaro

26:10 *Removing it may send the impression that it's okay not to. There would be that question that it was in the rule but they've taken it out.*

Jennifer  
Flood

**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.

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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?

**Speaker & Committee comment**

**Time**

- 28:10  
Sydney  
Montanaro *The proposal is about stipulation, but this whole rule should be clarified. The language of the rule is confusing and needs to be clarified to include stipulations and orders from the hearings division as well. In section (3) of rule 0155 it's also confusing about what constitutes a violation. An easy fix would be to alter the definition of a violation to make clear that it includes stipulations and orders from the Hearings Division and WCD. This would be consistent with what appendix B matrix is trying to achieve, which is to penalize insurers and employers for repeated violations. I think that makes sense because claimants don't have a choice which jurisdiction they are in, whether it's WCB or WCD, so I think it makes sense and it's fair.*
- 29:23  
Julie  
Masters *This matrix is for penalties paid to the director. The title is about penalties paid to the worker. The fact that it kind of ties those two together, no one predicted that from reading the title of the rule. I think that doesn't come up that much. If parties entered into stipulation then they've agreed that either there wasn't any unreasonable action, or if there was they've agreed to an amount. Sometimes they stipulate to get it resolved. To have that be the basis of a penalty that the director is going to assess against the insurer to the director – seems like all the stipulations should be excluded. Doesn't come up that much for us.*
- 30:52  
Fred  
Bruyns *Appendix B – how many days late you are – those penalties are payable to the worker?*
- 31:10  
Jennifer  
Flood *There are times when an adjuster may pay a penalty on a late payment just by agreeing to do so that's not in an order or anything, and I know that annoys some people because it can't be added on, but it resolves the issue at the point in time. I see it as one claim, and if there were late payments and a penalty was assessed through an ALJ, and late payment was assessed through WCD, or the penalties that were assessed through a stipulation, it's all happening to the same worker. This is kind of a repeated offense, and that's why I think all of them for that claim should be counted in the matrix.*
- 32:14  
Julie  
Masters *I apologize for not really understanding this. I agree with the theory that if the carrier is basically stiffing the same worker over and over again the consequences should be greater.*
- 32:41  
Sydney  
Montanaro *That's what the division states here that that's what its policy is, but I do think the language is a little confusing. Making it clearer would be helpful.*

32:54            *On the other hand, if they stipulated to something maybe it included an understanding (inaudible) time.*  
Julie  
Masters

33:03            *Sometimes the stipulation may say sometimes we agree to disagree. The worker says this action was unreasonable and insurer contends it wasn't and we agree to resolve it through a stipulation – this is what you are going to get. It's kind of hard to argue from a policy perspective that that gets counted even though we agreed to disagree. If I'm the attorney and I'm really upset with the insurer that keeps jerking us around, I'm going to say no; I'm not going to agree to disagree. I'm going to take my thing to the department.*

34:39            *I would add that I think most of these get resolved over at the board. You can plead any type of issue and it takes it out of director's jurisdiction. I think a majority of these go over to an ALJ. By allowing one kind of order and not another is sort of inconsistent.*

**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.

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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?

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

36:17  
Dan Schmelling      *Just wondering why would there would be a 656.307 issue if the insurer voluntarily reopened a boards own motion claim. It should only be when the insurer sends a recommendation that the claim not be voluntarily reopened, and they're sending their response to the board saying no. Otherwise, there is no issue on responsibility. In that case you would still need to go to the board, but the voluntary resolves the responsibility issue. When you send the 3501 you are voluntarily reopening it under the boards own motion. For practical matters I don't see it having an impact, but it still needs to be in there for when you have those instances where it's not voluntarily reopened someone needs to go to the board.*

37:51  
Jennifer Flood      *Would current statement be sufficient?*

38:23  
Dan Schmelling      *Yes. Is compensability an issue? No.*

**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."

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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?

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

40:05  
Julie Masters      *I think that if someone wants to get reimbursed they have to show they paid the money. If that is the suggestion to add something about what the non-responsible insurer needs to do to recoup their payments, then maybe it should say that – If that is what the question is.*

40:40  
Fred Bruyns      *I guess it is the type of documentation that would have to be provided. There is kind of a missing step. I guess it would make it clearer for some people, but I think it's a fairly rare occurrence. Would there be any concerns about doing this?*

41:05 *Not really. That's what you have to do to get reimbursed for something. You have to show you paid it, you have medical bills and your EOB, temporary disability, or some sort of pay-out record.*  
Julie  
Masters

41:26 *I was curious even though it's missing a piece but still happens, what is it that WCD wants?*  
Jennifer  
Flood

41:49 *Information sufficient to resolve the dispute between two insurers.*  
Dan  
Schmelling

41:53 *When we are having the insurer asking which one I need to submit to for reimbursement because they are not reimbursing (inaudible) to support your request for reimbursement.*  
Melissa  
Schnell

42:10 *I would think that you'd take steps to not have it come out of the fund. That you try to resolve it between the parties.*  
Jennifer  
Flood

42:26 *It kind of implies it's the insurer's responsibility to make their case. Short of explaining what that is because each case could be different, so maybe it needs to say if there is a dispute you need to write to the division. Beyond that the insurer that has the issue could be spelling out what the issue is.*  
Dan  
Schmelling

44:04 *You would prefer to be less detailed?*  
Fred  
Bruyns

44:08 *Keep it simple. Once you start outlining too many rules people get more confused.*  
Melissa  
Schnell

44:37 *Julie provided a case example.*  
Julie  
Masters

**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.

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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?

***Speaker & Committee comments.***

***Time***

46:15            *No concerns about this.*

*Keith*

*Semple*

**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).

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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?

***Speaker & Committee comments***

***Time***

48:16            *Are you trying to get to situations where there might be a supplemental disability overpayment that your processing agent has identified, and then you want to take that overpayment and apply it to benefits that the insurer paid in the related claim that gave rise to the supplemental disability? Provided an example.*

*Dan*

*Schmelling*

49:22

*Sally Coen*

*I know that situation was not litigated where (inaudible). I don’t remember that circumstance.*

49:34

*Mary*

*Schwabe*

*I don’t remember either, but there were a cluster of cases where all of them seemed period of time. DOJ said you shouldn’t be limiting yourself to official audits. If the department identifies an overpayment they should be recouping.*

50:04            *As a practice SAIF administers their own supplemental disabilities program. If we  
Dan                identify an SDB overpayment, we are going to recoup it from future time-loss  
Schmelling        payments in that claim or other claims as we are able to do, and in future  
                      permanent partial disability as we are able to do.*

50:25            *When do you pay back the department?*  
Jennifer  
Flood

50:27            *Then we reimburse the department when we recoup that money. SAIF has an  
Dan                internal audit process where we identify any recovered overpayments that were  
Schmelling        previously reimbursed by the department to make sure that WBF money goes back  
                      as appropriate. We would not have any concerns with this administrative rule.*

**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.

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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?

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

52:33            *(inaudible) This is saying we won’t approve settlements that waive overpayments  
Jennifer            involving WBF reimbursements.*  
Flood

52:50            *Ultimately comes out of WBF, so maybe that is what we meant?*  
Fred  
Bruyns

52:57            *SAIF agrees that could benefit from some clarification that approval of the  
Dan                settlement and approval of the reimbursable amount out of this settlement needs to*

*Schmelling* be distinguishable so that insurers clearly know they need to go to the division first to have their settlement approved for the reimbursement portion before it goes to the workers' compensation board for approval of the settlement; however, I would disagree with the waiving of the overpayments. There may be situations where the insurer is able to demonstrate significant future exposure of SDB out of the WBF. It may behoove the department to go ahead and approve the waiver of the overpayment given the exposure in the future of the supplemental disability amounts.

**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.

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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.

### *Speaker & Committee comments*

<i>55:30 Julie Masters</i>	<i>We talked about the date stamp before. Maybe we already talked about some of this in terms of rules, but tend to identify an image of a piece of paper that may still look like a piece of paper but other times it's more like a data stream. It doesn't look like a piece of paper and doesn't get communicated as a piece of paper. To the extent that the rules can anticipate that it would be better.</i>
<i>56:12 Fred Bruyns</i>	<i>Such as when the rules prescribe a form be used? I would like any comments on best methods for communicating with workers: is there a lot of email communication going on, are there privacy issues, all sorts of things to be considered.</i>

57:10 *I just quickly went to division 060-0140 acceptance or denial of a claim, and sub  
Dan (3) says insurer must give the claimant written notice of an acceptance or denial.  
Schmelling We communicate a lot with workers my email right from the start of the claim. The  
worker gives us their email address.*

57:28 *That's written notice. At least in division 050 it's defined as including electronic,  
Fred but I'm not sure we have that in 060. Maybe that is something we could have.  
Bruyns*

57:50 *Workers really run the gamut in terms of how tech savvy they are. One size fits all  
Keith doesn't work for injured workers.  
Semple*

58:35 *We agree we don't want to force this on the worker and say this is how we are  
Dan going to communicate, but we should be allowed to communicate in that manner.  
Schmelling*

58:41 *Division 060 defines "written." Read definition to committee.  
Cara  
Filsinger*

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

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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?

***Speaker & Committee comments  
Time***

01:04:05 *I think that we have a statute that clearly says here's the condition of which the  
Julie employer may be entitled to information, and they have to agree to keep it  
Masters confidentially. For the department to extrapolate on that to say this type of  
information but not that type of information would seem to be beyond the scope of  
that statute.*

01:04:48  
Mark Hopkins  
*Without access to information that's contained in a claim including medical information – two things here: one, in our company we actively manage our claims and we don't rely entirely on our insurer to do that for us, and secondly, how does an employer gage the performance of the insurer on whether they are doing what they need to do if they don't have access to that information. I struggle with this one, because even in our company we have a limited amount of people that are able to see and work with that information, similar to HR. I don't see any difference between an HR scenario and a workers' compensation scenario. Having said that, how are you able to manage the claim, work with the insurer, and assess the insurers performance if you don't have access to it?*

01:06:21  
Jennifer Flood  
*I believe that it's important for employers to have return to work restrictions so that the worker can safely return to work. Coming from a worker's perspective, my employer having my medical record and everything that is going on, even outside of workers comp, medical records don't come in with HIPPA, FEMLA, and all that stuff. It's troubling that when a worker believes or knows that their employer is getting their complete medical record when it has nothing to do with their job ... where that blends together is when the worker is being released or potential of being released to modified work in making sure their job duties and restrictions they are put on are fully understood.*

01:07:26  
Melissa Schnell  
*I would agree with Jennifer. It opens Pandora's box, and there are ways you can identify if your carrier or TPA is not being proactive in handling claims, because you will see more disabling claims, extended modified work, and increased litigation cost because they are denying everything. There are other methods of them looking at the actual medical record to determine whether they are adequately being proactive in managing the claim.*

01:08:08  
Dan Schmelling  
*I field that lots of phone calls from both workers and employers regarding this topic, and I think that everyone here can look at the statute and what it means, but when we are talking about plain language no place does it say "hey employers all you get is this medical information to help with the return to work process." So you have employers out there demanding it of their insurers, and claims adjusters that don't know enough to say I don't have to provide it because there is not that plain language that says employers you don't get it. I don't think we need something in the administrative rules, but it would be nice if there were some type of plain language that just said employers you get return to work information only. I think this is the disconnect.*

01:09:42 *There's intention inherent in it and maybe employers want stuff that technically they could be entitled to under the statute, but do they really need it? Does it protect the worker's confidentiality? One the other hand, if you were to make a rule that says they are only entitled to the return-to-work information, then how does that fly when the matter goes to a hearing and you have an exhibit list with employer testifying, and reading an order that describes medical information that needs to be weighed in order to determine issues in litigation. Happily, most claims don't litigation, but then all that would be in violation of that rule. I think that the statute tried to find a balance there. I guess it's up to training the adjusters to say we don't feel that it's necessary for you to have this.*

01:11:27 *I think there is a big difference between an opinion and order, which discuss findings versus medical terms. HIPAA laws become stricter over the years. If I were an injured worker I would not want my employer to see my family history ... or what medication I'm taking.*

01:12:21 *We wouldn't want our adjusters to have that responsibility to share that information with the employers. It's not their information but the workers information.*

01:12:37 *Obviously this is a concern for injured workers, especially those that are required to attend insurer medical examinations that don't come back very favorable. It can have an extremely detrimental impact on the employment relationship. For injured workers, that is one of the biggest concerns – the opinion of one doctor can have an extreme affect on worker. All the family medical history and other medical history that is often not pertinent to the claim and that being released. The other concern we would have is trying to enumerate some limitations on who gets access to that in the place of employment. I believe the Americans with Disabilities Act has some requirements in that regard. It would be nice if those requirements would be enumerated in terms of who would have access to that information, as opposed to the whole HR department. It should be a very limited amount of people if not even just one person that has the decision making authority.*

01:14:04 *Would you want that same kind of limitation if it were just limited to return to work information?*

01:14:07 *I'm not as concerned about the return to work information because it doesn't tend to contain a lot of the other medical information that would be viewed unfavorably by an employer. It just says if they are released to work or not. The concern is where there is substantive medical history and information that would otherwise be protected in the context of any other discussion, and suddenly isn't protected because it's a workers' comp claim. There has to be some balance I understand between an employer's decisions about the claim and reviewing what their insurer is doing, but the privacy of the worker – we don't want that to go out the window when it comes to a comp claim. This is an important issue and a challenging one though. In general the statute is fairly clear but it would be nice to have a little bit of enumeration to flush it out.*

01:15:22 *From an employer's perspective I can see where in smaller employers, sharing this type of inform inappropriately could probably happen a little easier than in a larger company when they have set rules and staff that deal with this stuff all the time. A company like my own would have strict procedures and vetted people that do this as their job. I want to make sure you all understand that for an employer like us to do our job properly, we need to have access to a certain amount of records. What those records are, I'm not here to suggest to you what they might be, but we need some because we can't do anything without it. Everything from return to work information to basics of the medical information of things that are pertinent to the claim – I'm not suggesting things that are not pertinent to the claim. Give employers a chance to do the job.*

**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.

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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.

*Speaker & Committee comments*

*Time*

*01:17:35 Asked for additional comments in writing within the next 30 days.*

*Fred*

*Bruyns*

*01:18:59 End of meeting.*