

Rulemaking Advisory Committee Meeting
Revisions to rules to reflect Supreme Court's decision in
[Brown v. SAIF Corporation, 361 Or 241 \(2017\)](#)

April 20, 2017

9 a.m.

Workers' Compensation Division
350 Winter St NE, L&I Bldg Rm 260
Salem, Oregon

Committee Members Present*:

Andrea Giddings, CFM Strategic Communications, Inc.
Andrea King, Liberty Mutual Insurance
Andrew Wilson, TriMet
Angelina Vega, AIG Insurance
Billie Farris, Zenith Insurance Company
Bin Chen, Reinisch Wilson Weier PC
Dale Clough, Travelers Insurance
Dan Schmelling, SAIF Corporation
Elaine Schooler, SAIF Corporation
Jaye Fraser, SAIF Corporation
Jennifer Flood, Ombudsman for Injured Workers
Joe Martinez, Concentra
Joslyn Keating, Cummins, Goodman, Denley & Vickers P.C.
Julie Masters, SAIF Corporation
Julie Riddle, The Hartford
Julie Tucker, SALEM HEALTH
Karen Nitsch, AIG
Keith Semple, Johnson Johnson Larson & Schaller PC
Kimberly Wood, MLAC | Perlo Construction
Laurel Gunderson, Providence Health Services
Mary MacDuffy, Integrity Medical Evaluations
Mike Van Leuven, Integrity Medical Evaluations
Paul Altstadt, Matrix Absence Management
Rafael Barajas, ATI Specialty Alloys and Components
Richard Pike, Nationwide Insurance
Ryan Denno, Mason & Weeks Vocational
Ryan Weeks, Mason & Weeks Vocational
Shawn Hjort, PARKER | SMITH | FEEK
Sheri Sundstrom, Hoffman Construction
Tim Simmons, COMPRO Inc.

Department Staff Present:

Cara Filsinger
Cathy Ostrand-Ponsioen
Danae Hammitt
Denise Williams
Fred Bruyns
Jennifer Millemann
Jim Van Ness
Louis Savage
Nathan Johnson
Robert Andersen
Sally Coen
Tasha Chapman
Troy Painter

*Some customers who joined the conversation by telephone might not be listed.

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Minutes

Please note: Committee members' comments are summarized and paraphrased, and some are not in the sequence presented at the meeting. For a complete record of the meeting, please refer to the audio recording posted to <http://wcd.oregon.gov/laws/Pages/2017-information.aspx>.

Fred Bruyns opened the meeting, thanked the members for participating, described the advisory committee process, and asked for advice on fiscal impacts of potential rule changes.

Overview of *Brown v. SAIF Corporation*

Cathy Ostrand-Ponsioen described the general effects of [*Brown v. SAIF Corporation, 361 Or 241 \(2017\)*](#). The Supreme Court issued its decision the end of March. The Court's decision alters the meaning of "compensable injury." When the Court of Appeals issued its opinion in 2014, the Workers' Compensation Division looked at the rest of the statute where the term compensable injury and similar terms are used, and identified areas where we would change the rules to encompass conditions directly resulting from the work injury. The affected rules were primarily those addressing claim closure and permanent impairment. With the Supreme Court reversing the Court of Appeals decision, we reviewed our rules and decided upon some very narrow changes – removal of references to "conditions directly resulting from the work injury." The temporary rules were effective April 11. We wish to have the committee's advice on the temporary rule changes and whether other rule changes should be made as a result of the Court's opinion. Temporary rules may only remain in effect for 180 days. We have heard from a couple of folks already that we do need to make more changes.

Temporary rules

The committee did not discuss the temporary rules in depth, but proceeded to recommend changes to the rules that are adopted to replace the temporary rules.

Terminology

Elaine Schooler: We recommend that the following rule be revised to refer to the accepted condition instead of to the injury (in addition to the ones requested by SAIF Corporation in writing on 4/19/17 – relevant rule extracts provided at the meeting and [posted to the division's website](#)): 436-010-0280(5)(a) and (b).

Fred then referred to agenda item #6: "Terminology – The statute uses various terms: accepted injury, accidental injury, compensable industrial injury, compensable injury. The term "compensable injury" is used throughout the rules. Is the meaning of these terms clear?" Given the Supreme Court's decision, has the meaning "compensable injury" changed, making terminology changes in the rules unnecessary? There was some committee support for this view, but in general the committee members advised that clarification would be helpful, either through use of definitions or by referring to accepted conditions throughout. Definitions in several divisions of chapter 436 might need to be somewhat different. The division was cautioned about

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having definitions in the rules that differ from the one in statute. On the other hand, people are not generally going to read the Supreme Court's decision.

Jennifer Millemann: OAR 436-035-0006 addresses compensable injury for an initial injury, for an aggravation, for an occupational disease, and for a new or omitted condition. Is that helpful? The committee members expressed some support for this approach, though one member thought we could reduce the description to three categories.

Medically stationary

Keith Semple: (Keith addressed medically stationary status and referred to the letter of advice submitted by Attorney Julene Quinn. The division made some copies of Ms. Quinn's letter for the committee, and it has since been [posted to the division's website](#).) The [Carlos-Macias](#) decision has not been overruled, so diagnostics are still available for the worker's "injury" as opposed to just the accepted conditions. The statute also says that the "worker" must be medical stationary, not the accepted conditions. ORS 656.268(1)(a). We would like some rules enshrining the arguments being made around [Schleiss](#) and that combined conditions must be accepted and denied before insurers may use that as a basis for apportionment. We would like some rules that define medically stationary in terms of the worker, and that the worker isn't stationary unless the insurer has all of the diagnostics. Claims are being closed and providers are told they cannot continue treatment. If there are ongoing diagnostics requests, that should be taken into account when determining if the worker is medically stationary – this should be enshrined in the rules. Also, many providers and workers understand closure to mean the end of treatment, and don't understand that there may be ways to continue treatment. The Brown case isn't final. We still may see more analysis from the Court, and would have preferred to wait until the decision is final. There may be additional wording that may change the discussion.

Sheri Sundstrom: The committee said something similar in regard to the Court of Appeals' *Brown* decision not being final, when we were doing rulemaking before, knowing that it was going to the Supreme Court. I'm somewhat concerned about that now.

Julie Masters: ORS 656.268(1)(a) has been interpreted repeatedly by the courts and the board to mean the compensable injury, which is those conditions accepted in the claim. This provision should be read in the context of other requirements. The idea that there cannot be claim closure without acceptance and denial of a combined condition or apportionment – the department took a reasonable approach in making these rules and the board has followed that position. There are a number of cases that are not yet addressed by the courts. Unless the courts reverse the board, it seems premature to change the rule to reflect OTLA's interpretation of the [Schleiss](#) decision. The rules suggested here pretty much hit the mark and provide a balanced approach.

Diagnostics

Jennifer Flood: If a strain is the only accepted condition, but there are other medical issues going on, for those workers' claims to get closed without getting their diagnostics for other conditions really impedes their ability to receive medical treatment. Providers will call the insurer, the

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insurer will say the claim is closed, and the providers won't see the worker any more. While the worker can file a new condition claim, that just creates a delay for the worker.

Dan Schmelling: Workers have the right to file a new or omitted condition claim. To say that the insurer cannot close the claim until any possible new or omitted condition is exhausted in its investigation, when it hasn't been brought forward, it seems we would never be able to close a claim without going to the worker and asking if they will make a claim for additional conditions, or going to the attending physician and asking if there are any possible conditions that are work related. The rules just say that if the accepted conditions and direct medical sequela are medical stationary, we may close the claim. If there are other conditions out there, chances are that at reconsideration, that closure will be rescinded. Or, if the worker requests a new or omitted condition, we are in jeopardy of having that closure rescinded. It seems we have a check and balance already in the system without rewriting rules to say you have to go through all of these steps before you close the claim.

Andrew Wilson: I don't think we should continue to chase after diagnostics after the attending physician has declared a condition to be medically stationary. The balance is already present.

Jennifer Millemann: Would education for doctors be helpful? At claim closure, a notice could go not only to the worker but also to the attending physician, explaining what claim closure means as it pertains to new medical services.

Keith Semple: That might be one part of the solution. The diagnostics at issue are ones that are pending at the time insurers are closing the claim.

Joe Martinez: The attention of the provider is focused on the accepted conditions. It would help to get some definitive language on what you want to see in closing reports, so we can address anything to the best of our ability. If you send us information, we will distribute to our providers.

Bin Chen: The department has very helpful information on its website in its provider handbooks, including information about treatment after the worker is medically stationary, but I don't think that information is widely used. Notice to providers could explain that the resources are there.

Laurel Gunderson: I am receiving a number of complaints from facilities about diagnostics that won't be approved for payment because the claim has been closed. Also, if a doctor is asked to address the accepted conditions at closure, often times that doesn't include conditions that have already been diagnosed. I think the statute requires that if the medical record shows additional conditions due to the injury, the insurer is supposed to update the acceptance. That doesn't happen. It is much easier to have providers address the accepted conditions at the time of closure. Something could be done regarding allowing diagnostics during the open period of the claim, so claims examiners really do know what should be accepted. One of the problems is that some claims examiners have huge caseloads.

Tim Simmons: Workers are almost never medically stationary – there would be combined conditions over time. They consistently get older and will get worse over time. Only the

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conditions, not the worker, become stationary. A worker may file a new or omitted condition claim at any time. You tell them that in acceptance letters.

Elaine Schooler: It is not fair to employers to bear the cost of unrelated conditions, and the system is set up to balance the interests. The option to file new or omitted condition claims is there for the worker. Our adjusters are good at recognizing additional conditions at claim closure – we don't want to have to reopen it later.

Julie Masters: Despite the Court of Appeals decision in [Carlos-Macias](#) in support of diagnostics (for the injury, not just accepted conditions), we are still hearing about problems with diagnostics. At one time, House Bill 2764 (2015) included additional provisions for diagnostics in ORS 656.245, but the bill was narrowed to focus on attorney fees. The statute says what it says, and the courts are likely to interpret the words of the law and not policy considerations about diagnostics. Claims could remain open for a very long time if there are repeated requests for various diagnostic procedures.

Ryan Weeks: The onus is falling often on the worker and the medical provider, when most of the people here represent insurers. Employers wonder why their workers haven't returned for more than a year following a back strain, when in fact there is much more than a back strain present. Even if a herniation is accepted, the employer doesn't know the difference, and that is the frustration from the vocational perspective. We see the worker, we hear from the providers, but we hear something entirely different from insurers. It isn't a worker's job to understand all of this. Where do we really want to put the influence?

Sheri Sundstrom: The attending physician is given much weight in Oregon relative to other states. I am curious how often adjusters amend the acceptance. If I had a worker with a knee injury accepted for a tear, but he is not getting better, I would be pushing for information to tell me what else is wrong.

Kimberly Wood: I am concerned with ongoing diagnostics, but at times when I have asked for a claim to be closed, the adjuster has explained that diagnostics are pending, and they need to determine whether there is something more serious. Is the problem really one of poor claims practices on the part of some adjusters and not a systemic problem? One thing I hate doing is making rules to address the outliers.

Fred asked the committee for any additional written input by early next week. Cathy asked the committee about any concerns members may have if the temporary rules were to remain in place a bit longer (though they do expire in 180 days regardless)? We might get some additional direction from the Supreme Court. No committee members expressed concerns about slowing the pace of rulemaking and leaving the temporary rules in place somewhat longer.

[Post-meeting note: The division will not file proposed rules by May 12 as announced. Fred notified committee members of this and provided additional time to provide written or telephone advice – now due by May 15.]