Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR chapter 436, divisions 060 and 075

Implementation of House Bill 2338 | worker-requested medical exams | other issues

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Aug. 23, 2017, 9:30 a.m. to 11:30 a.m., Pacific Daylight Time Room F (basement), Labor and Industries Building, 350 Winter Street NE, Salem, Oregon Teleconference: 1-213-787-0529 | Access code: 9221262#
Facilitators:	Chris Clark and Fred Bruyns, Workers' Compensation Division
9:30 to 9:35	Welcome and introductions; meeting objectives
9:35 to 11:25	Discussion of issues – see attached.
11:25 to 11:30	Summing up – next steps – thank you!

Attached: **Issues document**

DIVISION 060 – RULES ADDRESSING WRME ELIGIBILITY AND FATAL BENEFITS ISSUES DOCUMENT FOR AGENCY ADVISORY COMMITTEE MEETING
August 23, 2017

ISSUE #1318 – OAR 436-060-147(1)(c) - "WRME Eligibility"

Issue: Should a worker be eligible for a WRME if the attending physician has not responded to the IME report that the denial of the workers' claim was based on?

Background: Statute provides that a worker may receive a worker requested medical examination (WRME), paid for by the insurer, if the insurer relies on an insurer requested independent medical examination (IME) report to issue a compensability denial, the worker timely appeals the denial, and the worker's attending physician (AP) or authorized nurse practitioner (ANP) "does not concur" with the IME report. See ORS 656.325(1)(e) and OAR 436-060-0147. At issue is the interpretation of "does not concur."

Currently, the division interprets the phrase "does not concur" to mean the AP or ANP has provided a response to the IME report that demonstrates a lack of agreement. If the AP or ANP did not comment on the IME report, the division will deny a request for a WRME, reasoning there is not evidence that the AP or ANP "does not concur" with the report. Two ALJs recently issued orders reversing WRME denials issued for this reason, arguing our interpretation of "does not concur" was inconsistent with the terms of the statute. The division has also received feedback and testimony from several stakeholders expressing disagreement with the division's interpretation of the statute.

In addition to the disagreement with the division's interpretation of the statute, stakeholders, including the Management Labor Advisory Committee (MLAC), have suggested that expanding access to WRME's may help reduce the perception of bias in the IME system. In its final report, dated January 18, 2017, the MLAC IME Subcommittee identified the requirement that the worker's attending physician specifically not concur with the IME report as "particularly stringent." The final report included a recommendation to "Allow a WRME if the attending physician sends written objections or provides no response to the IME report within 30 calendar days from the date of the insurer's denial."

The division would like to amend the rule to be consistent with the MLAC recommendations.

Alternatives:
- No changes
- Amend OAR 436-060-0147(1) to interpret "does not concur" in ORS 656.325(1)(e) to allow a WRME when there is no response to the IME report from the AP or ANP within 30 calendar days from the date of the insurer's denial. If this alternative is implemented, one or more of the following changes may also be necessary:
    - Amend OAR 436-060-0140(8)(d) to provide insurer must provide contact information for worker to obtain information about WRME's "If paragraph (8)(a)(B) or (8)(a)(C) of this rule applies"
    - Amend OAR 436-060-0147(2)(e) to clarify that documents that demonstrate that the AP or ANP did not concur with the IME report is only required "if available."

- Other

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1340 – OAR 436-060; 436-075-0020 - "New rules for death benefits."

Issue: Several rules address fatal benefits, but many issues remain unclear. A new rule addressing fatal benefits processing could resolve longstanding confusion on how to process these claims and improve benefit delivery.

Background: ORS 656.204 provides for benefits when a worker dies from a compensable injury. These "fatal benefits" include payment of the costs of final disposition of the body and funeral expenses, and monthly benefits to the worker's spouse, children, and other surviving dependents. ORS 656.208 provides for these benefits to be paid when a worker dies during a period of permanent total disability and leaves a surviving beneficiary.

Several rules currently address aspects of fatal claims:

- OAR 436-060-0012 provides requirements for notices and correspondence following the death of a worker.
- OAR 436-060-0140(5) provides instructions for issuance of the Notice of Acceptance on a fatal claim.
- OAR 436-060-0140(11) provides that The cost of final disposition of the body or funeral expenses are not payable
- OAR 436-060-0150(6) provides timeframes for payment of fatal benefits.
- OAR 436-030-0015(c)(B) provides instructions for the simultaneous issuance of an Updated Notice of Acceptance and Closure in the case of an instant fatality.
- OAR 436-035-0018 provides for closure of a claim following the death of a worker.
- OAR 436-075-0020 and OAR 436-075-0040 provide for retroactive program reimbursements on fatal benefit claims.

The division believes a new rule providing specific guidelines for the processing and payment of fatal claims could clarify some longstanding issues related to fatal claims. In addition to consolidating some of the rules above (particularly claim processing requirements found in OAR 436-075), topics the new rule may address are discussed in the following sub-issues. The division would also appreciate recommendations about other areas of fatal benefit administration that are unclear and could benefit from rulemaking.

ISSUE #1340.1 – OAR 436-060; 436-075-0020 - "New rules for death benefits."

Issue: ORS 656.228 does not provide clear guidance on how an insurer should stop payments to a parent or guardian and begin payments to a child or other beneficiary that becomes independent.

Background: ORS 656.228 provides that an insurer may make pay benefits directly to a beneficiary, if sui juris; or directly to the parent or guardian of the beneficiary if otherwise. The law does not provide clear guidance to when or how an insurer should stop payments to a parent or guardian and begin payments to a child that becomes independent.

The term "sui juris" is not defined in statute. Black's law dictionary defines "sui juris" as "having capacity to manage one's own affairs" and "possessing full social and civil rights; not under any legal disability, or the power of another, or guardianship." Under Oregon law, a person often becomes sui juris at the age of 18, or upon marriage. In addition, under ORS 656.132 a minor working at an age legally permitted under Oregon law is also considered sui juris.

HB 2338 (2017) requires fatal benefits to be paid to a child until the age of 19, and also restructures the benefits for children and dependents who receive benefits while attending higher education. Because more beneficiaries may be receiving benefits while sui juris under the new law, the division believes that it would be beneficial to provide clearer guidelines for the notification of beneficiaries of their right to be paid compensation directly, and the process for an eligible beneficiary to make claim on compensation due.

Alternatives:

- Require insurer to cease paying benefits to a parent or guardian and start paying benefits to an eligible beneficiary upon notice that the beneficiary has become sui juris.
- Require insurer to notify eligible beneficiaries of entitlement to benefits before the beneficiary's 18th birthday.

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1340.2 – OAR 436-060; 436-075-0020 - "New rules for death benefits."

Issue: Some insurers believe a workers' death requires claim to be reopened and closed. This is not necessary to begin payments under ORS 656.208.

Background: ORS 656.208 provides fatal benefits to surviving beneficiaries when a worker dies during a period of permanent total disability. Some insurers reopen the claim and send an Updated Notice of Acceptance at Closure when this occurs; however, these claims are already closed and a new opening is not necessary to begin payments of benefits under ORS 656.204. The division believes making this clarification in rule could reduce confusion over processing these claims.

Alternatives:

- No changes.
- Provide that no Updated Notice of Acceptance at Closure is required when a worker dies during a period of permanent total disability in new rule.
- Provide that no Updated Notice of Acceptance at Closure is required when a worker dies during a period of permanent total disability in OAR 436-060-0140.

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1340.3 – OAR 436-060; 436-075-0020 - "New rules for death benefits."

Issue: It is not clear that temporary or permanent disability must be paid up to date of death if there are surviving beneficiaries, and through the date of death if not.

Background: OAR 436-075-0040(2) provides that permanent total disability benefits must be paid to the date of death, at which time fatal benefits will begin. Where fatal benefits are not due, permanent total disability benefits must be paid through the date of death.

The division would like to move this claims processing requirement to the new rules in division 060. In addition, the division is reviewing the appropriateness of the two different standards for payment of permanent total disability benefits. If possible, the division would like to simplify the rule to provide that permanent total disability benefits are always payable through the date of death, and that benefits to surviving beneficiaries begin to accrue the day after the date of death.

Alternatives:

- Move OAR 436-075-0040(2) to OAR 436-060
- Amend rules to provide that permanent total disability benefits must be paid through the date of death, and fatal benefits begin to accrue the day after the date of death.

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1340.4 – OAR 436-060; 436-075-0020 - "New rules for death benefits."

Issue: There are no clear guidelines for what documentation may be used to support a dependent's claim for fatal benefits.

Background: Under ORS 656.204, if a worker leaves a Parent, grandparent, stepparent, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker, a monthly payment must be made to each dependent that is equal to 50 percent of the average monthly support the dependent actually received from the worker during the 12 months preceding the occurrence of the accidental injury.

The issue of what documentation is sufficient to establish dependency and calculate benefits has been litigated several times (see *Gallegos v. Amalgamated Sugar Co.*, 81 Or App 68, 72 (1986) for one example.) The division would like to provide guidance to insurers on what documentation may be acceptable, and would appreciate input on what types of financial or other evidence are commonly

received to support a claim for dependent benefits. Some examples may include bank statements, receipts, or billing statements.

Alternatives:

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1340.5 – OAR 436-060; 436-075-0020 - "New rules for death benefits."

Issue: Insurers sometimes pay monthly benefits in advance, often leading to overpayments.

Background: Insurers sometimes pay monthly benefits in advance, often paying every four weeks instead of every month. When this happens, overpayments may accrue, sometimes for several months' worth of benefits. At some point, the insurer may recover the overpayment, interrupting the beneficiary's payment schedule. To prevent this from happening, payments for monthly benefits (PTD and Fatal) should be made for benefits that have already accrued, not for future benefits.

Before 1996, OAR 436-060-0150 provided that "subsequent payments of permanent disability and fatal benefits are made in monthly sequence *as earned*," (Emphasis added) but this language was subsequently removed. The division believes establishing a similar provision in the current rules may help clarify this requirement.

Alternatives:

- Add a paragraph to OAR 436-050-0150(6)(b) providing that benefit payments under that subsection must not be made in advance.
- Other

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1339 – OAR 436-060; 436-075-0020 - "Eligibility for Higher Education Benefit on Fatal Claim"

Issue: The rules lack clear guidelines for processing claims for higher education benefits as provided by HB 2338 (2017).

Background: HB 2338 (2017) amends ORS 656.204(8) to provide:

> "If a child or dependent is between 19 and 26 years of age at the time of a worker's death, or becomes 19 years of age after the worker's death, monthly benefits must be paid for not more than 48 months until the age of 26 during a period in which the child or dependent is completing secondary education, is obtaining a general educational development certificate or is attending a program of higher education. The child or dependent must provide an insurer or self-insured employer with documentation that enables the insurer or self-insured employer to determine the child's or dependent's eligibility for monthly benefits."

The division would like to clarify the procedure for a beneficiary to claim these benefits, and for an insurer to process the claim in rule, and the applicability of the new provisions to existing claims. The division would also like to address several long standing questions on eligibility for education benefits including whether or not benefits are payable during summer breaks.

In addition, the law requires a child or dependent to provide "documentation that enables the insurer or self-insured employer to determine the child's or dependent's eligibility for monthly benefits." The division would like to clarify by rule what documentation is acceptable, when this documentation must be provided.

Many US colleges and universities provide enrollment verification through the National Student Clearinghouse during an academic term. Academic transcripts also can establish dates of attendance and course loads after the term is completed. Secondary education institutions and GED programs may provide similar documentation. The division believes that these would be acceptable forms of documentation, and would like input on what, if any, other forms of documentation are commonly submitted.

These benefits are sometimes poorly understood by beneficiaries. The division is also considering including a requirement for insurers to inform potential benificiaries of how and when they can claim higher education benefits before other monthly benefits under ORS 656.204 terminate.

Alternatives:

- No changes
- Establish guidelines for child or dependent to claim higher education benefits and provide proof of enrollment.
- Clarify whether benefits are payable during summer breaks:
    - Beneficiary may only claim benefits for months in which they attend classes at least one day.
    - Beneficiary may claim benefits for regular breaks, assuming they were enrolled in the previous term.
- Require insurer to notify child or dependent of education benefit requirements:
    - When benefits become payable to beneficiary (see ISSUE #1340.1)
    - Prior to termination of other benefits (i.e. 19th birthday.)
- Other

Discussion:

Fiscal and economic impacts, if any:

ISSUE #1165 – OAR 436-060-0150(6) - "Death during Permanent Total Disability"

Issue: OAR 436-060-0150(6) provides timeframes for payment of fatal benefits, but does not address when payment of fatal benefits must begin under ORS 656.208.

Background: OAR 436-060-0150(6) provides that fatal benefits under ORS 656.204 must be paid no later than 30 days after the date of a notice of acceptance or the date of any litigation order which orders benefits. The rule should also provide for timely payment of fatal benefits following death during a period of permanent total disability.

According to an industry notice published by the division on November 9, 2015, "any monthly surviving spouse or dependent benefits due must continue on the established PTD payment schedule, and burial benefits must be paid to the beneficiaries/estate of the injured worker within 30 days of the injured worker's death."

Alternatives:
- No changes
- Amend OAR 436-060-0150(6) to provide that monthly surviving spouse or dependent benefits due must continue on the established PTD payment schedule, and burial benefits must be paid to the beneficiaries/estate of the injured worker within 30 days of the injured worker's death.

Discussion:

Fiscal and economic impacts, if any:

Housekeeping Issues:
- ISSUE #1368 – OAR 436-009, 436-010 Appendix A
    - Amend rules to refer to "osteopathic physicians" instead of "doctors of osteopathy" as required by HB 3363
- ISSUE #1367 – OAR 436-010-0265(10)(b)
    - Move the requirement for an insurer to forward a copy of the signed IME report to the attending physician to OAR 436-060-0095.
- ISSUE # 1301 – OAR 436-060-0025(4)(b)(a)
    - The current rule states that an insurer must exclude any extended gaps in *employment* that were not anticipated in the workers' wage earning agreement when calculating a worker's average wage. This does not clearly communicate the rule's intent that a leave of absence, or a period when a worker does not work without pay for more than 14 days is an extended gap even when the worker is still in the employment of the employer. The language may also be read to include the off season of a seasonal worker who was not guaranteed a job in the next year. The division intends to correct this error by changing "employment" to "earnings."
- ISSUE #1274 – OAR 436-060-0025(4)(c)
    - A stakeholder commented that it is not clear that the analysis of when a new wage earning agreement begins included under OAR 436-060-0025(4)(b)(B) also applies to

OAR 436-060-0025(4)(c). The division intends to restructure the rule to clarify that when a wage earning agreement has been changed due to reasons other than a pay raise, it is a new wage earning agreement for the purposes of the rule.

- ISSUE #1366 – OAR 436-060-0147(6)
    - Clarify that rule requires only requires the worker or workers' attorney to schedule a date for the WRME and inform the director and insurer of that within 14 days of the directors' notice, and that the WRME itself may take place outside of that 14 day window.
- ISSUE #1159 – OAR 436-075-0001 to 436-075-0003, OAR 436-075-0006.
    - Combine all into OAR 436-075-0003 "Purpose and Applicability."
- ISSUE #1160 – OAR 436-075-0005(9); OAR 436-075-0020(3) - "Social Security Offsets"
    - Delete definition of "Social Security Offset" in OAR 436-075-0005(9). Social security disability benefits of a surviving spouse only offset for fatal claims with a date of injury between July 1, 1973 and April 1, 1974.
- Issue #1166 – OAR 436-075-0010(4)
    - The reference to ORS 656.054(3) should be corrected to 656.054(2).
- Issue #1152 – OAR 436-075-0065(1)
    - Clarify that to be eligible for reimbursement from WBF, a settlement of claims disposition must be reviewed by WCD before it is submitted to WCB for approval.
- ISSUE #1154 – OAR 436-075-0070(5) - "Form and Format of Reimbursement Requests"
    - The rule requires retroactive reimbursement requests to be submitted in the format prescribed by the director, but does not reference specific guidelines or where to find them. Reference Bulletin 102 and Form 3285 in the rule.