

**Workers' Compensation Division
Rulemaking advisory committee meeting
OAR 436-030 and 035**

**Room F, Labor & Industries Building, Salem
Tuesday, November 19, 2019**

Members attending:

Eric Boling, Matrix Risk Management Solutions
Jennifer Flood, Ombudsman for Injured Workers
Jaye Fraser, SAIF Corporation
Nathan Goin, Reinisch Wilson Weier PC
Colin Rockey Hackett, Colin Rockey Hackett Law PC
Todd Johnson, NCCI
Terri Johnson, Albertsons
Andrea Knight, Edmunson Barnhart Knight PC
Chris Moore, Moore & Jensen
Erin Nielsen, City of Portland
John Oswald, Bottini Bottini & Oswald PC
Jovanna Patrick, Hollander Lebenbaum & Gannicott
Sonya Powers, Argo Group
Alma Raya, AFL-CIO
Dan Schmelling, SAIF Corporation
Elaine Schooler, SAIF Corporation
Paloma Sparks, OBI
Sheri Sundstrom, Hoffman Construction
Arthur Towers, OTLA
Kimberly Woods, Perlo Construction MLAC

Agency staff attending:

Barbara Hall
Cara Filsinger
Fred Bruyns
Jennifer Millemann
Jim Van Ness
Julia Hier
Sally Coen
Steve Passantino
Troy Painter
Yesenia Gonzalez

Transcript

Part 1 of 2

00:00: So, good morning and welcome to you all. I really appreciate you taking, could be the better part of your day to come down here and join us to talk about potential changes to two divisions of our rules. That's Division 30 and 35, claim closure and reconsideration rules and also the disability rating standards. So, some of these rules haven't been opened in a very long time, and that's actually contributed to the number of issues on our agenda, but yeah, we do want to have a good discussion with you. This is an advisory committee meeting, and it's not like a public hearing. It's an informal discussion. We want to get your best advice on the issues, and we take that all back and talk with our administration and weigh the options and then we do our best job at crafting proposed rules that you'll then have a chance to review and provide testimony on as you like at a public hearing or in writing. So, as we go along in talking about the issues, please let us know about any fiscal impacts, costs to you or the people that you represent, costs or savings in fact because we rely on the information when we estimate the costs when we file with the Secretary of State, and so we really need the input from you folks as we go along. If you are on the telephone with us today, please do not put us on hold because we will get your background music, and there's no way for us to turn that off unless we mute everyone, and we don't want to have to do that. You may leave and rejoin the conference as often as you like. And with that, my name is Fred Bruyns. I coordinate the rulemaking process for the Worker's Compensation Division, and I'd like us to introduce ourselves to the other

committee members starting with those of you who are on the telephone. And we had a little trouble with this yesterday only because we had so many people on the phone call. I guess if you're last name begins with the letters A through H of the alphabet, could you introduce yourselves to the committee?

02:06: Eric Boling with Matrix.

02:08: Okay, welcome Eric.

02:11: Jennifer Flood, Ombudsman for Injured Workers.

02:13: Thanks for joining us Jennifer. Anyone else? Okay, it sounds like we don't have so many. Let's just do the rest of the alphabet now, anybody who's on with us.

02:29: Terri Johnson with Albertsons.

02:31: Okay, welcome Terri. Anyone else? Okay, hearing no one. I'll turn to my left, and.

02:45: I'm Julia Hier. I am the claims policy analyst with the Worker's Compensation Division.

02:51: I'm Jovanna Patrick with Hollander Lebenbaum Gannicott and Patrick. I'm a claimant's attorney and also here for OPA.

02:57: John Oswald with the law firm Bottini Bottini and Oswald, claimant's attorney, also here on behalf of OPA.

- 03:04: Paloma Sparks, Organ Business and Industry.
- 03:06: Sheri Sundstrom, Hoffman Construction.
- 03:09: Kimberly Wood, Perlo Construction and I sit on MLAC.
- 03:13: Todd Johnson, NCCI.
- 03:15: Jaye Fraser, SAIF Corporation.
- 03:17: Elaine Schooler, SAIF Corporation.
- 03:19: Dan Schmelling, SAIF Corporation.
- 03:21: Erin Nielsen, City of Portland.
- 03:23: Sonya Powers, Argo Insurance.
- 03:25: Nathan Goin, Reinisch Wilson Weier.
- 03:27: Sally Coen. I'm the acting administrator for the Worker's Compensation Division. I want to echo what Fred said. Thank you all for being here. Your advice is very important to us today, and I apologize in advance that I can't stay very long for today's meeting, but I am with you in spirit. Thank you for being here.
- 03:45: Troy Painter, auditor with WC.
- 03:47: Barbara Hall, audit manager, Worker's Comp.
- 03:49: Jennifer Millemann, lead worker, Appellate Review Unit.
- 03:53: Yesenia Gonzalez, appellate reviewer.

03:54: Okay. Again, thanks to all of you for taking your day to come and meet with us. I'm going to turn over the conduct of the meeting to Julia at this point. But do you have any questions before we begin, or does anyone need to have us you know, review a particular issue kind of out of sequence if you have to leave early? Oh, I also forgot to ask. I don't want to put you on the spot, but we almost always have everyone introduce themselves, so I'm going to ask you three to introduce yourselves to the committee as well.

04:28: Cara Filsinger, Worker's Compensation Division.

04:30: Steve Passantino, appellate review manager.

04:33: Jim Van Ness, acting deputy administrator with WCD.

04:36: Okay. So, does anyone have a need to like, leave and have us review any particular issue early? Okay, Julia.

04:48: Okay. So, I'm going to give you guys a quick roadmap on where -- the order of things so that we can get our bearings. I plan to start with the Division 35 issues that initially talks about our temporary rules and the Caren case and changes that we're looking at in light of that. The second issue involves chronic conditions, and then after we wrap up the Division 35 issues, we'll go through the Division 30 issues document. So, starting with Division 35, some of you -- people may have different levels of recollection or knowledge on the Caren case, but I'm going to read through the background so we can all get our bearings on where we're at right now, and then we'll get into the specific temporary rules that we've got and looking at feedback in

regards to how to implement some permanent rules.

So, on August 8, 2019, the supreme court had published its opinion in the Caren B Providence Health System Oregon case, and they had concluded that the court of appeals, the worker's comp court, the appellate review unit of the worker's comp division had all incorrectly allowed for apportionment between claimant's accepted sprain/strain and her unclaimed unaccepted arthritic condition. So, I have a quote from the court. They -- and I'll read it out loud. "We conclude that the method for calculating impairment in cases of combined conditions is an exception to and limitation on the general rule that the employer pays compensation for the full measure of the worker's permanent impairment if the impairment as a whole is caused in material part by the compensable injury. We conclude that employers obtain the benefit of that exception only by issuing a denial of the combined condition and following the process that the legislature has specifically provided in 656 -- they put 286(1)(b) -- for reducing B workers' permanent partial disability. We understand the board to have found that claimant's 16% impairment was a new impairment caused in material part by her accepted lumbar strain, that's in the absence of a combined condition denial. The impairment as a whole was due to the compensable injury and should have been reflected in the award of permanent partial disability."

So, after that decision came out, we issued our temporary rules, and the purpose was to align the disability rating standards with that decision, and in short, the Division found that the supreme court had concluded that before impairment can be

apportioned based on a pre-existing condition there has to be an accepted and denied combined condition. And so, we found some of the provisions in our prior rules were not consistent with that requirement, which issued -- which resulted in the temp rules. Those are expiring at the end of February, and so we need to replace them with permanent rules; otherwise, our old rules go back into effect. And so, in our issues document, I broke down kind of by topic what the temporary rules did and addressed, and we want to further discuss the feedback in regards to, like I said, how to best implement permanent rules on these issues.

So, I'm on Issue 1A, which gets into Rule 7. So overall, Rule 7 had been amended to explain that when a pre-existing condition can and cannot be apportioned in determining awards for permanent impairment and that the loss has to be caused in material part by the injury. So, just kind of a little background on where we're starting. We've got our statute that explains in part that the criterion for evaluating for the evaluation of permanent impairment under 656.214 is the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease. And like we had discussed after analyzing statute, legislative intent, prior case law, the Supreme Court in Caren had said the legislature intended that the injured workers will be fully compensated for new impairment if it is due in material part to the compensable injury except where an employer has made use of the statutory process for reducing liability after issuing combined condition denial. They did not further define in material part in their decision, and our last part -- set of permanent rules had indicated a worker would be eligible for an award of impairment if the loss was caused

in any part by the compensable injury. The temporary rules adopted the Supreme Court's use of material part in Rule 7 in Sections 1 and 2 with one exception, which we'll get to in a little bit. These changes included referring to the loss caused in material part by the compensable injury referring to the apportionment of the loss rather than loss in general when assessing what should be rated under (1)(b) and stating that a worker was not eligible for an award of impairment for anything -- any impairment that existed before the injury.

And so, we're looking for your feedback.

Some of the options we had identified in handling this issue in particular is one would be to make the temporary rules permanent, and the rule would refer to in material part by the compensable injury rather than any part. The rule would refer to the loss when discussing apportionment, and the rule would state that the worker is not eligible for an award of impairment for any impairment that existed before the work injury. Another option we identified was, rather than referring to material part by the compensable injury, we could state that the loss was due to the compensable injury. Another idea is to revert back the language into the permanent rule -- that was in the prior permanent rule that would refer to any part, referring to the loss caused in any part by the compensable injury. And then there may be other options as well. And so, we want to hear your ideas on that.

And overall, as far as fiscal impact, we didn't expect the options to result in a significant fiscal impact beyond where kind of the Supreme Court has placed us at this

point, but we obviously request advice about costs and including costs for small businesses. Open it up for discussion on that.

11:00: I'll go.

11:01: Yes.

11:02: Elaine Schooler with SAIF Corporation. Our preference would be to mirror the statutory language, that it's due to the compensable injury because that seems to be the most consistent. Another alternative or backup would be to combine that with the Supreme Court's interpretation to say it's due to in material part the compensable injury. That would take both into consideration as well.

11:46: Anyone else have ideas on -- I guess I see people looking around too. While people are looking, I should also point out here as we go through this, there was -- when we issued the temporary rules, some people had provided some feedback and suggestions as we were developing those. On Page 12 of our issues document, I do have a summary of people's thoughts at that time, and I know that was a few months ago, and so things may develop and change with time, but it gives just a little bit more background on somewhat -- what some stakeholders have thought previously on all these issues related to Caren, not just the one we're talking about, so. What do people think about using the statutory language of "due to"? Any thoughts on "due to" versus -- I guess kind of the summary of the options that we had identified, but there might be others, is using "in material part" or "in any part" or "due to" the compensable injury or SAIF had also suggested putting the "due to" and the "material part" together and

combing them somehow. Anybody have additional thoughts on that? Any experiences on the current temporary rules if you want to share?

14:01: I haven't seen a significant difference in the way that claims are closed.

14:04: Okay.

14:05: And the way that medical arbiters have continued to apportion to pre-existing conditions that they say exist but that there is no combined condition acceptance or combined condition denial. So, I have not seen in the probably dozen notices of closure I've seen since then a single difference in the way things are done, and they have all -- they're all up on appeal. So, I mean I think that the rules need to be clear. "Due to" is the statutory language. The case makes clear that it's "due to" means in material part. So, I would think having both of those phrases in there would be helpful in further guiding the way that it "due to" should be interpreted because I think the court said that that's what the statute said, and it wasn't being interpreted correctly before, and in my just, you know, experience in the few months since then, it's still not. So, I don't believe that the temporary rules are accomplishing what we want in letting people know what -- how to actually apportion these out.

15:09: Does everyone agree on what material is for a person processing claims?

15:15: In material part?

15:16: Yes.

15:18: I think from a compensability standpoint, that's certainly, you know, one

of the compensability standards that people do understand.

15:26: Doctors understand it? Claims processors?

15:32: I'm not a doctor.

15:33: Yeah.

15:33: Or a claims processor. I mean I talk to doctors on compensability questions, and that's what -- that's kind of the wrinkle here. Do medical arbiters understand what in material part means? Well, I wouldn't know as a claimant's attorney because I have no opportunity to talk to them, to cross examine them, to ask them why they -- what they thought it meant when they signed it. So, from a compensability standpoint, there is education to doctors on what material part and major part mean. I couldn't say if medical arbiters have a proper understanding.

16:04: This is Elaine again too. I would agree, and I would point out too at least that the temporary rules just went into effect in September, so at least I haven't seen a lot of cases either, you know, taking these changes into consideration. It's still pretty early on, on our end, so I think that it -- you know, it remains to be seen how sort of these temporary rules flush out procedurally.

16:39: Okay. I'm going to -- is anybody -- is everybody comfortable with me moving on to 1B here? And if anybody has any thoughts as we -- a lot of these issues - Issue 1, 1A, 1B, 1C - all relate to the Caren case. And so, as we're discussing stuff, if you identify something that may be related to an issue we just passed - the "in any

part" issue and "material part" thing - feel free to speak up. We can always go back or readdress something if you have another thought as we continue talking.

So, apportionment. So, the issue is that the last set of permanent rules had allowed impairment to be apportioned for pre-existing conditions even if the claim was not accepted as a combined condition with the subsequent pre-closure denial of the combined condition. The Supreme Court in Caren had concluded that the legislature again intended for the combined condition acceptance and pre-closure denial to issue an order for the insurer to receive the benefits of this apportionment. And so, ORS 656.225 addresses the pre-existing condition being otherwise compensable if the claim does not involve a pre-existing mental disorder. The pre-existing condition is compensable if the work conditions or events constitute the major contributing cause of a pathological worsening of the pre-existing condition. If it does not involve a mental disorder, the pre-existing condition is compensable if the work conditions or event constitute the major cause of an actual worsening of the pre-existing condition and not just of its symptoms.

Again, in Caren, they said -- talked about this combined condition exception for evaluating the permanent impairment, and again, you can't get the benefit of that combined condition acceptance -- exception without going through that claims processing. And so, the temporary rules had clarified that the portion of the loss caused by a pre-existing condition is not rated if that pre-existing condition was accepted as part of a combined condition and there's a denial of the combined

condition under 262(6)(c) unless the pre-existing condition's otherwise compensable under that 225 that I just mentioned.

And so, the options we had identified here is whether we'd want to make this temporary rule that we have - and I have it quoted here - whether that temporary rule should become permanent on this particular issue. And as far as fiscal impacts, the Caren case specifically we thought could increase costs for some combined condition claims and produce the corresponding benefit to workers, but again, inviting input on that issue as well as fiscal impacts. I see a lot of people thinking, so I'm going to give it another minute.

20:11: John Oswald. You know, in my years of experience, I don't -- I can't remember the last time we had a case involving 656.225. Frankly, in my going on 28 years, I don't think I've ever had a case where I've dealt with that, so I'm not sure that putting that provision in, in a sense really -- I mean I guess I'm ambivalent about it, but you know, it's either there's the accepted combined condition and then it's denied before closure and apportionment happens or not. So, I don't know. I might -- I'd have -- I'm not sure what to think about it other than I don't know that I've ever had a pre-existing compensable condition case under this statute.

21:02: And it may be because here we're talking about an exception and then an exception to the exception. The notation to 225 might be better placed over in, you know, the Rules 07, you know, big B, I, kind of the -- you know, the worker's eligible for award of impairment for -- and then the -- you know, a pre-existing condition that's

otherwise compensable under 225 to add it to the list of things that claimants are eligible for rather than it being an exception to the exception to entitlement to impairments. And I think one thing that is not covered here and that was suggested before the temporary rules went into place is the finality of that combined condition denial because, if there's a combined condition denial and then it's litigated you know, it could take months, it could take years to get to a decision on whether that combined condition denial is actually proper or not. So, the question is what happens with the closure during that time, and I think under current rules, I suppose the claim would get closed assuming the combined condition denial is proper. And then if that gets overturned through litigation, then I suppose it would have to be reopened and then reclosed given the current status of the case, so that could cause, you know, additional costs and litigation when we don't really have a final decision on that combined condition denial. You know, a denial itself is not a final decision. It's an initial decision that starts off a whole process. So you know, as a broader concept, this may be something we need to grapple with whether just the denial itself is enough to trigger closure in apportionment or whether that denial needs to be final through a litigation.

22:55: This is Elaine with SAIF. We oppose to inserting a finality requirement. That's not part of the statute for rating impairment under 656.262(6)(a). It's just that the combined condition has been denied, that it's denied and final. In addition, I think it's like 313 - I don't remember the exact cite - but there's another statutory reference that says denied conditions are not rated for impairment or (inaudible 23:23) combined conditions. So, at the time of closure, the combined condition is denied, it's contrary to

the statute to rate impairment for that combined condition as if it were compensable. And as Jovanna pointed out, there is a mechanism if that denial were to be set aside and the claim returns to an open status, and then the insurer has to process that combined condition to closure and then rate impairment for the old components of that combined condition. In addition, for other conditions that are just denied as a standalone condition, that's the process that occurs today. The last piece is that, for these denials involving combined conditions, the litigation can take time, and procedurally, I'm not sure what would happen then if the condition was rated entirely for impairment and then the denial was upheld how an insurer would be able to recover what could be a substantial impairment award when that award may have already been issued and paid out.

24:36: Paloma Sparks with OBI. I would also express some concerns about a finality requirement.

24:56: Any other thoughts on this one before we move on? Okay. So, we're on Issue 1C, and this is relating to residual functional capacity with Caren. So, the last set of permanent rules had allowed for residual functional capacity to be adjusted if the worker's capacity to perform work was diminished by a pre-existing condition even if that pre-existing condition was not processed as a combined condition and then denied, and that may be inconsistent with the Supreme Court's decision in Caren.

So, the Caren case we've kind of gone through about needing to have this combined condition processing before there is an apportionment of impairment. And

so, based on that concept, the temporary rules had similarly required that combined condition processing in order to adjust residual functional capacity. After the temporary rules had issued, the Division had received feedback that there were instances where the insurer denies the combined condition without first accepting the claim as a combined condition. Under the current temporary rules, the Division may include the denied component of the combined condition until the denial is overturned by the board, and that raises the question of whether the rule should also make mention of the pre-existing condition being accepted as part of the combined condition prior to issuing a combined condition denial. When looking at the sections of the rules, under (c) and (e) of -- or in Rule 12 -- hang on, so under 10(c) and (e) is where we have the modified language. And so, it requires residual functional capacity to be adjusted based on the superimposed pre-existing or denied condition, and that's the previous permanent rules. And we look at that as tying it -- so, we've got -- sorry, I'm going to kind of step back. So, the modification that we've got is that the worker's capacity to perform work is diminished by -- it used to say superimposed pre-existing or denied condition, and then what we've done is for the temporary rules, which we're looking for feedback on whether that should become permanent, is get rid of the word pre-existing in general and replace that with or pre-existing condition that's part of a combined condition denial as allowed under 262(6)(c), so incorporating the concept from Caren into our residual functional capacity rule. Then the rule goes on - I'm reading from (c) - "The worker's residual functional capacity must be adjusted based on an estimate of what the worker's capacity to perform work would be if it had not been diminished by

the superimposed pre-existing or denied condition.” In looking at that, I read the superimposed pre-existing or denied condition should relate back to what we had just identified as the pre-existing condition as part of that combined condition denial. So, what we are looking at feedback on, what people’s thoughts are on the temporary rule in general, as well as kind of -- as that sentence closes out at the end of (c) and (e), thoughts on reference to the superimposed pre-existing or denied condition just in general, or if we should kind of repeat what is already stated as the pre-existing condition as part of the combined condition denial as allowed under 262(6)(c) and any other thoughts people have in regards to these sections of the rule as related to the Caren case.

28:57: I have a question.

28:58: Yes.

28:59: If we’re reading -- my name’s Colin Hackett by the way. I’m a claimant attorney. From reading the Caren case, it looks like they’ve said that there’s only supposed to be apportionment for a processed combined condition. Am I -- is that -- are we -- is that what the department’s position is as well?

29:25: Are you referring in a combined condition case?

29:28: Yes. Well, in any case.

29:29: Yes.

29:30: It has to be only apportionment for a condition that’s been accepted and

denied as a combined condition.

29:38: So, I think it depends what -- how you're saying it. The way that the -- the way that we have our temporary rules, there could be apportionment out -- and correct me if I'm wrong Jennifer -- for superimposed and denied conditions, and then there's also the combined conditions, which would need to be processed as a combined condition for that apportionment to occur.

30:00: Okay. So, maybe we're reading the case differently. Jovanna, did you -- is your reading of the case the same as mine?

30:08: Well, you know, I think OTLA's position on how we have read it is that there are two options here. There are, you know, impairment due to in material part of a work injury and then there is the exclusion for legally cognizable pre-existing conditions that have been accepted and then denied as part of a combined condition denial. So, nowhere in that framework is there an idea of superimposed conditions. It doesn't exist in the statute, and as Chris Moore wrote in his comments, it does create some illogical results for someone who, you know, might have a condition like obesity or pregnancy that they would get a different result depending on that condition of their body at the time of injury and at the time of closure.

I think the other main problem with the superimposed conditions or, you know, being able to apportion for superimposed as the rules have continued to do is the portion of the Caren case that talks about notice of a reduction or denial of your compensation and a meaningful opportunity to challenge that compensation denial.

That is what the Caren part was saying, was this major problem with apportioning to pre-existing conditions that a doctor just said were pre-existing, that the claimant had no opportunity to litigate that. It's the same with a superimposed condition. So you know, imagine you're a worker and you're working, just going along just fine you know, maybe you're older, but you know, you're doing your job no problem. You suffer a work injury. It gets accepted. You get paid time off. You get all your medical bills paid. You think everything is fine, and then the doctor says, okay, go back to work. But you're like, but my back still hurts, I don't think I can lift that. Oh, well you have arthritis, that one has ever litigated, no one has ever told them before, and suddenly they're told to go back to work when they have some impairment, and they don't get anything for it. And they have no way of challenging that because, you know, they're going to think, well, I don't think arthritis is causing that, so how could they request acceptance of a combined condition? They wouldn't, and that's what Caren said. It was just ridiculous to expect a worker to do those things.

The same holds true with a superimposed condition. If my claim gets closed because, well, let's say, you know, I happen to be pregnant when my claim gets closed even though 2 years ago when I got hurt and had my surgery, I wasn't. Well, suddenly I have a superimposed condition and suddenly they're going to reduce and say, oh, well you have back pain because you're pregnant, for example. A doctor just says that, and then it gets apportioned because that doctor said it was a superimposed condition. I have no way of litigating that. I have no way -- meaningful opportunity to challenge that denial of my compensation where I would if the doctor said, oh, actually it's

because of arthritis. Well, the Caren court addressed both of those things. And so, there's just no place anymore in the rules for apportionment for superimposed conditions that have not actually been litigated at a level before at the board where the claimant could have a chance to prove yes or no that those conditions contributed.

33:14: This is Elaine with SAIF. Our position is that Caren only was looking at impairment between a pre-existing -- qualified pre-existing condition and an accepted condition in the absence of an acceptance of a combined condition and looking at 26(a) to see what the statutory requirements are for rating impairment where a combined condition may exist. The Supreme Court did not look at superimposed conditions or address that piece of the impairment rule, so that's a separate issue that needs to be further addressed potentially through litigation. In addition, impairment is to be rated when it's due to the compensable injury and whether it's due to the compensable injury is up to the medical providers to determine. In the example of the pregnant woman, if the doctor is attributing some of the impairment to pregnancy as opposed to the lumbar strain, that's the medical provider's determination, and they're in the best position to render that opinion. And alternatively, if the individual is still having issues, then they can challenge their medically stationary status because perhaps it was a premature claim closure. So, there are other mechanisms to address that situation, and we would take the position that Caren is limited in its application.

34:48: Well, I think Caren was clear that the reconsideration process is not the same meaningful opportunity to challenge denial compensation as would be litigation

before the board. You know, there are limitations on evidence. The medical arbiter basically gets to make the final decision without being able to cross examine that person, so it's certainly not a meaningful opportunity to challenge a denial of compensation the way that it would be if you get a denial, you know, of compensability with appeal rights that you can take to a judge. And I also think that, although Caren didn't specifically talk about superimposed conditions, it said there were two things. There was impairment due in material part to compensable injury, and there were legally cognizable pre-existing conditions, which was the exception only if they were accepted and then denied. So, Caren set out, there's only these two. Superimposed conditions just has no place in that.

Furthermore, if you look at Schleiss, in Schleiss we really had, you know, what could be argued was a superimposed condition, the accelerated aging. The obesity, I don't know if he was obese before or that happened afterwards, but the -- but accelerated aging is certainly something that happened during the course of the claim. It could be said that was a superimposed condition, and Schleiss says you cannot apportion for that. So, you know, frankly, Schleiss said it and Caren says it again, that the only two things you should be looking at are the compensable injury and a pre-existing condition that has been accepted and denied. So, superimposed conditions are this thing that frankly a lot of people don't understand, I'm not sure if doctors understand them, and they have no place in the statute or in these cases that set out how the statute should be interpreted.

36:38: You referred to Schleiss, and I'm just wondering, I think there might have been a footnote in Schleiss specifically saying that we're not looking at a superimposed condition. If there was, would that change your opinion on it?

36:50: I think with the two put together make it clear that superimposed conditions have no place in the rules, but I haven't read Schleiss in detail more recently. I will admit that.

37:08: I guess my other comment and/or question would be why the concern about superimposed conditions? Why as a matter of policy is the department putting this in the rule? There doesn't seem to be any legal basis for it because it's not in the statutes. So, what's the legal authority for including a superimposed condition, and then as a matter of policy, why is this a concern? Because it's causing workers to not get benefits when otherwise they would or might, so it's limiting the permanent partial disability awards for people. It's not in the statute. So, what is the -- why include it in the first place?

37:56: So, the superimposed conditions, I haven't gone back to how long they've been in the rules, but they've been in there for a long time. The goal on the temporary rules is to take the steps necessary to -- when we issue temporary rules, we are not going through a full rulemaking process. We are only making changes that we feel are required to be made to make the rules in line with current law. So, Caren changed the current law, and we took the steps we felt to be necessary to address directly what was very clear to us needed to be addressed as a result of the Caren case.

At this point, in the permanent rulemaking process, we're looking for feedback on all of these issues and hearing what different perspectives there are on things like superimposed conditions, what's the scope of Caren, what -- you know, do you see concerns in these parts of the rules elsewhere? Like, we're having that discussion, and so that's part of the permanent rulemaking process right now.

38:58: Okay. And then as far as the legal basis for including superimposed, and I'm just trying to get an understanding, is the department -- what is the legal basis for including that?

39:13: So again, for the -- I'd have to go back to when they put superimposed conditions in the rules way back when to see what the statutory changes were at that point. Like I said, right now, we're looking at feedback from stakeholders on what people feel to be the scope of the Caren case and where statute places us. And so, if you have further concerns on that, I want to hear those, and that's something that we'll be considering when we issue -- draft permanent rules.

39:51: Okay. Well, then I guess just briefly I would say my comment would be that there's no legal basis for apportioning based on superimposed conditions. It's not a word that exists in the statute. It doesn't seem to be justified by the statute, and because as a matter of policy it tends to reduce people's permanent partial disability awards, I don't see the reason for including it. And people should, as Jovanna spoke about, have a meaningful opportunity to litigate any reduction in permanent partial disability awards. They really are in dire straits, a lot of our clients. Because of the

injuries, they're not able to work. They're not able to do the kind of work they did before. They've been oftentimes without income. The medical services that are part of the worker's compensation benefits tend to be administered poorly and inefficiently, so they're just in a bad situation. And the permanent partial disability award is supposed to help them get back to some, you know, material -- ability to support themselves materially. Reducing those awards doesn't seem to help the situations for our clients. And so, there should be a good reason for it when it's not in the statute. It doesn't seem like there's a good basis for it, so that would be my comment thing.

41:10: Thank you.

41:12: We've been mentioning the pregnancy as a superimposed condition and that I -- that happens. I don't know the last time the folks in our office have rated a client where the superimposed condition was pregnancy, but I think more of a common occurrence is, let's say a worker has a knee strain due to work. Everyone knows he has a knee strain, and then a month later, he or she is playing softball, slides into second base and tears their meniscus and has surgery because of the meniscus, and they have impairment because of that. I think we all can agree that the strain is work related, and the insurer should cover everything related to the strain. But isn't the meniscal tear a superimposed condition? It's superimposed on that same body part, on the strain. So, taking superimposed out, we're saying, hey doctor, you can't look at the range of motion, the strength loss, and everything else related to the meniscal tear. You have to rate everything related to that knee. So, then the insurer is paying for the

range of motion decrease because of the meniscal tear, the strength loss related to the meniscal tear, hopefully not the meniscus tear itself because that's obviously not work related. So, I think superimposed conditions do have a place in the administrative rules for those situations where there was that injury, that event, something happened after the date of injury that's impacting the worker.

42:48: We see it all the time in the construction industry. Somebody hurts their knee or has a back injury, and then motorcycle riding has another event, another intervening event. So, I would be very concerned, and I appreciate what you're saying, but I don't think your intent is to pay for the things that come after unrelated to the work event, the work condition including the pregnancy. And I agree, let's not talk about the pregnancy. Let's talk about some of this other -- these other real things that we know are happening on our claims. I've never had the pregnancy thing, but I would suggest that, yes.

43:30: Well, I think superimposed is something that doesn't need to be in there. The issue is cured or solved by simply having the rules state that the ratable impairment is -- well, it's impairments can be rated because it's due to in material part, the work injury or the compensable injury. So, I would agree with Jovanna. I think the Caren decision made clear that there is a very limited carve out of when you can apportion, and it is when there's a legally cognizable pre-existing condition that's been accepted to be combined condition and then denied. Superimposed, I think it's something that, number one, is not in the statute, so I agree with -- and I don't think

it's necessary, just the determination or necessity that the impairment that's going to be rated is due to and caused in material part solves the problem.

44:32: So, if you had let's say a worker with a knee strain and he ends up having a motor vehicle accident, and he now has a total knee -- his knee gets banged up, are you saying that if the rule said due to in material part and say they -- the arbiter or the doctor or AP says, 10% is due to the material part to the work injury, the accepted condition, and 90% is due to this motor vehicle accident, in that case, would you believe the worker should get 100% or 10%?

45:05: Well, that's a good question.

45:07: That's why we're here.

45:08: Yeah, no.

45:09: Yeah, that's exactly --

45:10: No, sure. But I mean to use Dan's, you know, if somebody has a knee strain and then all of a sudden thereafter, however long, a couple months, a year or two later, all of a sudden they play softball and twist their knee and have a torn up meniscus or ACL and they have to have a reconstruction. I mean that presents a different situation and how it gets dealt with I guess is --

45:33: Yeah, Dan's is you could say, well, maybe there was a pre-existing condition now when he was playing softball, which was the work injury. But if -- you know you could say that, that left the worker in a weak position possibly, and so

softball just worsened a weak position that the injury caused. Like, we also have cases where we see most of our cases would be something like a very traumatic motor vehicle accident, something big that just kind of ripped that knee apart. So, does the employer then become responsible for any future accidents and injuries if there's any combination of impairment?

46:17: So, are you talking about responsible for future conditions or future impairment?

46:22: Impair -- are they responsible to pay a worker permanent impairment if you have any combination between your strain and this motor vehicle accident? So, any accidents they have. They fell down the stairs at home, they you know, did all these -- is the employer and insurer then responsible for any future accidents if there's a combination between the impairment?

46:48: Well, I think that the -- you know, what Caren set out is that there's only two -- there's only one thing you can apportion and that is pre-existing conditions that have been accepted and denied. And so, it's really more of a medical question for a doctor to determine. Well, let's say the, you know, traumatic meniscal tear, and you've got problems afterwards. Well, is the doctor going to say, yes, you know, I think that your impairment afterwards is due to in material part your knee strain from the work injury? Then apportionment is not proper. If the doctor says, no, all of your impairment is due to this meniscal tear, not to the strain, then there's no impairment award. I think Caren sets out that it is a black or white situation except where you can

legally apportion for pre-existing conditions that have been accepted and denied.

Now, is that going to be unfair to some workers? Sure, in individual cases. Might that be unfair to an employer here and there for impairment award? Perhaps. It doesn't mean the employer's going to have to pay for the meniscal tear surgery or any treatment after that unless the worker in your example that you gave -- well, the worker says, well, the knee strain made my knee weaker and I wouldn't have torn it otherwise. Well, in that situation, the worker is going to request acceptance of the meniscus tear as a consequential condition that's going to be meaningfully litigated, and then we'll know at the end of that litigation if that claim -- if that gets accepted as a consequential condition, then it's part of the claim. If it gets denied, then it's not part of the claim.

48:20: Why would a worker request, in that specific, acceptance if they could get the permanent impairment up front, but if they request and get a denial, they won't get it? What would be their incentive in asking for that condition?

48:32: To get the meniscus accepted.

48:34: To get the surgery, to get the time off paid, to get job protection so they don't get fired because they exceed FMLA. You know, most of these workers are not looking for the pot of money at the end of the rainbow. What they are looking for is, I can't work and pay my mortgage tomorrow. I need surgery and I don't have insurance. I have no way of getting surgery so I can get back to work. So, those things, if they needed to be litigated, they would be litigated.

49:03: Can I ask you a question? Is superimposed mentioned at all in the Caren case?

49:10: No.

49:11: So, why are we talking about it here if it wasn't part of that case? I understand that the -- Jovanna would like us to expand it, and certainly that's the way she has read it, but the case itself doesn't actually say it, so now we're theorizing whether or not that's what the court intended, and I don't know why we're even having that discussion. It's not part of Caren, and I thought that was what our discussion today was about, is the effects of the Caren rule. And so, I'm not sure why we're even having this discussion about superimposed.

49:50: Well, I think the point of the temporary rules is to make them consistent with Caren and Caren says there are two options. There's --

49:59: With respect to a pre-existing condition.

50:02: No.

50:02: Let's begin --

50:04: They say there are two options, that the general rule is that you get impairment for a condition -- you get compensation for impairment caused in material part by the work injury and the only exception to that, the only exception -- Caren says it three or four times -- the only exception that should be limited is a pre-existing condition that has been accepted and then denied. So, although they didn't specifically

say, oh and by the way, where did you guys even come up with this superimposed thing, it doesn't exist. That wasn't an issue in that case, so the court's not going to make a decision on superimposed conditions when that wasn't raised. But I think the point of Caren is that we should not be apportioning except in one limited circumstance, and the rules give you multiple circumstances and sup -- I mean I understand denied conditions. I am not arguing against denied conditions because you know that's what Caren talks about. If it's been denied, then you can apportion. But superimposed, you know, you asked where is superimposed in Caren? I, you know, take a step back and mirror what Colin said, where is superimposed in the statute? How is there authority to have it in there in the first place if we can't point to anything in the statute where the legislature intended this idea of superimposed conditions to be an exception to impairment caused in -- you know, due to in material part of the work injury?

51:30: So, what happens though after the injury occurs and there's something after? You're speaking to pre-existing, but did Caren come out and say that if there is anything with that body part, you own it, anything that happens after the injury, any intervening event. Could you help me with that please? Like, we're talking about --

51:53: It says impairment due --

51:53: -- the car accident.

51:54: -- in material part to the work injury, so it's not -- and I think that you know, backing up to like, 1A that we talked about I think the initial rule said you know, due in any way or in any -- you know, any part. Now, that's not what Caren said.

Caren reiterated that it was a due to, in material part, the work injury. And so, as I explained, you know, I think that a doctor would be able under the framework of taking out superimposed and having it just be the Caren, you know, pre-existing accepted, denied that if someone did have, you know, a completely separate injury and the doctor felt that that -- that all of their impairment was due to that separate injury, that there would be an argument for not giving them impairment.

52:41: Or apportioning it.

54:42: But Caren also talked about -- I mean there's also the idea of taking the worker as you find them, and sometimes that might mean that employers have to pay for something they don't think they should get or that they don't think they should have to pay for and that they haven't been paying for, for years. So far, what has been happening for years is that workers are fine. I can't tell you how many times I have this conversation every week with workers. They come in and go, I was fine, I never went to the doctor, I never had a back pain. You know, I've worked hard, I lifted these things all the time, I had no problems, and then I, you know, lift this heavy thing at work, I feel a pop, and suddenly my back is killing me. And now they're telling me I have arthritis, and it's my problem. Before I was working fine. This event happened at work, now I can't do it, and they're blaming me and saying it's arthritis, go away, leave us alone, you can't go back to work, we're not paying for it, put it on health insurance. And so, you know, they're -- Caren makes us swing the pendulum a little bit the other way and not have all of this coming off the backs of workers. Some of it's going to

have to start coming off the backs of employers, and I know that's not attractive to employers or insurers, but you have to realize that how many years all of this impairment that has happened because of a work injury, in material part of an injury, has been coming off of the backs of workers and forcing them into poverty, forcing them out of jobs, forcing them out of health insurance and onto public benefits.

54:13: And two more points. The first is that, yes, while you may think the worker as you find them for something that happens after the work event, it's not taking the worker as you find them. It's compensating them for something that's wholly unrelated. The second piece is that the Division and director are granted broad authority to promulgate the rules to carry out the rating of impairment and it's within the department's and the division's discretion as to how impairment should be rated, the calculation and the manner in which that's carried out. And so, to include an apportionment for a superimposed condition falls within that discretion that the Division already has as noted by others here when we are talking about pre-existing conditions and not superimposed conditions.

55:00: And I just point out that as Julia explained with the temporary rule, we had to do the minimum required to make the rule or align the rules with the revised understanding of the law. Now that we're gathered here to talk about what the permanent rules should look like, we're willing to listen to all -- you know, all recommendations and advice, and as I say, we won't come to a decision here today. I'm sure we'll take it all back with us and talk with our administrator and decide -- you

know, make our best decision, which then is again subject to public testimony and will be. You'll all be copied on that as long as I have your contact information, and I think I do, but you know we appreciate hearing from you because that's -- we don't want to live in a vacuum, and we can look at -- we can try to find out where superimposed came from, et cetera. It may have been based upon a comment under -- or our understanding, our best understanding of what the statute said at the time. I'm sure that was the case, but we can certainly look back and see if we can find where that term came from. Sometimes it -- you know, it could be decades ago, and sometimes the research is not fruitful, but we can have a look.

56:12: Arthur Towers with the Oregon Trial Lawyers. In the instance that has been described with the workplace event causing the ailment and then a subsequent motor vehicle accident worsening the body part, the payment for the subsequent treatment would only come back to the employer if the worker asked for it. So my --

56:44: Yeah.

56:46: Okay. And so, if the worker doesn't ask for meniscus surgery to be paid for by the employer, then it's a moot point.

56:59: But what about the PPD?

57:01: Yeah.

57:01: What if the strain -- and I'll just throw it out there. You have an exam, and the doctor says the worker has a strain, full range of motion, full strength loss. I

want to see him in one month for a closing exam. Then he's in a motor vehicle accident, blows out the knee. We have medical treatment immediately preceding that's saying no impairment, nothing, and then we go to the doctor and you go, well, in material part, maybe 10% is related to the strain, I don't know, and we've bought everything. That's what I think we're getting at with the superimposed.

57:40: Well, I think if the doctor said, maybe, I'm not sure, I don't think that would carry weight in -- I mean --

57:48: But the process --

57:49: -- that's not enough. If the doctors says -- you know, I mean in your situation you've got a good example. The doctor said there is nothing related to the strain, and suddenly he has all this impairment. Now, if the doctor said, well I think that I changed my mind, and even though my chart had said nothing before, now I think part of it is due to the strain. Sure, in the initial closure, the person would get full PPD, but the employer can appeal the closure as well and go back to the doctor and get a different letter.

58:15: And you commented that taking out superimposed creates an all or nothing. You either get nothing because none of it's due in material part or you get all of it because something might be in material part. So, some workers lose, some workers win, as you commented. The process that we have now I'm not going to say all workers win, but all workers get what they deserve because we're allowing apportionment for superimposed conditions, so we're letting the medical doctor say

what's related and what's not related and what's due in material part too and then giving the worker that portion that's related to their work injury.

59:00: And what I'm --

59:01: So, it seems like we're there now.

59:02: You're looking --

59:03: And going and taking it out is creating the all or nothing, as opposed to you're getting something based on the medical evidence.

59:14: And what's creating the all or nothing is the statute in Caren in my view point. And so, you know, hey, it's been working how we're doing it now. That's fine if it's been working -- if you think it's been working for SAIF and you think it's been working for workers, but that's not what -- what we're saying is the statute doesn't justify doing that, and the Caren case doesn't justify doing that, even if it was -- you think it was working, and it might be, you know, substantial justice throughout. If it's not permitted by statute or by case law, we simply can't do it.

59:50: And another comment I'd just like to make is that it doesn't appear to be working for workers on our side at all in any way, shape, or form. I mean we get -- what we look to -- as a claimant attorney, what appears to me and my colleagues as being completely inequitable decisions on permanent partial disability, and a very common occurrence like Jovanna said, people call us on the phone every week and they have the same story. I got hurt at work, I was fine before, I'm not hurt now, my

doctor says he's -- I'm fine, and he's sending me back to work. They say I have some pre-existing condition that's not related. The whole system is rife with this inequitable application of the law, and anything that allows workers to get better access to the permanent partial disability awards is going to be an improvement of what appears to us to be completely inequitable applications of the law as it has been applied for as long as I've been doing it and as long as I know it's been since the law changed in the late '90s I believe.

1:00:50 And in Caren, I mean unless the insurer has -- employer has accepted and denied a legally cognizable pre-existing condition that worker might get some money for degenerative changes or arthritis that was never denied as part of a combined condition, and Caren's okay with that. I mean we're so concerned that the employer might have to pay for that random meniscal tear that happens to take place afterwards and the doctor happens to say a portion is due to the work injury. But the Caren case looks at, you know, non-legally cognizable pre-existing conditions, things that people might have before, and says you have to pay for those unless you follow this one specific way to not pay. And so, why we treat superimposed conditions differently than, you know, how the worker was before doesn't make sense.

1:01:43 As an employer, I'm not concerned about the meniscus tear and having to pick up and pay for a meniscus tear. I'm concerned about having to pay for a quadriplegic. That's what I'm concerned about. You're telling me I have to buy that because I'm an employer, and it's my turn to pay for that. I didn't contribute to that

auto accident. It didn't have anything to do with me as an employer. I didn't cause it. I wouldn't -- I didn't contribute. I had nothing to do with it. They have a back strain, which we were taking care of as an employer, and the way that you want this to go is now he's a quadriplegic, and I'm on the hook for life for a quadriplegic. And you think that's -- and you think that that's an acceptable response. I don't -- that's not. It's absolutely not. We're talking about pre-existing conditions. I don't think I've heard anybody here say that the exact scenario that he talked about, that you didn't deny on arthritis and now you're stuck with it -- I don't think anybody here is arguing about that. That's the pre-existing condition. That's Caren. But we are talking about the superimposed and that I do have big issues with because that can have catastrophic events for an employer. It really can. And so, I understand that you've got an employee, you've got a client who now can't work, but that's not the fault of the employer. And I understand that they need to have some way to care for themselves, again not the fault of the employer. And so, what you're wanting to do is put that on the backs of employers, and that's not fair. I get you're trying to protect your clients, but when it wasn't caused by the employer, which is what worker's comp is about, we shouldn't -- you're talking about something that shouldn't be included. It absolutely -- this is just a discussion of superimposed, is -- no, we're -- I just absolutely disagree that that should be what you guys are asking for.

1:03:45 (unintelligible)

1:03:46 Yeah. No, that's not --

1:03:47 Well, let's be clear. You know, you guys didn't want to talk about pregnancy because that almost never happens. Okay, how often does it happen that someone is a quadriplegic from an accident that happens while their worker's comp claim is open? Probably not very often. What I'm more concerned about is not those very rare cases where, oh, I had a minor strain, and now I'm a quadriplegic because I got hit on my motorcycle. I mean what if I have an accepted disk herniation, and I get surgery, and then I get in a motor vehicle accident and maybe I need a second surgery because maybe the first surgery's failed? Well, now are we saying that that's -- well, that's a superimposed condition, so we need to apportion that. Where in the rules, or where in the statute would it allow that? And now we're talking about someone who certainly has impairment caused in material part from the work injury. Maybe the motor vehicle accident made it worse. Maybe accelerated aging made it worse, then we're back to Schleiss, but you know, I think that -- I certainly understand your concern in that situation. I think that situation is a once in a lifetime issue that would need to be addressed then, and then it's upon the insurer or the employer to talk to that doctor about whether that knee strain had anything to do with their paraplegic status. But we shouldn't allow for a rule that is inconsistent with statute only because there's that one-off case where an employer is fearful that they're going to get stuck with some catastrophic injury that no one is expecting to happen.

1:05:19 I'd just like to bootstrap. This is Colin Hackett again. I'd like to bootstrap another comment onto what Jovanna is saying. Of course, there are going to be, you know, different specific scenarios that seem unfair to the worker and unfair to the

employer. That's going to be true in any system with any set of rules, and you can think of the catastrophic situations on both sides, fair enough. It certainly wouldn't look fair from the side of an insurer or employer if something crazy like that happened where somebody became a paraplegic after they had a serious work injury, and then the employer had to pay permanent disability on the paraplegic. And then Jovanna comes up with a lot more probably common or realistic scenarios where the worker would get unfairly treated by a pre-imposed condition.

But going back to the discussion about the legal analysis, I think Jovanna's reading of Caren is correct, and I suspect that if you look at when you originally included the superimposed language in the rule, it would've been based on the language that Caren had analyzed, which is the due to the injury. So, due to the injury and then the department justified apportionment based on the due to language. And when the Supreme Court looked at the due to or because of language, it said there's only two scenarios where this can be applicable, and it's either material cause because it's due to, and that's what due to means is material cause, that means the whole shebang, or it's this other statute that talks about pre-existing condition, and you can do that too because the legislature authorized that. The legislature never authorized a superimposed condition rule, and it, therefore, shouldn't be included. And the court did do the analysis in Caren, and it is applicable in this exact same way.

So, you'd be going back and creating you know, another ten years of litigation to find out that all along workers should've been getting compensation, and we've been

down that road where it was 30 years of workers not getting compensation because of an interpretation of the statute that really, really harmed a lot of individuals, and destroyed their lives frankly. We see it every day. And so, I think the reading of the statute and the reading of the rule -- or the reading of Caren that Jovanna advocates for are correct, and it is fair to interpret it, but it's also the law to interpret it that way, and we're going to end up there either way unless the legislature makes some change. So, that should be what the rule reflects, that superimposed is not part of the statutory scheme, there's no justification for it, and that's what the legislature intended. That's my comment.

1:08:00 Nathan Goin, Reinisch Wilson Weier. We've had a lot of conversation, and I think part of the issue here is that we're trying to make Caren much more expansive than it was meant to be. Caren was a conversation about a statutorily pre-existing condition and whether or not you can apportion for it, right? We've somehow gone into this morass about superimposed conditions, where they came from and why they exist, their theoretical impact on both workers and employers all in response to a court case that doesn't address that issue. So, we are going to substitute our decision-making for the courts in trying to resolve this issue. The court didn't change it, which in my mind means that it doesn't need to be changed. I think there's another issue of substituted decision-making going on here where we are saying a physician can tell us that a component of a work injury or a worker's condition rather, their permanent impairment, is not related to a work injury, but we are going to jettison that medical opinion in favor of the worker's subjective belief that the entirety of their pain or their limited range of

motion or whatever finding is wholly related to the work injury. So again, we are substituting our decision-making and the procedures for that to occur with the medical professionals, and I think that has a huge impact on how we look at permanent impairment and raises a lot of additional issues.

Also, in terms of the superimposed condition concept, Caren says that permanent impairment should be materially related to the work injury, right? So, worker's comp is a benefits delivery system. Workers should absolutely get what they're entitled to, and if that means that they have a trip and fall or if they were otherwise injured, however you want to typify that injury, they were injured on the job and that resulted in some level of permanent impairment, great, they need to be compensated for that. I think everyone would agree with that, and that's what's fair and right. That's what worker's comp is here to do, but that worker should not get permanent impairment for the motor vehicle accident or the softball injury or the pregnancy or the motor vehicle accident results in quadriplegia or any other scenario we can think. However we want to craft that rule, great, but I think those fundamental concerns of ethics and what's right in this benefits delivery system need to be taken into account, and I'm not so sure that we're getting to that with the proposed rules or even the proposed revisions to those rules. And I think there's significant -- I think this is going to be a long process I guess is what I'm saying, and I don't know if what we have currently is going to get us to that point of equality that we're looking for.

1:10:55 I just have a little bit of confusion in that comment about jettisoning a

doctor's opinion because the worker thinks that they have impairment, so we just pay them. Well, that's not what Caren says, that's not what we're asking for. What we're saying is that, yes, the doctor needs to make that determination, but what apportionment rules apply need to be consistent with statute and law. So, certainly it is the doctor's opinion and the doctor's decision on whether a portion of impairment is due in material part to the work injury or whether it's a superimposed condition or -- I mean a doctor can -- I mean under the current, you know, Caren, if a doctor said, well I -- and I see this all the time - oh well, I think they have arthritis because he's 63, and so 50% arthritis, 50% work injury. Now, if a doctor wrote that opinion under Caren, and there's no acceptance or denial of a combined condition, that person gets 100% of their impairment regardless of what the doctor said because the doctor apportioned between something that the statute doesn't allow apportionment. The same would be true as if the doctor apportioned between aging or obesity or pregnancy that happened afterwards or a motor vehicle accident. So, we're still relying on the doctors, but I think Caren makes -- I mean Caren shows the problem that was happening so much, is that doctors, one, they don't understand, and two, they get sent to an IME that simply says, oh well, strains get better in six weeks, you're not better, it must be because you're old and you have degenerative problems, so zero. And then occupational med doctors just sign off, and they get zero, and there's nothing that can be done about that when they had no right -- no ability to challenge that, and it didn't really conform with function or the statute. So, I think that all needs to be considered. I mean I had doctors write things like, well he's got 20% impairment in his spine from a, you know,

L5-S1 disk herniation, but he's got five vertebrae, so that 20% should only be four, and the person gets 4%. I mean just the most ridiculous results because doctors and insurers were giving free reign to apportion between things that the legislature does not allow apportionment, and the claimant did not have a meaningful way of challenging that through the reconsideration process.

And so, if we leave in superimposed conditions, we're going to end up with the same problem we had with pre-existing conditions, doctors making these things up. Well, he has to be better from the strain, so it must be something else. Well, he -- I've seen things in compensability disputes. Well, you know it's possible that he got in a motor vehicle accident, and if he did, he would have hurt his back, so we shouldn't accept the back strain. We will get to decisions like that, they will be appealed, they'll get them to the court, and we'll end up back here with a rule that needs to be changed again as Colin said. So, while we're here and while Caren has made it very clear that there's only one way to apportion, the rules should reflect that one way and that one way only.

1:14:02 Nathan Goin. Removing superimposed conditions removes the ability of the physician to provide apportionment analysis. I think you're taking that away, and I think we're already basically in a hostage situation under Caren. The employer, TPA, insurer, whoever, they do a calculus, right? They're looking at a worker whose case is being closed. They're being told by the attending physician 50% apportionment with arthritis, and then they look at the value of that. Let's say it's \$10,000. Well, I can

either pay the worker the \$10,000 that's due to the arthritis that really isn't my problem, or I can issue a combined condition denial, pay the defense attorney \$15,000 to defend this for the next year and a half, potentially have fee exposure for a claimant's attorney for 10 to 15 more thousand dollars depending on depositions and other workup, pay medical experts. So, they're stuck in this untenable position where they're going to end up -- and they are paying permanent impairment for cases where they shouldn't have to because the simple cost of the defense on those issues is much too high for them and it's not worth it. So, we have them in a hostage situation on one hand, and then on the other, if we remove the superimposed category, they don't even have an option to apportion now for conditions or injuries that happen after the fact. So, it creates this increasingly draconian policy for employers and insurance companies, and I know that they're nobody's favorites, but their interests have to be considered.

1:15:35 Well, it's been pointed out that this is an informational discussion meaning permanent things are going to happen later. What we're asking for is for consideration that Caren be read and the rules modified accordingly. I'm not sure -- you know, I mean I can speak to my clients of being held hostage by pretty poor results of having many things apportioned away to the point where they're getting no compensation and trying to figure out how to pay their bills next and getting -- barely being put back on their feet.

So, beating a dead horse here, Caren makes it very clear there's one carved out very limited exception when you apportion. So, if that means the legislature needs to

do something down the road to put in superimposed or some other exceptions of how things get apportioned, then that's something for the legislature to deal with at a later date. I think when you look at crafting rules that comply with what Caren says, it becomes very clear on what's allowed -- what situations are allowed to apportion and which aren't.

1:17:06 Any other thoughts on that? I see some.

1:17:09 Deep breath.

1:17:10 And we did get a little -- so, we had gotten to this discussion about superimposed conditions, but I just want to ask if anybody has any other comments on Issue 1C before we move on because that really gets to the residual functional capacity question, adding in some language about that capacity being -- separating out capacity that is diminished by -- I know we talked about superimposed but also -- or denied conditions or a pre-existing condition that's part of the combined condition denial as allowed under the 262(6)(c). So, any other thoughts on this residual functional capacity issue before we move on to the next piece?

1:17:57 I will just mention on the language to adding about the pre-existing condition. You know, in the other section when we added more language to explain what a pre-existing condition was, whether it was accepted as part of a combined condition, and then there was a combined condition denial. You know you raised the question in the introduction to 1C, well, you know, what would happen if it was never accepted, and you know, a never accepted condition would never be closed, so. And

you would never get in the situation of being on a notice of closure or reconsideration for something that was initially denied as a combined condition, which I can tell you happens all the time in basically 90% of my cases that are denied outright there, that you're always raising a combined condition. And so, they're saying, you know, the work injury was never the major contributing cause, and when that happens you know, there would never be a closure because there never was an acceptance. So, you know, I would think that mirror language in the two sections would be helpful to confirm that, although I don't think you'd ever get in a situation of closing a completely unaccepted claim.

1:19:06 Yeah, I think that was in regards to not accepting the combined condition, so you've gotten an acceptance that the combined condition's not part of the --

1:19:15 Right.

1:19:16 So yeah.

1:19:17 Who would've made --

1:19:18 Maybe not.

1:19:19 I think that's the second option Jovanna's talking about being modified, and then the first bullet says to add language about the pre-existing condition being accepted and denied. To me, the inconsistency -- that makes sense.

1:19:28 Okay. Alright. I'm going to move onto 1D. So, this is -- in our temporary rule, we had deleted Section 1 of Rule 14. So, this is the general statement at the

beginning of the rule about pre-existing conditions. We had felt that that was contrary to the Caren decision. So, the quote that was in the rule before is that a worker is not eligible for an award for permanent disability caused by a pre-existing condition unless the pre-existing condition is otherwise compensable and that general statement was found to conflict with Caren, which found pre-existing conditions may result in an award for a permanent disability if they're not processed as the combined condition and denied.

Also, Rule 7 is our rule that talks about these general principles associated with impairment. Rule 14 is a little bit related, but it seems like the general principles would cover how to handle that issue. And so, because of that, we had deleted Section 1 of the rule, of Rule 14 completely in our temporary rules, and we're looking just for feedback on people's thoughts of that deletion if anyone has concerns or feedback on that piece.

1:21:16 This is Paloma Sparks from OBI. I guess I would be slightly more comfortable if it was something that was mirroring the language in Caren rather than just a full deletion of the rule. I think that could change that are ongoing related to this rule. I think it should be modified rather than deleted.

1:21:42 Yeah, in Rule -- so, the next issue that we're going to discuss, also discuss other parts of Rule 14, so Rule 14's still there. That was just one section that had come out, and kind of getting into the next issue, it also involves maybe whether we should consider moving language from Rule 14 into Rule 7. So, just a little refresher on Rule

7, which talks about our general principles for impairment, and then Rule 14 is about pre-existing conditions and combined conditions. So, one thought was, well, maybe we should consider incorporating that into general principles and just having all the -- all of those general principles in one spot and then what parts of Rule 14 would need to be adjusted, so this was just one piece of it.

Any more questions on 1D? It also might kind of -- people might have more comments as we go through the next issue as well, but before I move on and explain that, I want to make sure if anybody has any other thoughts on that. Okay. I'm going to go into 1E. So, this is also Rule 14. So, under Rule 14, like I said, this talks about pre-existing conditions and combined conditions. The definition of combined condition that was in Section 2 of the rule, it appeared unnecessary. The last permanent rules also refer to the combined condition being compensable, but Caren talked about apportioning impairment when a combined condition is accepted and then denied. And the last permanent rule also referred to estimating impairment after closure under 268(1)(b), but for consistency and clarity, we could refer to the closure after the denial allowed under 262(6)(c). It's referring to the same denial, but it's two different parts of the statute that talk about it. So, go through the background a little bit more. So, Section 3 of the rule describes the worker as having a combined condition if the worker's compensable injury combines with a pre-existing condition under 656.005(7) to cause a prolonged disability or need for treatment. When assessing impairment for a claim involving a combined condition, again the inquiry under Caren is whether it's accepted and denied. And so, the temporary rules deleted the description of combined

condition. That's in Section 3 of the rule.

Section 3 also stated that if a combined condition is compensable, a worker is eligible for an award for permanent disability caused by the combined condition. Eligibility is described in Rule 7, and so for consistency, the statement about eligibility for permanent disability could be better suited for Rule 7, just kind of moving that information over. Compensability determinations are matters concerning a claim, so the jurisdiction's within the Board rather than the Division. So, Caren talks about apportioning impairment when a combined condition, again accepted, denied, and the temporary rules modified the statement to refer to an accepted combined condition. So when we were looking at our temporary rules, we talked about it's not just if the worker has a combined condition. It's if they have an accepted combined condition, they could be eligible unless there is a denial, so that was the modification that we imposed.

Section 4 of this rule was also modified. It describes the need to estimate likely permanent disability that would have been due to the current accepted condition after a major cause denial. We incorporated that into Section 3 of the rule and referred again to the denial under 262(6)(c). Previously, we talked about it being under 268(1)(b). Again, we're referring to the same thing. It's just for consistency within the statute. 262(6)(c) provides the insurer authority to later deny a combined condition if the otherwise compensable injury ceases to be the major cause of the combined condition. 268(1)(b) requires the insurer to close the claim and estimate likely permanent disability that would've been due to the accepted condition when there's no longer --

when it's no longer the major cause of the combined condition.

So, we're looking at Rule 14 in general and just getting -- wanting people's thoughts on the changes that were made in the temporary rule, which I've summarized in the options, and also whether -- people's thoughts on having this standalone rule related to pre-existing conditions and combined conditions versus incorporating these concepts into our general provisions rule, which is Rule 7.

1:27:04 Well, I would say as far as combining rules, I'll admit when you're going to look at apportionment rules and trying to figure out if a notice of closure is proper or trying to calculate a notice of closure for settlement, it's really difficult. I mean there are I think under 0007, there's like 14 different sections covering topics of impairment. The apportionment is also addressed in 0005 and 0013 and 0014, so that's four complex sections that you have to kind of toggle between to try to find the rules. And Caren puts out a pretty simplistic way of doing this. And so, anything that can be done to further simplify the rules being in one place in a more easily digestible way without a lot of repetitions, which I -- which is the -- I think would be positive. I don't have a solution for that as we sit here today, but certainly it can be very complex for attorneys to do it. Again, I'm sure it's difficult for adjusters and I can't even imagine a represented party trying to understand the impairment rules.

1:28:19 Any other comments on this? That is the last issue we've got as far as Caren goes, so any other comments on Caren before we move on? Like I said, the additional background, that is just the summary of feedback we had gotten previously

just for background back when we had talked about changes to the temporary rules, and we wanted to share the information we had received and perspectives at that time.

Any other comments on Caren before I move on?

Alright. So, we're on chronic conditions. So, this is Rule 19. A worker gets a chronic condition impairment value if they are significantly limited in the repetitive use of one or more identified body parts. The rule doesn't define what it means to be significantly limited. So, just to kind of get our bearings because it's a little bit of a shift. Before, we were talking about how to rate impairment. Now, we're talking about the actual rating of impairment, what sort of impairment awards people get, and so chronic condition is one impairment award that can be provided if the worker is significantly limited in repetitive use of one or more body parts and it -- the body parts are listed more specifically in the rule, and I've got them there in the background. So, the rule does not define significantly limited. In *Spurger v. SAIF*, the court of appeals had found an order on review is not supported by substantial reason because there was no adequate explanation of by -- of what was meant by the term "significantly limited: in the rule. Due to that decision, the Division had issued an industry notice back in 2014 to provide its interpretation of what we found to be what was significantly limited in repetitive use of a body part, and we provided an analysis and found the relevant inquiry to be as follows. I'll read the quote. "Because of a permanent and chronic condition caused by the compensable injury, is the worker unable to repetitively use the body part for more than two-thirds of a period of time." The Oregon Court of Appeals had recently acknowledged the industry notice in *Broeke v. SAIF*, and in that case, they

explained the Division's interpretation of its administrative rule was entitled to difference if possible and given the rule's context and other relevant sources of law. In interpreting the industry notice, the court did not acknowledge the Division's implementation of significantly limited, which is what I had described. Instead, the court thought the industry notice stated that a worker who is restricted from repetitive use of a body part for one-third or more of a period of time is entitled to a chronic condition impairment value. The Division maintains the inquiry would be two-thirds of a period of time, and we are looking at whether our rule, so for rulemaking purposes, whether our rule should be modified to change what it currently reads as significantly limited in repetitive use and instead have it refer to the interpretation statement that I had read before, which is because of a permanent and chronic condition caused by a compensable injury is the worker unable to repetitively use the body part for more than two-thirds of a period of time. So, we are looking for feedback as it relates to the chronic condition issue.

1:31:52 Colin Hackett again. I'll move up to the table since I can talk.

1:31:54 Thank you.

1:31:56 So, I guess the significantly limited language is not otherwise defined anywhere in the statute, right? And so, therefore, you're left with a simple textual analysis, which requires you to go to the dictionary. I think the court has talked about that. That's the court's opinion of how to analyze it. Significant I think means something that's important or significant. It sounds more like one-third to me than

two-thirds or one-quarter even or 10%, you know. It's something that affects you, it's significant, and so I think if you look at the dictionary definition, read all the definitions, understand the common usage of the term, what the legislature probably intended is something that affects you in a way that is, you know, enough to say that it's significant. It's a word used every day. A lot of times, people use it in a more common parlance to mean something that's, you know, a big deal, but that's not actually what the word means in plain English. It just means something that's, you know, more than insignificant, it affects you. So, as a claimant attorney and a, you know, member of the Oregon Trial Lawyers Association and as an attorney reading this statute and -- I would advocate for a much less restrictive rule for the same reasons that we've talked about. It's just the workers have been really not getting a lot of benefits for a long time, and they're really having a hard time. And this is a small issue award, I mean 5%. So, it would seem fair to follow the court's lead and impose a less restrictive interpretation of that rule. And also, the court is the last word on what the law means, so I think if you read the court cases that interpret the statute, you should follow that and change your interpretation to make it less restrictive. Does that make sense to everybody?

1:34:08 This is Elaine with SAIF. My reading of the case is that the court just found that the manner in which the insurer SAIF had asked about the chronic condition and the options presented to the doctor were inconsistent with the Division's industry notice. The court did not find that the industry notice was invalid or somehow inconsistent with the statute and rather found the manner in which the questions were asked to address whether the worker was entitled to a chronic condition award

contradicted what the Division had noted in its notice. And then the case was then referred back to the Board for determination of whether the worker's entitled to a chronic condition award under -- giving consideration to the Division's notice and then whether a penalty would be for an unreasonable claim closure. So, it's not that the issue -- the Division's interpretation was not invalid. I think this dates back to what's significantly limited and how the Division has defined it, and it just -- the wording can seem clunky at times to say if someone's unable to repetitively use it beyond two-thirds of a period of time. And it just -- the wording of it can be confusing and that's how it's been applied through, you know, various closures that we've litigated now, and we're now talking about it again. I think it is helpful for the Division to maintain its position because it maintains consistency and allows us to sort of modify a process to be consistent with that notice.

1:35:49 Well, I have read these cases recently, but I will just echo what Colin said about this award. I mean it's a small amount. What I see a lot of times is that the attending awards it and sometimes even the arbiter awards it and then there's all these follow-up letters from the Division. Kind of like what I take is, are you really sure, doctor? I mean what if we limit it this way, what if we limit it this way, and then it disappears on reconsideration. So, it kind of feels like the chronic condition award is something that doctors get kind of convinced out of, and so I would agree that putting -- making it more available is consistent with what the statute would want rather than these really rigid rules that convince the doctors to take away the award when they may of, you know -- how they understood significantly limited, they originally did get

the award.

1:36:52 What I see a lot too is an attending physician who's been following the worker for a long time will say, the worker is significantly limited in their ability to repetitively use a body part, and a chronic condition award is given. And then on reconsideration, it tends to more when there's a panel of three, but all the doctors need to say is -- well, the question is posed, is the worker significantly limited in their ability to repetitively use. The doctor just says no, no explanation and the award's taken away, but I would agree with Colin's, I think, comments. I think having a little less restrictive definition might be helpful.

1:37:35 Do people feel it would be helpful to replace that significantly limited with a more detailed language?

1:37:47 I guess it depends on the language, right? I mean what you have right now is just a weird semantic thing, and it's hard to get your head around. Is it more than two-thirds? Is it less than two-thirds? Is it -- and then it's the, is it due to the injury, or is it the body part or just all this kind of like, hairsplitting going on, and I think so it would just -- I think it would be helpful if you just said, the body part in material part due to the accepted condition is significantly limited, significantly limited means 10% reduction in functionality, you know. You got a significant amount, 10%. I mean 10% is always going to be significant. You've got a clear rule that says it's the body part due to in material part to the accepted injury. All those things are pretty straightforward, and then it kind of takes away a lot of this because I don't really want

it to be open season any time a chronic condition award is at issue for the attorneys to go and try to get the doctors to agree to sort of convoluted explanations and making an issue in every single case so that you always have to litigate it, because it costs a lot for the lawyers to get involved and get experts' opinions. And it's not a huge amount, although it is a big deal to a lot of workers. And so, something that's a little bit less technical and a little bit less restrictive would be something that I'd be in favor of.

1:39:26 Any other thoughts on Division 35 before we finish that up? Is it too early for a break?

1:39:35 No. I think if you're done with 35.

1:39:38 No. We're done with 35, so it might be a good breaking point so that we can come back and start with the Division 30 issues, if everybody's okay with that? Like 15 minutes we'll start back up.

1:39:49 Yeah.

1:39:51 Okay.

1:39:54 And un-mute. Just a reminder to those of you on the telephone with us to please speak up at any time that you want to say anything. You don't have the advantage of seeing who might be ready to talk next here at the meeting, so we encourage you to do that as much as you like. Thank you.

1:40:14 Okay. So, we're going to start back. We finished the 35s. And so, we're going to move into the Division 30 rules.

1:40:21 I have a question.

1:40:22 Yes.

1:40:23 Could I maybe -- just a thought on 35.

1:40:25 Yeah.

1:40:26 I'm sorry. I know that you're moving on.

1:40:27 No, that's okay.

1:40:28 Nathan Goin again. So, when I look at 35, I speak with a lot of physicians, usually multiple physicians on a given day, and I'm frequently told, give me guiderails, give me guiderails, what are the legal standards, what are you asking me, can you define this concept for me? And I think clear rules are imperative for that process and to achieve a good outcome, a reasonable outcome with a worker's compensation claim, whether that's from a claimant's perspective or defense lawyer's perspective. Again, we're all trying to do what's right for the worker, what's right in the context of the system, and I think that the proposed rule change is appropriate, and I think it provides really great guiderails for the physician. It tells them I think pretty clearly what repetitive use is and what needs to be considered, and two-thirds of the time frankly, I think this is appropriate and consistent with, you know, what we use in the context of worker's comp for a very long time. That's kind of ingrained in the system at this point.

Also, I would like to point out that the award for a chronic condition impairment

is 5%, which I think under the current state's average weekly wage is a little over \$5,000. So, I'm not poverty stricken, I'm not the wealthiest person either and frankly, I think \$5,000 is quite a bit. And also, I think it should be noted that that 5% impairment gets factored into the work disability award, so it exaggerates the work disability award as well. So, the impact of this rule and the actual award that it provides for is not the de minimis. It's pretty substantial, particularly if you factor in work disability.

1:41:59 Yeah, good point.

1:42:02 Thank you. Any other comments on that before we move on? Alright. So, to get our bearings since we're shifting gears again out of Division 35. So, our Division 30 rules as a whole are talking about claim closure and reconsideration. And so, we've got different issues identified throughout the rules. They're all kind of falling under that umbrella. Our Rule 20 is requirements for claim closure, and under Section 1, there's five specific situations on when an insurer has to issue a notice of closure within 14 days. Two of those situations refer to a period of time in which the worker fails to seek treatment or attend an exam, which are included in our Rule 34, which is our administrative closure rule, and that affects the start date. The administrative closure rule affects the start date of the 14 days, but without referencing Rule 34 in our Rule 20, there could be confusion about when that 14 days starts for having to close the claim.

So, a little bit more background, (1)(c) of Rule 20 provides that unless the

worker is enrolled and actively engaged in training, the insurer must issue a notice of closure on an accepted disabling claim within 14 days from when the worker fails to seek treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules. Our administrative closure rule, Rule 34, requires the insurer to give the worker 14 days to provide evidence that their lack of treatment was either authorized by their attending physician or authorized nurse practitioner or it was beyond their control. The worker is notified of that pending claim closure and their need to provide that evidence via a letter that the insurer gives. Some people refer to that as a bug letter, if people have heard that term before. The section of the rule is also applied in claims where the worker fails to seek treatment for more than 30 days with an authorized healthcare provider, and that's Section 2 of Rule 34.

It's the intent of the rules to allow the insurer 14 days from when the claim qualifies for closure to be able to process the closure, so once they're supposed to close, they get 14 days to do that. And so, in the context of administrative closure for failure to timely seek medical care, the insurer should be allowed the 14 days from when the worker is failing to respond to that letter to close the claim, or they respond that no additional treatment's needed. The current rule requires closure within 14 days from the worker has been notified of the pending actions, and that could be interpreted to overlap with the timeframe where the worker is provided that notice to respond. So, it really gets into when does that 14 days start to be able to say, okay insurer, you had to have issued your closure by the state.

I'll explain 1D as well, just because it's related. That part of the rule says that, unless the worker is enrolled and actively engaged in training, the insurer has to issue a notice of closure on an accepted disabling claim within 14 days from when the worker fails to attend a mandatory closing exam for reasons within their control and they've been notified of the pending actions. Our administrative closure rule, which talks about how to proceed in that way, says the insurer needs to wait seven days from that missed mandatory closing exam to give the worker an opportunity to demonstrate good cause for failing to attend. So, since the insurer would generally be provided 14 days to close the claim, the question would be whether the Division should consider for 14-day timeframe to start when the worker fails to provide that good cause for the missed exam. And when looking at the options that we had identified, rather than saying, you need to close within 14 days from this event and after you -- the worker's been notified, we could change the rule to say, you need to close within 14 days after this event and the insurer satisfied the requirements for closure under Rule 34, and that would just clarify when the 14 days would start.

And we didn't identify any fiscal impacts but, again, invite input on that issue as well. So, I'll open it up for people's feedback.

1:46:32 So, just that we're not changing the timeframe to do things. You're just clarifying like, when that timeframe starts?

1:46:40 Yeah, so it's still 14 days to close the claim, and it would be clarifying that it's after the requirements of Rule 34 are satisfied, not just the date. You don't have to

close within 14 days from when you send a bug letter. You have to close within 14 days after the worker hasn't responded to that bug letter, right, so.

1:46:59 Gotcha, right. Okay.

1:47:03 So, you need to wait just -- currently, we wait the full 14 days with or without a response, and then we have 14 days to close, and this is just clarification of that.

1:47:15 Correct.

1:47:16 And yes, Dan Schmelling, SAIF Corporation. We appreciate the clarification of the rules, and we have no issue with that.

1:47:27 Alright. I'm going to move on unless anybody says otherwise. Okay. And again, same thing as when we talked about rule -- the Division 35, if anybody thinks of something as we continue talking and you want us to go back, feel free to speak up. We can always touch base on something if you have another thought. And again, anybody on the telephone feel free to speak up if you guys have any thoughts, concerns, issues related to these as well. Issue number two is having the regular -- so, the short title, having the release to regular work in the closing report close -- currently, the rules indicate that when a worker is released to regular work, the closing report is sufficient if it includes a statement indicating that the worker either has no permanent work restrictions or is released without restriction to their job at injury. Occasionally, that information is established in the record but not in the closing report, and so we were looking at our rule to figure out if it should be adjusted to handle those situations.

So, more detailed background, the closing report is required to close a claim if there is that reasonable expectation of permanent disability, has to have certain requirements. The qualified provider has to give or concur with the closing report. They have to have certain information about permanent impairment or permanent work restrictions in the report. And again, if there's -- if the worker has no work restrictions, having the closing report include a statement that the worker has no permanent work restrictions or is released to the --- without restriction to their job held at the time of injury.

It's paragraph B of the rule that we're looking more closely at, which indicates the closing report is sufficient in cases where the worker's released to regular work if it's including that statement about the no permanent work restrictions or release to the job at injury, and thinking while it might not be necessary to require that in the "closing report" if the qualified provider's already established that the worker is released to regular work. And so, and if you look at the options identified, we had prepared some drafts kind of -- all of our draft language is not proposed rules yet, but this is kind of the concept that we have in mind. So, it is subject to change, but it is if we modify paragraph B, we could say if the worker has no permanent work restriction and the provider identified in Subsection A, so that's providers who's the AP or the ANP has not already clearly established the following information, then the closing report would need to include a statement that the worker has no permanent work restriction or the worker is released without restriction to the job held at the time of injury.

1:50:10 I would oppose that change. Again, this is Colin Hackett, claimant attorney. So, the issue of work disability is a battleground. It's a huge battleground in closures where there is permanent impairment or if there is a permanent impairment because it's a large portion of the award. And so, my experience is that insurers and their counsel are really hot on finding any way to kind of not have a work disability award awarded in cases where there's any question whatsoever if there could or couldn't be a work disability award. And obviously, workers want it, need it a lot of times. So, the problem I see here is that a worker may be, you know, kind of back at work in a provisional capacity, and it may not be clear at the time of actual closure whether or not the worker is able to continue and whether or not the worker is back at work in a regular capacity or a modified capacity in some informal way or the way that the doctor's not aware of. Doctors don't tend to pay a whole lot of attention to this because it's not coming out of their bottom line, you know, and they're just there to do medical treatment. They're not there to administrate worker's comp benefits, so they're not paying a lot of attention and if there's something in the record or they had some very cursory conversation with the injured worker that he's working, then it's out of mind for them. And so, anything that creates some kind of, you know, blinking light, red flag, hey, pay attention to this right now when the claim is closed, is this guy able to permanently go back to his regular work, here's his job description, make sure you talk to the worker about it before you sign this thing because it's really, really important, then that would be better for the system and fairer because workers are getting claims closed left and right when they're not back at regular work. They're not

getting work disability awards when they should, and then we have to go back, and after the fact, it's difficult to fight it once a claim has already been closed. There's all kinds of practical reasons, time limitations, resources we don't have to invest because we're not necessarily getting attorney fees for challenging an order on -- or a notice of closure and then getting all of these doctors', you know, opinions and stuff like that after the closure issues. It's not really set up for that. Unfortunately, we have to do it and kind of take a hit as a claimant attorney when you're doing all this work and not really getting paid very much. That's just kind of how the system's set up right now.

So, work disability is a really big deal to injured workers. Their ability to continue their job permanently affects their lives in an important way because they oftentimes will kind of try to limp along at work for as long as they can because that's the culture and the value that people have. They're always telling me, my injured workers, they can't work, well if I got to, I'm just going to go back to work. And then they try, and then they can't, and then their claim is already closed, and it's too late and they can't do anything about it. So, we need to really care -- pay careful close attention, please, please, please, to whether these injured workers are really able to do their job like they were before because that's a big part of where the PPD awards come from and they need that. So, any kind of procedure that flags that issue, makes sure that the doctor has reviewed the evidence, and please put a rule in there -- if I could make a request -- that the doctor discuss this issue specifically with the patient before signing off on it because most of the time, they don't, and it's just not a big deal to the doctor, but it is a big deal to everyone else in the system.

1:54:08 This is Dan with SAIF Corporation. We appreciate the change in the administrative rule, and the added burden it really is putting on the insurer that if we're going to close without the regular release being noted in the closing exam that the record needs to already clearly establish the following, that the worker has a regular work release. And I'll say from a systems standpoint, this actually puts us in jeopardy if we don't follow this administrative rule because if it does close without the work disability because we're relying on a clearly established as a regular work release and then it goes to recon and it's determined that it's not a regular work release and there is work disability, then we could be on the hook for an unreasonable claim closure and penalties associated with that. So, I think from the insurance perspective -- and we take this very seriously -- but we appreciate that it's saying look at the entirety of the medical record, and if it's not clearly established, you need it in the closing. But if it is clearly established, you can go ahead and close without going back to the doctor and saying, hey, I know you released them to regular work six months ago and three months ago, but you didn't put it in your closing exam, can you please put it in your closing exam so we can close the claim?

1:55:31 Well, and this is Jovanna Patrick. I think I would you know, echo some of what Colin said, which was that, you know, the doctor is simply stating, yes, regular work, is not the same as getting the job description and the worker getting a chance to review that because I think -- you know, it happens with -- in front of judges all the time, is that I find that, you know, people really don't understand what other people do for a job. You know, you might think so, oh you work at a gas a station, oh you work

as a housekeeper, you know, you work in a grocery store. But you know, what does that actually entail, what are their actual physical exertions, what do you do for the majority of your day? I think that a lot of that, it just gets written off and, oh yeah, that's the sort of job you can go back to, the doctor thinking, you know, their own idea of how they see people work in those jobs. So, I think that it's a really important step for the worker to have some say there in what their job is because they know what it is and at a time when they understand how important that is.

What I am concerned about is that oftentimes we get regular job descriptions maybe early on or as part of like a big packet of, you know, 10 pages the client needs to fill out, and they may not give it the attention that it needs at that time, but having that, you know, clearly at closing when they're returning to that job maybe if they've tried to return to it, and at this point they can kind of tell which -- where the problems areas are now that they've, you know, mostly recovered, I think there's a real benefit to that. And I think having a softer requirement will actually create more litigation because now it's a yes or no question where it's going to be a judgment call on whether something is clearly established or not.

The other thing that happens a lot of the times that doctors may not know about is that people change to easier jobs either with the employer or with another employer. So, if a guy -- you know if my client comes in and says, oh yeah, I'm working. The doctor says, oh great, he's working, regular work. They might not delve into the fact, well actually, I switched my professions and now I work at this other job where it

doesn't require me to do what I did before. So, the doctor is seeing, oh they're working, it's not a problem. You know, it doesn't necessarily tell the whole story of the job at injury and evaluating that at the time of closure.

1:57:44 Yeah, it would be to me a great improvement to the system to have a checklist for the doctor when it comes to the issue of work disability to go through with the claimant where are you working, are you working the same job you worked before, are you doing all the same things, are you at a new job? They're going to ask that question otherwise. It doesn't have to do with medical decision-making generally, so something that's more, you know, prescribed procedure that involves the doctor and the worker talking about it. Because what happens now typically is the attorney for the employer will talk to the doctor, but the doctor won't talk to the patient about it, and then the decision kind of ends up having to go -- you have to go back. And I agree with Jovanna that this change would actually create more litigation. It's a problem when somebody's released to work, regular work, a month ago before closure because the issues at the time of closure -- what's the worker's status -- and that is the legal standard. And so you're kind of making it a little bit of an open question about, you know, well were they released to regular work permanently a month ago, but it changed and then the doctor didn't know about it. Well, then we're always going to have to go back to litigate that if that comes up. So, creating more litigation, more cost to the system in that sense might not be a better thing. And it doesn't seem like -- if they're already going to the doctor and you're already going to have to ask the doctor, you know, get all this other information, well it's one or two more questions, you know,

so that would be my input on that.

1:59:16 (unintelligible) There's a rule that requires the insurer to send the doctor a job description. There's, you know, convincing evidence that they're released to regular work, so that's already present. The situation is where the doctor has already indicated that the worker's released back to regular work, has been released without restriction. So, there seems to be a narrow application in those instances where the doctor already made it clear for the parties, including the worker because they're required to inform the worker when they are released back to regular work, to not have to do that additional step that can be redundant. I mean the doctor's already made clear indications in their chart notes that the worker is released without restrictions, so this application seems to be a very narrow piece to what can be otherwise a complicated determination where the worker may not have returned back to regular work or may have some modified work restrictions. It does present different situations that are addressed in other parts of the rules.

2:00:20 Nathan Goin from Reinisch. A thought on this too and I'm sure our friends at the ARU could comment on this better than I can, but it's been my general experience that most physicians have a terrible time simply providing permanent impairment findings. That is hard enough for them to do, and I think adding an independent checklist, as has been suggested, for work disability or return to work would further complicate and hamstring the closure process and would put a significantly greater burden on state units like the ARU for going through and making

that assessment, well, did the doctor check off everything on the list?

2:01:00 Jennifer Millemann from ARU. I will say on behalf of ARU what we generally is that doctors -- we get feedback that there's a lot of hassle in worker's comp. I'm sure you've all heard it, and they often sometimes get offended and say, you know, I released him to regular work two weeks ago and why are you bothering me. So, there is a balance of hassle factor. So, there is in the rules that the requirement for sufficient findings that it has to be clear and convincing evidence that they've been released to regular work, looking at the evidence as a whole. So you are looking for things about, hey, I -- you know, six months ago, I'm back with my employer, but Johnny's helping me now. It's not clear and convincing evidence. I'm back at my employer, but you know, now I'm doing my job at AG versus the job at injury. So, that's the type of evidence that we're looking for, for that clear and convincing evidence. I don't know if that helps, you know, to alleviate anything, but that is part of what the rules currently have and would still have.

2:02:01 Yeah, I mean I guess I would respond to that. It just needs to be a big deal, and it needs to be discussed with the worker in a way that it's procedurally more likely to cause a clear and definitive and accurate answer about whether the worker has been released to regular work, and anything that makes it less formal and less clear about when and how it's supposed to be done is going to create more problems down the road, if not in the administration of the claim, in the life of the worker where they don't get that work disability award when they maybe should have. So, in this case, it's

one of those things that it's worth putting more, you know, procedural safeguards in the system because it's such an important part of the benefits that workers get. That would be my opinion.

2:03:07 Julia, I just want to pop in here. I've been in this system for probably longer than most people in this room, and I can recall a problem -- Colin, I actually agreed with you about a checklist. It made perfect sense. Why wouldn't the doctor? -- and participated in a workgroup. It was actually before I went to work for SAIF. I was actually a customer of SAIF's at the time and worked with multiple parties to try and put a checklist together, and we floated it out to some of the docs in the community. And fortunately, we were -- I wasn't in the room when the response came out. The doctors were not amused and sort of -- I guess I'm echoing Jennifer's comment about they feel like they're doing their jobs, and we were telling them how to do their jobs, and worker's comp is so much hassle. We have docs who are -- practices pulling out of the system. So, I mean I hear what you're saying, and it makes -- seems that it would make a lot of sense, but from a practical standpoint, I think I just have some concerns that doing too much procedure and trying to regulate the doctors and give them one more thing to do will actually create maybe unintended consequences that will be harder on the workers than we can imagine.

2:04:27 Yeah.

2:04:28 So, just to say, we tried it.

2:04:30 Yeah. Well, I mean, I see and tell me, Jaye, right?

2:04:33 Yeah.

2:04:34 That in 90%, 99% of closures are done by professional closure situations where it's either an IME doctor or a physical therapist's office that is doing just this, and then the attending physicians are signing off on it or not. That's what I see, is 99% of permanent partial disability assessments are done through delegating it to somebody that specifically does that for a living and that the issue of permanent work restriction is glossed over in the WCE or PCE by the physical therapist, or if it's an IME doctor, of course, you get the most favorable response to their client, which is like, oh yeah, this guy's back at regular work, and they don't really take the time to interrogate that issue. So, I do see it as a problem that there isn't enough attention paid to work disability at the time of closure, and I'm always concerned about doctors not wanting to do their job as treating doctors anymore. But again, I still think it's better to err on the side of having more conversation with the worker about whether they're really back to regular work.

2:05:57 Any other comments before we move on to our next issue? Anyone on the phone? So, we're still on our Rule 20, which are requirements for claim closure. Under 2(C)(a), it states that the job description's required to be sent to the worker and any legal representative of the worker with no exceptions, and we're exploring whether there'd be times when that would not be needed. So, unless there's -- we talked a little bit -- unless there's clear and convincing evidence that an attending physician or authorized nurse practitioner has released the worker to the job held at the time of

injury or that the worker has returned to the job held at the time of injury, the insurer is required to send an accurate description of the physical requirements of the worker's job held at the time of the injury to the worker and the worker's legal representative, if any, either before closing the claim or at that the time the claim is closed. The Division identified some instances where the limit -- where there was limited to no added value in sending that, and the closure was rescinded due to the worker's failure to -- or to the insurer's failure to technically comply with the rule. So, an example would be a job description may not be necessary if the record clearly established what the worker's regular work was or if the worker had already indicated an agreement to the physical requirements of their job without the insurer actually mailing them their description - they might have indicated an agreement elsewhere - or if the worker's already rated at the very heavy category at the highest skill level, so they're already kind of getting the maximum work disability that would be awarded based on that rating category of their job, or if there was a prior rating of permanent impairment during a prior closure, so it could've already been established under a prior closure. And so, the Division wanted to discuss whether the rule should create any type of exceptions for physical -- when the physical requirements would need to be met or need to be sent.

Options identified: Create an exception explaining the description of physical requirements wouldn't need to be sent if the record clearly established the physical requirements of the job held at the time of injury. A second one -- a second option would be to create an exception explaining the description of physical requirements wouldn't need to be sent if the record clearly established the worker was in agreement

with that information, or no change at all or something else.

And if the -- as far as fiscal impact, it would seem like there'd be a fiscal savings if there was additional limitations on needing to send it, but inviting input on that issue as well.

2:08:41 It seems reasonable not to impose a technical requirement where it's not necessary, so I don't think this is -- I think this is a reasonable change.

2:08:52 This is Dan with SAIF Corporation. We appreciate the change in the rules, and we would support those changes, both options.

2:09:02 Nathan Goin from Reinisch Wilson Weier also supports the change.

2:09:13 Did we just (unintelligible)? Did we all just agree?

2:09:16 I just want to see how far you'd (unintelligible) got one of those.

2:09:25 Yeah.

2:09:29 Any thoughts on either the record clearly establishing it versus the worker indicating an agreement? Benefits, drawbacks to each of those or either sound reasonable or appropriate?

2:09:43 Couldn't you do or both? Couldn't you do it or?

2:09:46 Uh-huh.

2:09:47 Or, and then you cover both instances.

2:09:50 Okay. Any other thoughts before I move on? If I ever move on too quick

and people are still processing whether or not they have thoughts, just let me know, and I'll give time for people to absorb what we're reading.

So, Issue 4 is the scope of the job description. Again, we're still under Rule 20, and parts of that rule require that the job description provide the physical requirements of the worker's job, but a worker can sometimes have work restrictions that are not based off of physical restrictions. So right now, we're -- the current rule only talks about physical restriction. So, when an insurer closes a claim and the worker has not returned to or been released to regular work, the insurer must consider their work history including an accurate description of the physical requirements of the worker's job held at the time of injury. That work history covers the period from five years before the date of injury to the mailing date of the notice of closure, and it lists the dates or time spent at each position, the tasks performed or the level of specific vocational preparation, the SVP, and physical requirements.

So, 2(C)(a) and 7(C) of our Rule 20 requires the insurer to send to the work and their attorney an accurate description of the physical requirements of the worker's job held at the time of injury, and occasionally, the worker would have restrictions that are not based off of physical restrictions. So, an example would be maybe a worker had a lung condition. They could be advised not to work with a certain type of chemical or a certain type of product. Technically, that's not a physical -- arguably, it's not a physical restriction. And so, having this information in the job description sent at closure could assist in determining whether work disability could be due on those types of claims.

And so, we were looking at whether the rules should be modified to require the job description to include all of the physical requirements and essential functions of the worker's job held at the time of injury with the idea that incorporating the essential functions would cover those other situations where there might not be a physical requirement -- or restriction. And then otherwise, it could be no change or something else. There would be some fiscal impact expected associated with requiring the job description to list the essential functions of the job, but we would expect that to be minimal but, of course, invite input on that as well.

2:12:26 Can I ask a question because I've never seen this? I don't know that I even would've known to recognize it. Work history, what is that used for? Because we don't have workers where -- we've got union workers. They come and go. They're dispatched for short periods of time. So work history, we wouldn't know the work history for five years prior to the worker coming to work for us. On a one-hit wonder, like out at our Beaverton campus, they were there, you know, a year, two years. So, what is that work history? When is it used?

2:13:08 Jennifer Millemann for ARU. The work history is used to establish the worker's base functional capacity and their skill level five years before the date of injury. You have to know that information if they're going to be entitled to work disability. So, if you don't get it when you're hiring, you would need to at some point during the process of the claim ask the worker for that five-year work history. So, if the job at injury was, say, a light, but three months before they were hired, they were

doing the heavy, then their work disability benefit would be a heavy versus a light if they were entitled to work disability.

2:13:40 Yeah, I just don't ever -- and believe it or not, I was on MLAC when we came up with the new work disability. I just don't remember that, so.

2:13:50 Yeah, they have to interview the worker around the time of closure to get that information, and then it's --

2:13:56 And who's they? The adjuster? Does the adjuster do that?

2:13:58 Yeah. Yeah.

2:13:59 Okay.

2:13:59 It would be the adjuster or --

2:14:00 Or --

2:14:01 -- the worker's attorney or whoever's involved.

2:14:02 Got it.

2:14:02 Yeah, someone has to ask for it.

2:14:05 And the five-year work history has been in the system longer than work disability.

2:14:08 Was it for a scheduled and unscheduled?

2:14:09 Yeah, so MLAC didn't miss anything.

2:14:11 Right. Okay.

2:14:11 It's just it's been around for decades.

2:14:14 Oh, so that's not just specific to work disability. It was scheduled and unscheduled.

2:14:18 It used to be scheduled and unscheduled, right.

2:14:20 Correct.

2:14:20 The unscheduled was --

2:14:21 And that requirement was still there as well.

2:14:22 Yeah.

2:14:23 Well, and I'm sure is a carpenter is a carpenter is a carpenter unless there's a change from a finish carpenter to a I guess a-- okay. Thank you.

2:14:33 So, this requirement that the job description not only include all physical requirements, but essential functions. So, using your example, essential functions would require the worker to work around certain chemicals or products, is that?

2:14:47 Yeah, that's -- the idea is that it would cover -- looking at the work history, you'd know what the worker's required to do. And so, if they have a restriction of preventing them from doing that job, even it's not physical, it should be captured within knowing the essential functions of the job.

2:15:04 And if they can't meet that, then work disability follows.

2:15:08 Right, they can't return to their job at injury. Yeah.

2:15:11 Yeah, I guess what -- John's comment kind of triggered something that I thought too when I read this, which is that, well, we don't want to create an infinite list of things that the worker's doing. It's only important in so far as it might trigger a restriction that they're not able to do some function. So, maybe if the language included something that said that it was related to impairment or a lack of ability to do the task, then it's -- then it definitely needs to be included.

2:15:43 What's the terminology in the statute? Does somebody have that exact terminology for that with regards to the work history?

2:15:54 Yeah, with the job description.

2:15:57 Is there something by statute that's really clear if -- does it say physical or does it say -- and I'm not -- I just want to understand what the statute says. We're not rewriting the statute, right?

2:16:10 I was guessing it says regular job at injury.

2:16:12 Is it in 214?

2:16:12 I'm not sure what section's that in.

2:16:13 Well, I don't believe there's any statute that specifies anything other than the regular job held at the time of injury, or it might just be regular work, and case law has established that it was held at the time of injury. I believe job description was rule based.

2:16:33 Yeah, it just says if the worker has not been released to regular work by the attending physician or nurse practitioner or has not returned to regular work at the job held at time of --

2:16:39 And regular work is defined by rule.

2:16:43 Yes.

2:16:44 And what does, right -- and I'm sorry. I deal with so many different facets across the United States that I just want to make sure. It's like we can very easily, you know, put something askew. What is the definition of regular work and by rule?

2:17:01 The job held at the time of injury.

2:17:02 Okay, that's all it says. Okay.

2:17:06 Well, it says regular work that -- yeah, it is defined as the job held at the time of injury.

2:17:15 This is Dan from SAIF Corporation. We'd actually suggest or choose the option of no change at this time. And I'm a little outside of my lane on this because I don't rate claims every day, but if a worker's not released to their regular job and adaptability is not based on the physical findings or the physical requirements, it's based on the ultimate chart, and I think when we start getting into the essential job functions versus the physical requirements of the job, what if the doctor says, your restriction's not climbing ladders, but the job description doesn't really mention

anything about climbing ladders, then --

2:17:52 So Dan, let me interrupt you if I could. Adaptability is determined two ways. One way is your impairment equates to a certain adaptability. The other way is based on your -- a scale of heavy to light, and the worker then gets the higher of the two, so you do still have to determine it both ways.

2:18:08 Yeah. So, I guess that we're just -- it gets to almost, I don't want to say a fishing expedition, but what are the essential functions. And to go back to the doctor and say, well -- or I to go back to the employer at injury and say, well, is climbing a ladder an essential function of the job? Well, they may have to climb a ladder, but it's not an essential function. So, I guess it just seems to create more burden on going back to the employer to clarify beyond the job description of what are the essential functions of the job.

2:18:43 So, the essential functions are -- that's an ADA. That's under the ADA, the terminology comes out of the Americans with Disability Act.

2:18:51 It does.

2:18:52 So, you are right. You don't -- if you cannot climb a ladder, there's other options. That's what Alimaks are for and stair towers, so you may not have to. So, that's a really good point though because I can see where that can add more confusion in litigation, so.

2:19:17 Well, I guess the other thing I would just add is I think about, you know,

Julia, you were asking about burden, and I'm thinking about small employers who we can barely get a job description out of, and then you start asking them to be more sophisticated and more sophisticated and, you know, clearly to all of us concerned about making sure that worker's going back, that they're rated appropriately. Just somewhere there's that balance that I do worry about small employers and the added burden to them, as Dan said, and going back and saying, no, no, we need you to think about what are the essential functions? And you know, you've got a small employer going, what are you talking about? So, I just have some concerns about that.

2:20:08 So, yeah. Just curious, what is the department -- what is the basis of including? I understand what you're saying. You're saying if they can't do something that's essential to the job, that's important to include in the job description because it's essential. It seems like a circular problem that --

2:20:27 Yeah.

2:20:28 -- like, it's what -- what's the problem that you're trying to -- I know you said it in here, but.

2:20:34 Yeah, so that there could be work restrictions that aren't physical in nature.

2:20:38 Yeah.

2:20:38 And so, currently the job description just has to include physical requirements and so it may not capture work restrictions that aren't physical in nature.

2:20:49 Yeah.

2:20:49 So, the doctor releases the worker, is releasing him to this job presented as just physical requirements.

2:20:56 Right.

2:20:56 He doesn't know that the worker has to deal with chemical products, and that he would've restricted --

2:21:04 That seems like a --

2:21:04 -- had he known about it.

2:21:05 Yeah, that seems like a reasonable and even necessary change because, otherwise, you've got a loophole basically where the doctor doesn't know that the worker has to do these activities that are related to the injury. So you know, it seems like the change is reasonable.

2:21:19 Call me silly, but if I can't -- if the doctor gives me a work restriction that I can't deal with chemicals, it's because of a physical reaction and so that would be -- I don't see how that's different --

2:21:36 When I hear physical versus nonphysical, I'm thinking about, for example, I'm supposed to think every day. I'm called to, but I don't, but you know, that is, for me --

2:21:51 That is an essential function.

2:21:52 Yeah, that's an essential -- is an essential function for me to be able to listen to people and hear what they're saying and to translate back to other people. That would be considered -- and actually, it is in my job description, but. So, I guess I'm now listening to this. I'm a little concerned that we're not really talking about the same thing because, to me, it's very different to say essential versus physical and nonphysical job requirements. It's like climbing a ladder. That's a physical -- that is a physical thing you're supposed to do.

2:22:34 Well, you're making an argument that physical would encapsulate chemical, you know, being around chemicals. Any time where you have to kind of make an argument when there's a rule, those are kind of the rules that we would want to make more clear, so there isn't litigation saying, well, that was included. It is physical to think, those sorts of things. So, we have seen cases where, you know, insurers have argued that, well, those aren't physical requirements for the worker to do. Like you had just said, a physical requirement is climbing a ladder, so why are we required to get it? But it happened to be a restriction that the worker was under, and when rating the work disability, we want certain whether the worker was released to regular work or not because that specific issue was not in the job description, so we've seen cases like that.

2:23:28 Because I don't think there's any way you can describe everything that people do. I don't. But anyway, go.

2:23:34 Well, I was just curious like, how often has that actually come up or been

a concern?

2:23:38 Yeah. That's a good question.

2:23:38 Because if it's a small number where we have to-- you have to go back and clarify it, then maybe that's just the one-offs versus requiring all employers to identify every essential function. It just seems that that would be a challenge for an employer to identify every essential function. I can't even begin to imagine --

2:24:00 That's true.

2:24:01 -- what that would look like because then you'd have like a job description that's like 20 pages long and who wants to sift through that and then get concurrence or not.

2:24:08 And the problem would be in those cases that are the one-offs, if you have no requirement for it, how could you encapsulate that requirement without putting the extra burden on the employers?

2:24:18 Well, wouldn't you -- couldn't you just go back to the doctor and say, okay, this -- you gave this worker this limitation or they have this prescription --

2:24:26 They're a painter. They can't work around certain types of paint.

2:24:28 Yeah, just ask the doctor. Okay --

2:24:31 I think --

2:24:31 And it does happen.

2:24:32 And have the employer get that additional information and go back to the doctor.

2:24:36 The things that ARU would see would be we would ask the insurer for that information --

2:24:41 Yeah.

2:24:41 -- and they'd say, there's no requirement that I provide you that information.

2:24:44 Well, isn't the requirement then that you just rescind the closure --

2:24:46 Yeah.

2:24:46 -- pending sufficient information.

2:24:47 I was going to say --

2:24:48 Not if you make --

2:24:48 -- you guys have the power.

2:24:50 Not if you make the argument that it's a -- that I gave you all the physical requirements and told you that they climb ladders and they did this. We've met that, so I appreciate that SAIF would respond to our inquiry, but that's not always what we find.

2:25:06 As an employer, I'm kind of curious. I've got different jobs, and this job, there might be chemicals that this carpenter is using on this job, and it might be just an

anomaly --

2:25:20 Yeah.

2:25:20 -- that he gets injured on that job, but --

2:25:22 It's not a (unintelligible).

2:25:22 -- being exposed to that -- yeah, being exposed to that chemical has nothing to do for the majority of the jobs that we're on. And so, I mean like I can just see this being -- and for us -- and we actually have a standard job description for our field workers so that we know, hey, these are the -- this is the essential functions, and they may not, when they're injured, be doing all of those things, but that's the basic job that they have.

2:25:46 So, you -- but you do have it providing the essential functions.

2:25:49 We do. You know, so I mean on this particular job they may not have to crawl, but when you look at our regular job description, it says that they may crawl, you know, infrequently or whatever it is that -- I don't know what the categories are. But for me, like what you're asking when you're talking about those other things, that becomes a much bigger thing. Like, could they -- can he go back to that particular job because he can't be exposed to that chemical? No, we can't put him back to that particular job.

2:26:22 Was that the job he was doing at injury?

2:26:23 Uh-huh.

2:26:24 Then, he would be entitled to work disability, and we would need to know if he could go back to that job.

2:26:28 I could put him on another job. It's not that job that is relevant. It's the fact that what's the work that I have available to him as a carpenter, and I can give him work as a carpenter that's normal. That's that just happened to be an anomaly to that job.

2:26:47 Yeah, I mean the statute --

2:26:47 So, essential function --

2:26:48 -- defines it as the job held at the time of injury, so that job is very critical for this analysis.

2:26:54 His job as a carpenter.

2:26:56 His job's a carpenter.

2:26:57 Yeah.

2:26:57 And he's used to carpenter --

2:26:58 The thing about essential functions, I don't think we understand because that is -- that is a very specific description, and I think maybe we need to look at the overall description --

2:27:07 Yeah.

2:27:07 -- used in the Americans with Disabilities Act because you could be

creating, yeah, a bigger problem.

2:27:13 Yeah.

2:27:14 Well, I was going to say, and I think Sheri raises a really important point, because of the use of essential job functions in the ADA, you may be opening a --

2:27:25 Yeah.

2:27:25 -- can of worms that -- and I'm just wondering if maybe there are, you know, a couple things. One, I think the department has the ability with bulletin to explain things and say this is what we mean without going through a whole job description. And as Elaine pointed out, how much of an issue is this and are we creating more burden and more -- creating the potential for more problems actually for you guys by making some of these changes that we could solve in another way? Just a thought.

2:28:00 Yeah, I -- Jovanna Patrick. I think that the words "essential functions" are problematic because I think they do too much and too little for what we're trying to cover here. Conceptually, I like what I'm hearing because there are things that -- it's like, well, is that a physical requirement? I think about driving, you know, people who have to drive for work. Like, is that a physical exertion? Is that a physical requirement? I don't know, but if I have someone who has to pick up a work crew or has to go out and get stuff, like driving is part of my job, I want that considered if my doctor says I can't drive. My concern with the essential functions though is that, well, what if I have to drive for work, you know, once a week? Under the ADA, that might

not be enough to be an essential function. But if I have to do it once a week, I should get work disability if I can't do it. So, in that way, it's -- it doesn't cover quite enough, and in some ways, it covers too much. So, I think it leaves -- just that term I think --

2:28:52 Do you have another --

2:28:52 -- is not the best terminology.

2:28:54 -- another term you want to --?

2:28:56 I mean all of the physical or other requirements? You know, if you just had a -- I know at like the end of job descriptions, there's usually like, you know, vibration, do you work outside, do you work among chemicals, stuff like that. If there were maybe just an other box, you know, that would allow for things that -- you know, anything not covered in here that workers are required to perform in their job, that may cover the -- you know, what we're trying to do here without, you know, injecting employment law words into it that everyone might understand a little bit differently.

2:29:31 So, is the determination of whether the worker is actually back to their regular job at injury, you're only looking at the physical requirements of the job, is that the way the rule reads now?

2:29:42 Currently, the rule requires the insurer to send a job description to include all of the physical requirements, and it's --

2:29:45 Okay.

2:29:46 All the physical requirements.

2:29:50 Well, I know it's rather broad, but couldn't you say the require --
description of the physical or other requirements? I mean --

2:30:00 Yeah.

2:30:01 I mean --

2:30:01 It could be something as simple as that.

2:30:02 Yeah, because I mean I do have cases where workers -- you know, they
are put back to their job, but you know, before their injury, they could do A, B, C and
now they can only do A and B, and if C I guess isn't a physical requirement, I mean
that's a problem.

2:30:19 Yeah, it seems like the ARU must have the tools necessary to do their job,
and if Jennifer says, you know, this doesn't quite cut it, we got to do something for
them so that they can cover the people that have restrictions that aren't physical
because -- or that there's an argument, right? Because there are some things that
maybe really aren't physical and that needs to be included, so we got to do something,
you know.

2:30:48 All very helpful feedback.

2:30:51 I liked when everyone agreed.

2:30:54 Yeah, second that.

2:30:55 Can we just get back to that?

2:30:58 Yeah, it's helpful feedback.

2:30:59 I think the next issue we're all going to agree on.

2:31:01 Yeah. Anybody have any other thoughts on that or any other creative solutions on ways that maybe would capture the concern but not deal with the essential function language if it's something other than the other? Any other ideas?

2:31:24 The only thing I can think of would be some small definition of physical that maybe was given to what you were talking about.

2:31:30 We could, and that's a good point too, to define what physical means.

2:31:34 Now the problem there is what -- this is not related to closures where there's a mental health condition that's the cause of a disability.

2:31:41 Yeah, I like that even better.

2:31:43 You would relate to those as well.

2:31:46 So, stress claims is what came to mind when I read this the first time.

2:31:49 Yeah, that's another kind of category that could sometimes maybe fall where the job description might not address what might need to be captured.

2:31:59 Yeah.

2:32:00 I think we just craft a rule that the Division has the authority to get additional information if they think there are restrictions beyond this, something to that effect.

2:32:09 Yeah.

2:32:10 That they have the discretion to ask for more and that it needs to be provided and failure to do so will result in rescission of the closure.

2:32:19 Yeah, that would take care of your one-offs where people saying, yeah --

2:32:23 Yeah, then you have the option --

2:32:25 -- I do.

2:32:26 -- to do it, but it's not --

2:32:27 And you can say, yeah, you do.

2:32:27 -- in requested for every claim.

2:32:28 You know, for -- remind me, back in the day, and this is really ridiculous, but I can't remember what it was -- Jaye, you may remember. They used to bring these to MLAC, all these one-offs, and we would have to vote on them to -- oh, you know what I'm talking about?

2:32:41 I wouldn't suggest that.

2:32:44 That's how we got hit with all those one-offs. Do you remember?

2:32:48 Not me.

2:32:49 Well, Chris, you remember that, when they had to do that?

2:32:52 I think that's a different topic.

2:32:53 Is it?

2:32:54 Yeah.

2:32:55 We had to do it because we didn't have a specific way to read impairment. We had to do a rule addressing those too.

2:33:03 Okay.

2:33:04 Of a temporary.

2:33:05 But that's what I mean, is going to do -- like what Elaine suggests, I think would -- and it's --

2:33:13 It seems like the cleanest of --

2:33:14 Yeah.

2:33:14 It seems like the cleanest resolution that doesn't introduce unintended consequences.

2:33:19 Yes.

2:33:20 Right, so you're able to get what you need to do what you need without changing anything that could have some unintended consequences, and then we're back here trying to fix the unintended consequences. So, I'm always in favor of those. We know we have this -- we know where we're at today. We can add a little tweak that gets you what you need without it having --

2:33:40 Yeah.

2:33:41 Well, I would say that this isn't just what ARU needs.

2:33:44 Right.

2:33:44 I want to be cautious about that. It's really -- does the doctor know all of the functions this worker was doing when he says regular work? So, if you did for some reason have a carpenter that was required to be around these chemicals for some reason versus carpenter B that doesn't do it and he was injured here, that doctor would need to know, but he might have to go back to some sort of work around chemicals. He might be a slightly different carpenter than carpenter B. So, they aren't necessarily one-offs all the time. We do see doctors are not aware of the full scope of the regular job held at the time of injury.

2:34:27 It seems to me that, first of all, the employees are talking, and if there is a restriction that they can't be around a chemical, the employee is going to go, yeah, but that's what I'm doing. So, it seems like first of all, those discussions would and should be occurring, but if it hasn't and it gets to you, you have the ability now to address that. So right now, it's not in place, so we're talking about what effect comes to you, right? What's coming to you that you have to ask and this is a resolution that addresses that issue. I'm assuming that the rest are ones that are having discussions about, well, can I do this? Can I -- you know, if somebody said, I have asthma. If somebody told me I had to go work -- go back to work and I knew it would cause me an asthma attack because I was in that area, I'd be having a discussion about --

2:35:21 Are you saying with your doctor?

2:35:23 Yeah. Like, I'd be saying, okay, physically I can go do the things that I was doing, but this affects -- I still have this event, which is part of my claim, and I have to go back in there, and how am I going to do that?

2:35:32 Do that, yeah.

2:35:33 I would still be asking that, and I would expect that most -- even you know, our workforce --

2:35:40 My workforce is very verbal, but.

2:35:42 Well, they're generally not. I mean unless like -- the construction industry, they don't like going to the doctors, and they're very intimidated by the providers unfortunately, and so they don't have a lot of discussions, but they would speak up about --

2:35:55 Yes.

2:35:56 -- something like that. They would.

2:35:56 Yeah.

2:35:57 That they -- okay, I can't go --

2:35:59 They or their spouse would. I would say the spouse.

2:36:02 So, yeah. That too, right?

2:36:03 I'd say the spouse is usually the one that points that out.

2:36:07 But the thing that I was trying to point out earlier is that I think that

there's -- if there's a process for these one-offs that can be applied successfully, that that's -- that makes sense as opposed to something that would have a significant impact across the board on -- that's not -- may not be as -- may not get you what you want. It may create more confusion.

2:36:36 So, I'll just say this one last thing about this particular issue. ARU I think sees maybe 30% of closures, so then you're talking maybe 70% of closures we want to create the correct behavior from insurers and workers and doctors, that they're all talking about the same thing when they say regular work. And so, that's just one of the reasons this kind of came up.

2:37:02 Well, one suggestion, and I don't know if this is maybe too -- I don't know if this would work I guess is the best way to put it. But if you can't say like, relevant essential functions, I mean everybody has to open their own door, but you know, they don't always put that in there.

2:37:16 That sounds like full employment for workers.

2:37:19 I know. That's such a terrible idea. No, it's -- I mean you got to do something because they're trying to create a closed universe at the time of closure where everybody has the information they need and that's what the closure is based on. And so, when you say, we want to create a special rule or a one-off, well then, you know, it's not part of the system where it's not reviewed and it's not included in the information that's given to the doctor. So, I think what ARU is trying to do is make sure that the rule is clear that it is essential and relevant to the disability that it be included

in the record at the time of closure so the doctor can see it and the worker gets properly rated. Relevant, other, some kind of word in there --

2:37:56 And I think --

2:37:57 -- would seem to make sense.

2:37:57 I think by redis- --maybe defining physical to mean a little bit broader than just listing crawling, climbing, we might be able to solve this particular issue. So, the job description would be requiring kind of a little bit broader information than just what some would think is physical.

2:38:19 This is Elaine. Again, it may be helpful too to just for the Division to issue a bulletin that sort of explains when they see this, what are the scenarios. Then it puts the employers -- and giving them the notice of when they should be on the lookout for these situations. Because if it is coming up on occasion, it may just be that for the vast majority of us, we're just not seeing it with a frequency to put it at, you know, front and center.

2:38:47 Is there a way to link the job description to any prior work restrictions involved on the claim? Because presumably, these workers had previous work restrictions related to whatever this nonphysical thing is. So, the doctor might have said, you can't go back to regular work because you can't work with this chemical or because you can't think for two hours straight because you had a concussion. So, those sorts of things the job -- and I'm thinking out loud because this just came to me. The job description -- requiring the job description to include all physical requirements

and any other requirements related to prior work restrictions and then that might encompass. Just throwing it out there.

2:39:30 I don't understand the prior work restrictions.

2:39:33 Yeah.

2:39:34 Help me. I don't understand that, the job description related to prior work restriction.

2:39:39 Prior work restrictions under that claim. So, if the worker was told that they had a concussion, and they couldn't go back to work because they need to take breaks every two hours to rest their brain, or they can't work around chemical products because they had a lung injury. Well then, it's the work restriction -- the job description would need to include any requirements related to those restrictions, so they need to know what they need to do for thinking, how long they need to sit at a computer or how long they need to -- what types of chemicals they need to work with. But for a worker who has nothing -- has no prior indication of restrictions that were nonphysical in nature, there wouldn't need to be additional requirements. Just --

2:40:24 Well, I don't know. I get my work -- I have had some head injuries, but those people get -- they get back to work, and they don't have any restrictions. We wouldn't have -- want somebody out, you know, climbing steel that has -- so, I'm a little confused by this, and I don't mean to get a little passionate about it, but in my world, I know who can and can't do what they were doing when they got injured. So, you know, I'm not sure how that, you know, equates to their disability award, but if

they're released to their regular work, I just, you know -- I don't know. Sorry.

2:41:00 The question is whether they're actually going back to the full --

2:41:03 Yeah, and they are.

2:41:03 -- requirement.

2:41:04 In my world, they are, thousands of them.

2:41:06 Well, and I think if we're limiting this to your world, that's fine.

2:41:08 Yeah, I just --

2:41:08 Because your world is union people who have written job descriptions in very formalized ways.

2:41:13 No, it isn't, not always --

2:41:15 Okay.

2:41:15 Yeah.

2:41:16 But your world is not all workers, and we have to look at all workers, and a lot of employers are not as organized as yours is and are not amenable to say, oh well, I know he can't do that, but I just won't put him back to that. Well, that's not the question. Now he can't do something that he should be able to go out in the job market and do. And you know, I represent a wide range of workers. Most of them are not skilled or sophisticated enough or maybe not even speak English to be able to work at a sophisticated job site. So, I think we need to make rules that make sense for

everyone, not just for higher-wage workers who work with employers who have -- are well organized.

2:41:57 I don't -- you know, I'm just having déjà vu for all these discussions when we went through this with the changes back in the early, mid-2000s. I'd love to be able to go back and look at some of those discussions because I know this came up. It came up with, you know, the people that are the lower-wage earners, so.

2:42:21 Well, you know, maybe start with a rule that gives the Division authority to ask for the additional information specifically so that it's not a -- you know, so you don't have somebody going nah-nah-nah, and then a bulletin for more information and see if that moves the needle. I mean I guess I agree with Jovanna that we have employers who are small and are not sophisticated.

2:42:51 Definitely small, yeah.

2:42:52 You all, you know, have much more sophisticated operations and that's a different animal. But at that same time, I don't want to create -- I don't think we want to create a rule that will make it more difficult for organizations that are doing the right thing already and make it harder for them to be participants in this thing and not really get anything out of it.

2:43:15 Well, and can I just point out that I am concerned about what you're suggesting because we do have carpenters who are in the industry and they're union, so they're working for us today. They may not work for me tomorrow, but if you're telling me I have to be specific about the job they were doing at the day that they were

injured, I'm not going to list half of the job -- half of the actual functions that they need to do as a carpenter because on that job, they didn't use them and now he's going to get cleared because he can do all of those things, but he can't do these other three that I didn't -- it's not essential to my job. But if he wants to be a carpenter, he can't do that now, so I have a problem with the reverse side of that because now you're restricting that carpenter from actually not being a carpenter for any trade because I got him on a job that you want to talk about the fact that he's on -- he's got chemicals on this one specific job that's not part of what they normally do. But if you want to get that specific, I'm also cutting out all the things that he doesn't -- that he didn't do on that job that now could actually affect his employment down the road. If you want me to be specific, I'm going to be specific. I'm not going to be overinclusive. I'm going to just tell you exactly that this is what he did, and now he's actually not going to be able potentially -- because I can return him to that job, which by the way is done and doesn't exist anymore. Where's that guy going to work?

2:44:45 Yeah, because it should have been a --

2:44:46 It has a -- that's like -- that's a --

2:44:48 It's not something that AR --

2:44:50 -- two-edged sword.

2:44:51 -- ARU's doing. Statute of the legislature has determined that regular work is the job held on the day of injury.

2:44:57 Yeah.

2:44:58 So.

2:44:59 And we take that to mean --

2:45:00 I mean I see what you're saying.

2:45:01 -- the functions of a carpenter that works for us. That's what we take that to mean, and in fact -- I mean I believe that that's where -- when we did the job descriptions initially that that was how they were determined. We had somebody come in, and we came in and said, what are the essential functions of a carpenter, not of this particular person following this person around, but looked in whole and said, what's -- what do you require of this position, right?

2:45:30 So, you're talking essential functions, and that's kind of where we started.

2:35:33 Yeah.

2:35:34 We're talking more and I'm not sure. I think maybe the lawyers in the room could say what the Board and the Court of Appeals have defined as regular work. I believe they've talked about essential functions.

2:45:47 Well, yeah. I mean I -- pretty much. I mean I think you talk about, you know, is the worker actually going back and able to perform the full essential functions of the job they were doing at the time of injury. So, where litigation gets in is my client will -- there will be an indication, well, he's back to regular work, and my client will fill out an affidavit for reconsideration saying, well, actually I'm regular job injury was this

and, yeah, I'm back with the employer, but I can't do X, Y, and Z, so I'm not truly doing the full functions of the job held at injury, which is the determination. I mean I'm trying to determine, you know, is this person -- what jobs are precluded from it, and so in determination of work disability, are they truly back to the full functions of their job, the regular job they held at injury? Did that answer your question?

2:46:41 Yeah, and can a claims adjuster or ARU, when they're determining whether a worker is entitled to work disability, can they determine that entitlement because they know what the essential function is, or the real meat of that job, or is the job description silent on that?

2:46:58 Yeah, or how would you know the information's missing? I mean so let's say, you know, create a bulletin that you're entitled to go ask for it. Well, how would you know to go ask for it if you don't even know if the information's missing?

2:47:08 Well, and I brought --

2:47:08 I was suggesting a bulletin for that piece that, that should be a rule, that they can get the additional information and how they know is when the worker says, oh wait a minute, in part. But the other piece of my intent for that, my thought for the bulletin, would be that would be a direction to the industry to employers about what needs to be considered. It's explanatory.

2:47:34 Yes, and I think we need to explain it more to claims adjusters and processors than ARU. We're pretty savvy on -- we're not thinking this is clear and convincing --

2:47:43 Oh, yeah.

2:47:43 -- evidence that this is regular work because we're looking at all that evidence. But claims adjusters are -- you know, there's a lot of rotation for claims adjusters. There's -- you know, the laws change. We want to write rules where they can understand and give benefits based on what the law requires.

2:48:04 A couple -- no, not even a couple years ago, you issued the industry notice on calculating average weekly wage.

2:48:10 Oh.

2:48:11 That's been extremely helpful to adjusters. It's been extremely helpful for insurers working with employers, is to these are the requirements that you're -- payroll that you're required to give to us. You need to give to us, so that we -- yeah, can calculate an average weekly wage. This to me kind of sounds like an industry notice of here's some examples and kind of spell them out that these are the situations where the essential functions of the job may not be within the physical job description and you should go beyond and ask some of these additional -- or beyond this additional information because that's something that, you know, kind of -- we can keep and train to as we have staff turnover.

2:49:01 And that would help TPAs too.

2:49:03 Yeah.

2:49:05 And for employers, you know, I've said since we changed the structure of

PPD and I've been doing it religiously, is for employers, advising them it may be in their best interest to have job descriptions, you know. I don't think there's anything wrong with that. We do it on all of our claims, but it's not -- it's very expensive to have it done, but I do it because I want to make sure that we're all on the same page. So, I'm not advocating that there's a rule that everybody has to go get an individualized job description like I do, but you know, I think it is you know, a best practice.

2:49:46 Nathan Goin from Reinisch. I think Dan's suggestion, his suggestion is excellent and would meet the need for making permanent rule changes. We were talking about the intended consequences earlier on, and it avoids the mire that we find ourselves in when we start changing things, and sometimes for good or bad. So, I think an industry notice would be incredibly helpful, particularly for adjusters who could look at that at their desk level and understand what they really need to be providing.

2:50:18 Any other thoughts on that before we move to the next topic? Okay. So, we're still in Rule 20. Issue 5 relates to when to send the Form 1503. So, in most circumstances, the rules do not specify when that has to be provided to the director of the parties, the worker's attorney. Rule 15 says that when an insurer issues the notice of closure, they're responsible for providing all these people a copy of the notice of closure, the worksheet, the 1503, which is the Insurer Notice of Closure Summary, and the updated notice of acceptance at closure. Each of those documents with the exception of the 1503 has to be attached or sent on the same date as the notice of closure unless it's a new condition reopening, which is a little bit different under the

Division 60 rules. So, under Division 30, looking at when the 1503 has to be sent, it's silent. We just know it has to be sent. It generally is I think attached to this whole packet of information. I don't think that there's a problem too frequently with it not being there, but there's no rule saying you're supposed to include this within that packet with the notice of closure, the worksheet, the updated notice of acceptance. So, this would be a rule change to modify the rule to require that the 1503 be included with the notice of closure and the notice of closure worksheet.

2:51:50 Dan from SAIF Corporation. We thought it was, so.

2:51:52 We did too, Dan, to be honest.

2:51:53 So, just for clarification, that's when we send it, so.

2:51:56 It makes sense to send it all in the same envelope.

2:51:58 It generally is happening, so and I thought --

2:52:00 They tried to come up with a, well, the 1502 is required within 14 days. I'm like, no. This -- it's required.

2:52:12 Alright. That one's pretty straightforward. So, Rule 20, also job description stuff. So, in 7(c), it requires that the notice of closure include an accurate job description unless it's not required under 2(a) or it was previously provided under 2(b)(A). So, the references -- the rule references need to be updated. And so, 2(b)(A) relates to the qualified providers. It's just an incorrect reference. It should be updated to 2(c)(A), which talks about when the job description is and is not needed and if we're

modifying 2(c)(A), previously we talked about whether to modify 2(c)(A) to not require the job description when the record's clearly establishing the requirements of the job. So, depending on what happens with 2(c)(A), we might want to similarly update this part of the rule to explain that the job description does not need to be required to be sent if it's not required under that other rule, so it's a little bit of a housekeeping thing depending on where that goes. So, the option identified, modify the rule to explain the job description does not need to accompany the notice of closure if it's not required under 2(c)(A) or if it was not previously provided under 2(c)(A) of the rule. Any thoughts?

2:53:38 We agree.

2:53:40 Okay. Okay, and the fiscal on that would just -- if it's sent less frequently, not as -- a little bit of a savings, but.

Issue 7 is still Rule 20. Under Section 5 of the rule, there is a conflict in the rules about what date to put on the notice of closure. So, Section 5 suggests that the date on the document may not be the date it is mailed, but then we have 6(g) of the rule that says that the document needs to include the date it's mailed. So, looking more specifically under 5, it provides the notice of closure is going to be effective the date it's mailed to the worker, the worker's attorney, or the estate if the worker's deceased, and then the rule goes on to say that that's regardless of the date that's actually on the notice of closure. It's going to be effective the date it's mailed, but 6(g) says you have to put on the notice of closure the date that it was mailed. So, there's a little bit of a

conflict between those two. And then in our looking at the actual notice of closure form, the box says on their date of closure (mailing date). That date's important because the worker is notified on the form that they have 60 days from that mailing date to appeal the closure.

So, we were looking at -- some options would be under Section 5, it could be modified to say the notice of closure Form 1644 is effective the date it is mailed to the worker and the worker's attorney if they're represented or the worker's estate and just leave it at that, and that would make it a -- and then leaving 6(g) alone would make it so that the notice of closure would have to have the date it's mailed in all circumstances. The other option is under 6(g) that it could be modified to say that the notice of closure needs to include a notice of closure date and it would provide some leeway. I think the situations we often see could be like typo situations, or you might prepare a notice of closure today and put it in the mail tomorrow, so it might be dated today but mailed tomorrow, or you could put 2019 when it's 2020. You know, those -- at the beginning of January, we could see those issues. And so, trying to figure out should the rule have a little bit of leeway where it's saying, well, you need to include a notice of closure date on there and it's actually effective the date that it's mailed regardless of the date on the notice itself, or we can take away the leeway and say the notice of closure has to be dated the date it's mailed and that's the effective date, end of story.

2:56:26 So, the issue is the appeal rights are tied to the day of mailing, so

anything that affects that is important. If doesn't have the date of mailing on the notice of closure - am I following the issue correctly? - then that creates a problem for the worker who can't see when the 60 days is set from.

2:56:47 You know, the date on the notice of closure affects the appeal rights and also the aggravation end date.

2:56:53 Yeah.

2:56:54 And so, like I said, a lot of these are typo situations or like a day off you know, when you prepare it one day and it actually gets mailed the next day.

2:57:02 Yeah.

2:57:04 And so, I guess the question becomes, in those situations, should there be rescissions of notices of closure if they're a day off and they need to include the date it's mailed regardless of anything or should it be leaving in the kind of leeway language in 5 which is saying, well, it's going to be -- regardless of what you put on there, the date it mails is the effective date, and there could be a little bit of a difference.

2:57:31 Yeah. No, you definitely want the date of mailing on the notice of closure so nobody gets caught by surprise because that would be a terrible -- I mean, it is a terrible situation for a worker that doesn't have a chance to appeal that if it's a mistake -- if there's a mistake in it, so. If you can't look at it and figure it out and then it's a problem to prove, you've got to get the envelope with a stamp on it. My gosh, it's like a nightmare. So yeah, the date of mailing on the notice of closure, that's the date

everybody knows, keep it that way please.

2:57:59 Yeah, I agree with Colin because when the client comes into me, oftentimes the time a client's coming for the first time is they've got a notice of closure. They come in with the notice of closure. I don't know when it was mailed. I don't have the envelope. They tossed it weeks ago, so all we have is the date on the notice of closure, and that's the date that their 60 days should run from. I mean technically it stated the first on the notice of closure, and they don't mail it till the second, you've just reduced the amount of days that that claimant -- the claimant doesn't have 60 days to appeal it. They have 59, which sometimes makes a difference between benefits or not, so we should be able to rely on the actual date the same way that a denial would rely on the actual date rather than -- you know, I mean I always just assume they get mailed on the date that they say they're getting mailed or they say that that -- you know, the date of the document itself.

2:58:49 Yeah. Yeah, just put the next day as the date on it and send it out that day. It's fine. Just --

2:58:54 Yeah.

2:58:54 -- don't put a different date and then mail it. It should say date of mailing on there.

2:59:02 Julia, what happens if somebody puts the wrong year? So, what happens? Is that -- then that notice isn't valid and it has to be resent? Is that what the effect is? So, let's say somebody does make a mistake when they --

2:59:19 Like on January 2nd, they put --

2:59:21 Do we issue --

2:59:22 A corrected?

2:59:23 -- a corrected on that situation?

2:59:28 It depends on how strict the rule is. So, the current rule kind of gives some allowance for human error but also requires that the worker's rights run from the date it's mailed regardless of what the notice says. So, if you take away that and don't allow for human error, then you couldn't correct something because it was invalid. If you didn't put the mailing date on, there would technically be -- that would be an invalid NOC and you can't correct something that's invalid.

3:00:02 So, do you just have to issue a new one?

3:00:06 This is where this whole kind of -- this is why this came up. We actually do -- our claims coding section actually sees a lot of these where people start something on Friday and then they finish the documents on Monday. And so, really the question is for you guys, what do we do with this kind of scenario? Because if you give no kind of flexibility, then they're invalid, and you would need to issue a new notice of closure. That also adds confusion to workers because they're getting these weird notices of closures, so that's kind of the question.

3:00:41 All these years --

3:00:42 Would you agree?

3:00:42 -- I didn't know what the hell was going on. It's now becoming clear. I just always look at the date on the notice of closure and just assume I have 60 days from that date.

3:00:55 Well, the rules have been in there and it says it's effective the date it's mailed regardless of the notice because there were some human errors coming in. So, workers are getting, you know, their full rights, but they would have to, in certain circumstances, look at the envelope.

3:01:09 So, if the notice of closure says it's issued January 20th, but it's not actually mailed until the 26th or.

3:01:16 Then it's effective January 26th.

3:01:20 Are those all --?

3:01:21 Don't do that. Don't do that.

3:01:25 I was just curious if there's another.

3:01:27 I have a question on that. In those situation -- all the examples you've given, basically I understand the claimant actually gets more days, right? Because if it's dated the 1st but it's not mailed till the 5th, then they have 60 days from the 5th.

3:01:40 Well, they don't really get more days because it wasn't mailed for -- so those days, they didn't know about it.

3:01:45 They have more time than they thought.

3:01:46 They get their full 60 days.

3:01:46 But they come into me and it says the 1st and I assume that the 1st is the date, and yet I don't know because their, you know, wife who opened it and threw away the envelope. I don't know they have 5 more days and I tell them, you're on your 61st day, sorry, no luck. I'd help you if I could, but I can't because, you know, from the 1st to today is 61 days, you are out of luck. Well, that person isn't out of luck because the only person who knows that it was mailed on a date differently would be the adjuster or, you know, the savvy claimant who happens to keep their envelopes. I don't keep my envelopes in my office. If I represented that client currently, I wouldn't know because my receptionist opens our mail, and we throw away our envelopes because, otherwise, our piles would be enormous, so.

3:02:30 Yeah, I believe there's been some case law in this that has said that if it wasn't mailed -- I mean, this isn't something we've come up with.

3:02:39 Right.

3:02:40 It says you got to look at when it was mailed and I believe there are some board rules that talk about, you know, something's effective the date that it's mailed, so.

3:02:49 How frequently do you see this as a problem or an issue?

3:02:53 As far as timeliness of the appeal, we don't really see that very often. As far as a different date than what's mailed, I believe our claims coding sees it on a

somewhat regular basis.

3:03:09 And given the number of claims, there's --

3:03:11 Yeah.

3:03:11 People make typos, or they finish the document the next day.

3:03:17 Well, I think that's something as important as your claim closure and whether you have the right to appeal it. I think that everyone should be held at the highest standard possible so there's no confusion about how much time a person has, and they don't fail, you know, on that 61st day. What you're seeing is people who -- you're not seeing people who don't appeal because they think they're out of time when they're actually not, and they weren't actually given -- at that moment, they haven't had their full 60 days to consider it because the mailing date was later, so their time to think about appealing is actually less. The amount of time they have the document in their hand.

3:03:50 Would it help at all if the 1644 form said it's the mailing date regardless of the note -- the date on this -- on the notice itself so that the worker may have a --

3:04:02 Yeah.

3:04:02 -- better opportunity to grab that envelope?

3:04:05 Yeah. I mean I think if we're going to keep the rule of mailing date and it can be different than the notice of closure mailing date, then it has to be somewhere other than the envelope because I don't think people are trained to keep the envelopes.

I mean I -- you know.

3:04:19 We used to.

3:04:20 Yeah. There are certain times like settlement papers. I tell my clients, like keep the envelope because that's the only way we can prove when it's mailed, but you know, claimants get mail every single day sometimes. We're lucky if they keep them. People come to my office with trash bags like with, you know, folded up things, usually just their doctor notes. So, to think that claimants could track this sort of thing by envelope is just not the way it works, not even --

3:04:44 So, I have one other question then. So, would you -- if we're not seeing a lot of workers -- and you may, we don't, but if you're -- if we're not seeing a lot of workers who are actually losing their appeal time because of this, would you want to see notice of closures taken back and benefits held up for the majority of workers in lieu of it being very strict?

3:05:09 I think a worker waiting for benefits versus a worker not getting benefits, I would go for the worker waiting if I had to make that call.

3:05:17 Yeah, it sounds like people are losing appeal rights without knowing it --

3:05:21 Yeah.

3:05:21 -- in that situation most of the time. In other words, they are actually missing out on opportunities to appeal things that they could've appealed if they would've known and was issued on the different day than it what it says it was issued

on. In that case, it would be better to hold the claims processors to the higher standard of actually putting the right date on the document because that's very important.

3:05:44 Was there somebody on the phone trying to say something?

3:05:49 This is Jennifer, Ombudsman for Injured Workers. I want to just share that, yes, I think workers need to be aware of what that actual date is, but from my understanding regarding the data, there's many more closures that it's a wrong date by one or two, and if we were to require those to be corrected, that would delay much more benefits to workers than those that may not be completely informed regarding the appeal rights. What I will share is that in our office, when a worker calls and they've got their notice of closure and we're like three days before the 60 days and they haven't gotten their attorney yet, one of the things we will always, you know, say to them is one, do you have your envelope, which you're right, most of the time they don't, but letting them know that that timeframe runs from the actual mailing date. If they request for a hearing and get in contact with an attorney as soon as possible, but to keep in mind that that timeframe -- or if they're calling two days after it's expired, it might not be expired and just having that knowledge to share. Again, the only people that are going to get that information are the ones that are talking to us or their attorneys, being aware that that timeframe may be different than what's on the closure. But I do have a concern about numerous notices of closures not being determined valid and delaying that first payment of PPD out to these workers.

3:07:28 Thanks, Jennifer.

3:07:30 This is Dan with SAIF Corporation. I think the expectation should be that the date that the insurer puts on the notice of closure is the actual mailing date and should be held accountable to it, and maybe if it's more information to the insurers and first party administrators. You know, we have a 2:30 cutoff for the mail. If someone throws it in the ongoing mail at 2:45, well, it's not going to get picked up and postmarked until the next day, and we train folks to the cutoff's 2:20. If you don't get it in the outgoing, you need to walk down to the mailroom, find a mail person, physically hand it to them. And so, I think that's some of the problem here is it's a lack of understanding of just our own internal processes, when the mails picked up, but we should be held accountable to the mailing date's the mailing date.

3:08:27 I agree with Dan. How hard is it? I mean, it's important. You got to put it in the mail when you say you put it in the mail because there's appeal rights that go with it. Do it right, you know, and Jennifer's point that benefits are going to be delayed. Well, that's a problem of claims processing agents not doing their job right, or they need to be educated that this is the right way to do, and one way to do it is take them back or send those closures and maybe some of us lawyers will try to bring a case to the judge for a penalty on that or something, you know, and try to fix that problem that way.

3:08:56 Now, I will say on the rescission, if the reason to rescind is it was dated this date and mailed that date, but the request for reconsideration came in timely, I

don't see that as a reason to rescind the closure because the worker didn't lose out on the timeframe because they got their request in timely, so.

3:09:18 Yeah, there could be some --

3:09:19 So, that's kind of how I think we would've thought, well, it seems reasonable. The problem is there's other rules that say rules -- in the face of notice of closures, you have to be in strict compliance with the rules, and we've been seeing actually I think some lower level ALJ cases that have been actually invalidating these closures. So again, it's kind of bigger than us.

3:09:42 So, they can slap us all on the wrist and tell us to do our job without rescinding a closure --

3:09:48 Right.

3:09:49 -- without strict compliance --

3:09:51 Yes.

3:09:51 -- when the worker did meet their timeframe to request a reconsideration and that should go through, to Jennifer's point, without rescinding and making us go through the process again, which might just delay a valid closure and an appropriate secondary review by ARU of, you know, is the permanent partial disability accurate.

3:10:15 And I think -- I wasn't here and probably not many of us were here when the rule was put in that said it's effective the date it was mailed regardless of the notice of closure, and I think they were having the same problem back then and they were

trying to have a balance. And so, now we're coming to you.

3:10:32 I believe that's true.

3:10:33 Jennifer, I --

3:10:35 I was around. I think that's true.

3:10:37 Thank you, Jennifer.

3:10:38 Jennifer, this is Jaye. I forgot --

3:10:39 Yeah.

3:10:39 -- you were on the call. You've been doing this as long as I have almost.

But what I'm confused about is how do we know the dates are different? You said they're dated wrong? Would it -- how do they -- what do they -- are they looking at the envelopes?

3:10:56 Well, the way we typically find out is because some of the documents have one date, and then the other portion of the documents have a different date, so that --

3:11:05 We know at closure --

3:11:05 -- cues you in that something happened. They started it on one day, and maybe finished it two days later and that's when they mailed it.

3:11:12 So, you have one, one document that says the 19th.

3:11:15 Right.

3:11:15 And the next document says the 20th.

3:11:17 Yes.

3:11:18 And if the notice of closure is the one that's dated earlier than the letter that's dated two days later, you kind of know that we didn't send it out when we said we did or when we dated it.

3:11:26 Or we will look at the received date. And so, if we don't receive something for a month after --

3:11:32 Well, yeah, that would be a clue.

3:11:34 Although given the way the post office is --

3:11:36 Exactly, but those are some of the indicators.

3:11:39 Okay. I just wasn't sure how that worked.

3:11:41 And my -- I should know the answer to this. Are notice of closures sent certified?

3:11:49 Yes.

3:11:49 Yes.

3:11:50 Yes, they are.

3:11:52 Well, there's some evidence there then.

3:11:54 Aren't we required to send the workers copies certified and then they get

a regular copy also?

3:12:03 I think so.

3:12:03 Think so.

3:12:05 Yeah, you're right.

3:12:06 But no one else gets a certified copy.

3:12:08 No, just the worker.

3:12:14 If there's a way you can write the rule to allow the allowance to not slow down the process on a technicality, that would be great, with still letting us know and holding us, the insurer or third-party administrators, accountable for clean up your processes. Sorry, maybe I didn't just notice that.

3:12:38 Yeah.

3:12:40 That we may or may not.

3:12:49 Now we're supposed to break for lunch at some point.

3:12:52 Oh, time's flying by. I'm not even --

3:12:54 Yeah.

3:12:55 The last time I looked up, it was 11:00. So, we should take a break for lunch, which is -- actually, this is a good breaking point too because we just finished Rule 20, so that's all wrapped up. Any other comments on that issue before I close it down before we break for lunch? Alright, and then what do we need for lunch?

3:13:21 Oh, I don't know. I guess we need to give people at least an hour. There is no -- there used to be a restaurant in this building, and I apologize, it's been closed for a while, so you're kind of on your own for lunch. But I don't know, is an hour going to be enough?

3:13:36 I think so, yeah.

3:13:37 Okay.

3:13:37 At 1:05 we'll re-adjourn and start back up for the remainder.

3:13:42 Thank you.

3:13:43 Thank you guys.

3:13:43 And if you're on the telephone, I'm going to mute you again, so.

WORKER'S COMPENSATION DIVISION

Date: Tuesday, November 19, 2019

WORKER'S COMPENSATION DIVISION
Salem Meeting Room - Salem, Oregon

Transcript Part 2 of 2

0:01: Okay, we're back on the record, so go ahead.

0:05: We're going to go ahead and get started. So, we're back on the record and we had ended -- finished up Issue 7. We're on Issue 8, which is relating to Rule 34. It's our administrative closure rule. Before we start this, so I don't forget, we are scheduled to go until 4:30 today. I think we might be able to finish, but I'm not quite so sure. We do have another meeting scheduled on like reserved time-wise on December 4, 2019 at 1:30 if we need it, so depending on how people are feeling in terms of, if we get through everything today, great, and if we do not and we need a little more time, that is our next option to be able to wrap everything up. So, we'll see how it goes, but I wanted to let people know.

So, Issue 8 relates to how to send letters about administrative claim closure and to who. So, if an insurer wants to close the claim due to the worker failing to seek medical timely -- timely seek medical care, they must first send the worker a letter informing them of their rights and providing them with 14 days to demonstrate certain criteria to avoid claim closure. Similarly, if the insurer wants to close a claim due to the worker failing to attend a mandatory closing exam, they must send the worker a letter outlining specific information, things like date, time, place of the exam, consequences for failing to attend. Currently, the rule only requires that those letters be sent to the worker by certified mail, and under Section 7, the attending physician or authorized nurse practitioner has to be copied on applicable letters. The certified mail provides confirmation of mailing and receipt, but it also requires signature for delivery, so if no one's available to sign, delivery could get delayed. And since the insurer might close

the claim after 14 days, a day or more delay in the receipt of the letter could be significant for a worker. Also, when the insurer ultimately closes the claim, the notice of closure is required to be sent via certified and regular mail, and is it inconsistent for the letter about pending administrative claim closure to only be sent certified when the actual closure is being sent certified and regular?

And so, currently elsewhere in the rules, there were -- we explicitly required the insurer to copy documents to the worker's attorney if the worker's represented, so examples could be seen in a couple different rules, and there's no mention of copying the worker's attorney. So, if an insurer fails to copy the worker's attorney on the letter, the attorney could be unaware of the pending claim closure, so we're looking at adding a requirement that the letter also be sent regular mail and adding a requirement that it be copied to the worker's attorney, if any, and we could do both of those things or just one of those things. And so, we wanted to get feedback on that.

03:06: Well, this is Jovanna Patrick. I support doing both things. You know, the 14 days is actually not a lot of time once it gets delivered for the claimant to reconnect with a doctor that they might have lost contact with and then get rescheduled. Sometimes there are reasons why a doctor thinks they can't schedule that need to be worked out, sometimes with the attorney. Like, the doctor thinks, well, I told you, you were released to work. Well, but I need to come back for, you know, whatever it might be. And so, when I get these letters, they are a big deal. I put them on my calendar, you know, time-wise because it can -- you know, it's a pretty big deal to have your claim closed not on its merits, so anything we can do to make sure that there's notice,

the regular mail is great and the attorney as well.

03:57: Dan from SAIF Corporation. I guess we weren't aware that we didn't have to send it. We've been sending it regular mail. We have no issue with that.

04:06: You just anticipated the thought process.

04:11: Suggestions.

04:14: Okay, 9 relates to the timeframe to provide information about the failure to seek medical treatment. The insurer has to send the worker a letter before administrative closure for failing to seek medical care, and in that letter, the worker's advised the claim will be closed unless they establish certain information within 14 days. If the insurer inserts the requirements in our rule verbatim, the worker won't really know when the 14 days starts. And so, maybe they'd think it starts from the date of the letter, maybe they'd think it's the date of the postmark, maybe they'd think it's the date they are actually reading the letter. And so -- also if insurers do include a start date, there could be inconsistencies for what they might interpret that 14 days. And so, what we were looking to do was clarify in the rule to indicate that the insurer must notify the worker that they must establish certain information within 14 days from the date the letter was sent certified mail, and that would make it clear as to when that would start.

05:21: Well, from a claimant's attorney perspective, anything that gives the injured worker more information of -- well, when they're talking about what timelines there are and when they start, the better.

05:33: Okay.

05:37: And no issues, but I'll make the pitch that, if you're going to change requirements for what's written in the letters that we have to send out, that you give us ample time to do the technological changes. So, if these were being implemented 1/1, it might be a little tight to get the changes into our letters. But if they were implemented sometime after 1/1, we'd just have to work through our IT department to make these changes. It's not as simple as the adjuster making the changes at the desk level.

06:09: Okay.

06:10: That's a good point, Dan, but tentatively, the rules are on the same track as the Division 35s, which as you know have to replace the temporary rules by March 1 because the temp rule expires February 29.

06:26: 3/1 implementation?

06:28: That's tentative because the 30s don't have to follow the same track. They just may. They just may if it works out.

06:37: Okay. Issue -- are we ready to move on? Issue 10, this was the date the claim qualifies for closure during administrative closure. So, Rule 34 discusses claim closure. Section 1 requires the insurer to close a claim when the worker is not medically stationary and the worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner and for reasons within their control. Section 2 of the rule requires the insurer to close the claim regardless of whether the worker is medically stationary when a worker has not sought treatment for more than 30 days with a healthcare provider

authorized under 005 and 245.

So, the way our rule currently reads is the insurer must use 30 days from the last treatment provided or any additional time period by the attending physician or authorized nurse practitioner as the date the claim qualifies for closure upon the notice of closure. Some have asked is that 30 days from the last treatment provided and is it any treatment or treatment with the attending or treatment authorized by the attending, or is it 30 days from the last treatment provided authorized by the attending physician or authorized nurse practitioner? The other part is, is it that its additional time period authorized by the attending physician or authorized nurse practitioner, or is it 30 days from the additional time period authorized by the attending physician or authorized nurse practitioner? So, we thought the rule should be clarified to avoid those ambiguities. So, the statute has explained that the insurer or self-insured employer shall close the worker's claim as prescribed by DCBS when, without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control. The Board discussed the legislative history with that in the [Tat Hueng](#) case. Jerry Keene had testified it's a procedural provision about when the worker fails to seek treatment for more than 30 days unless it's because the doctor told them not to. And so, we were looking at modifying the rule in 1E to indicate that it's used 30 days from the last treatment provided which was authorized by an attending physician or authorized nurse practitioner unless the attending physician or authorized nurse practitioner authorized the worker to follow up

for more than 30 days after the last treatment, in which case, under that scenario, you would use the date the attending physician or authorized nurse practitioner authorized for a follow-up as the date the claim qualifies for closure on the notice of closure.

09:38: Sometimes you got to read these a couple times.

09:39: I know see people reading. That's the pause, so sorry for people on the phone. You just hear kind of a silence after I read this, so.

09:45: My head starts to hurt.

09:47: Yeah.

09:48: So, you would -- the claim would qualify for closure then if the worker didn't follow up on the more than 30-day appointment. If the authorized attending physician says, hey, follow up in 45 days and the worker doesn't follow up in 45 days, then that's the date that you use for closure, or--

10:12: That it qualifies for closure.

10:13: -- it starts the closure.

10:14: But then you still have to send the bug letter before closing it.

10:17: This is Nathan Goin. There's another, I think, complication here.

Sometimes we see a physician that would say, come and see me when you're done with physical therapy, and there's no timeline really attached to that, or come and see me, you know -- I don't know.

10:40: After the MRI.

10:41: Yeah, after the MRI or something like that. And so, there's really -- there's not a timeline that's being provided, and it leaves it open ended, and I don't

think that -- I don't know. I'm not sure that this as drafted really addresses that scenario. I don't know if it's going to be a super common scenario, but I know it happens.

11:00: Okay.

11:01 Well, and this is Jovanna Patrick. I think that this rule isn't meant to stop open-ended, you know, authorizations. I think those, there is a mechanism in the statute for the insurer to follow up with the doctor and like get a firm date on those. That's not in this section here, but for purposes of this section, I'm still a little bit confused if it's 30 days from the last time the attending physician saw my claimant and authorized time off of work, or if it's the last physical therapy treatment or MRI that they were -- that they said to go to. So, I'm still not sure which of those would trigger 30 days.

11:41: I think it's the physical therapy.

11:44: Yeah. Is that --

11:45: Yeah, PT.

11:45: Right.

11:46: An MRI that we --

11:48: The last treatment.

11:49: The last treatment.

11:50: Or (unintelligible).

11:59: So, just to clarify, the rule as proposed drafted, you're saying 30 days from the last treatment, which could be an appointment with the attending physician or

physical therapy or an MRI, but it's just a medical treatment that's been authorized at the direction of the attending physician. If there hasn't been treatment for 30 days and unless the attending physician has said, come back and follow up in 6 weeks, that 30 days would be the earliest date that we could send the bug letter.

12:38: Yeah.

12:38: If however the doctor, AP, said follow up in 6 weeks, we would need to wait 6 weeks from the last treatment, which could be the doctor's exam, the PT, the MRI, whatever that last medical treatment was, and then at that point in time, we could send what we call the bug letter and say, hey worker, are you continuing to treat?

13:03: Yes. Yeah, so it's looking at what the authorized treatment was, not that it was necessarily with the attending, but that it was an authorized treatment from the attending. So, if the attending says, go to PT, that is authorized treatment.

13:20: I think the rule as it's written timed the start of the timeframe to an actual appoint -- a medical treatment is good because that gives us all an understanding of it's a medical treatment and you can start counting, and we count that 30 days, and if when we look back at what the attending physician said in the last chart note if there's not direction, that it's more than 30 days at that point in time, a bug letter could be sent out. If the doctor says more than 30 days, seek follow-up, then we would know that we can continue to count. So, at least from an application consistency, that would be -- I don't want to say the easy -- it'd be the cleanest to apply because everyone could look at it and say when was the last treatment and what did the doctor say at their last appointment and does that conflict with the 30 days or, not conflict with, does

it extend beyond a 30-day follow-up.

14:29: Does it ever happen? I know that we have injured workers who have an attending physician. They have to have surgery, so they're referred to a surgeon who does not take over as attending. After they have the surgery, does the surgeon ever send them to PT, or do they always send them back to the attending who would then send them to PT?

14:53: It depends on the medical provider.

14:55: Because then what do you do? Because the -- right, how do you get the 30 days because the surgeon isn't the attending but he's saying go do PT? I didn't know if it happened. I don't think I've seen it happen, but I don't have that many claims, so.

15:12: If we review it, is that still compensable medical treatment and would it --

15:16: Nobody would say --

15:17: No.

15:17: -- to close.

15:19: They shouldn't be saying that.

15:20: Yeah.

15:22: I'm not saying that they would, but no.

15:23: Just one --

15:30: Any other thoughts?

15:33: Is the proposed language -- I mean is it designed to clear up a problem?

15:41: Yeah, so the current language because there's -- it's felt that the current

language doesn't provide clear guidance on how to apply the rule. So, it says you have 30 days from the last treatment provided or any additional time period authorized by the AP or ANP, so is it any treatment, 30 days from any treatment last provided even if it wasn't authorized, or does it have to be authorized and how to apply that 30 days, does that apply to both provisions or just one provision? So, it's really trying to clear up the current rule, which can be read differently.

16:21: Well, and it's also aside from what date, you know what treatment is as it says in this first example. There's been debate about whether it's 30 days from the last treatment -- let's say we agree there's this attending physician -- or whether it's 30 days from when the attending physician recommends follow-up care. So, if you recommend a follow-up care in six weeks, do you have to wait 30 days after that, or do you just wait until the six weeks is up?

16:59: My reading of this rule is because the 6 weeks is beyond the 30 days, at the six-week mark, that doesn't say oh, let's wait another 30 days. It's you can send the bug letter at that point. The minimum is you always have to wait at least 30 days, and it's when the doctor says follow up beyond 30 days that you then have to wait that additional time period before the bug letter, but it's yes, it's treatment with the AP or any another we'll call it compensable medical services.

17:36: Jovanna, you were -- is what you were saying is -- so, what I've seen happen where an injured worker, their doctor refers them to somebody else and then it just -- it happens, so do we call then and go, do you got an appointment or not? But -- so that could go beyond 30 days. I've seen it, and we you know scramble to help them

kind of make sure that they can get their appointment, and if they're confused.

Sometimes they think it's being made for them, and so they just sit and wait instead of they were the ones that were supposed to make the appointment. You're saying that that's handled someplace else, but that's not -- that wouldn't be in here, that if it was beyond 30 days and the doctor never really said what day to come back to see them, they just referred you out for PT.

18:27: Right, and I think there's a section that talks about like, open-ended release. So, sometimes they're like until next appointment or until you -- you know, after the MRI, and I believe that there is a way that the insurer can contact the doctor to get, you know, a current status on restrictions and then inform the worker that -- you know, that that is happening and I think that can happen. It says like until next appointment, and then the claimant misses the next appointment for whatever reason, and then it's a question of, well, you know, was it just until that appointment is it until they actually come in? And so there is a provision in there for dealing with that particular circumstance. And just to speak to the difficulty of getting into those ancillary services, it's much easier when there's an MCO involved because then there is approvals or at least someone to call who's centralized to say, hey, this -- you know, referral didn't go through, could you call? Otherwise, it's a matter of, you know, trying to reach out to the providers, usually they won't talk to you. They want a release, they want this, they want that, and trying to provide the information in that way, so it can get cumbersome if there's not, you know, clear authorizations and preapprovals going through.

19:38: This is Nathan. I didn't bring my statute book with me. I'm not sure, but the procedural mechanism that you're referencing, is that for actual closure administration or is that for time loss determination? I think it's for a time loss.

19:51: It's for a time loss, yeah.

19:52: Yeah, so specific time loss benefits, which would be a -- that's a different procedure than the administrative closure.

19:58: Yeah, certainly but it would trigger some action, on either getting the claimant back in or figuring out, you know, when that treat -- when that last authority is.

20:08: Well, if they're on time loss, but they could be working modified duty or having full duty release.

20:11: Very true.

20:15: I just don't see how anything in this rule would be helpful when someone does have an open-ended release. You know, if there's no date to measure the 30 days, then there's no date.

20:29: Well, I think this rule is just outlining when the insurer can send the bug letter, and that's all it's doing.

20:41: Right, so if a worker -- if the doctor doesn't provide a recommended time period. They just -- they don't say anything --

20:49: Right.

20:49: -- then the insurer has to wait 30 days to send the bug letter, and if the worker does have an open-ended time-off authorization, they can close the claim and

stop time loss as if the worker was -- they treat it as if the worker was medically stationary 30 days after that last treatment, so it does affect -- it does apply to this particular rule.

21:15: That's a good point. I didn't see that -- see it that way, yeah.

21:23: Any other thoughts? Okay. Our next issue relates a little bit to the prior issue. So, under Section 2 of the administrative closure rule, it's not clear on the date the claim would qualify for closure if the worker is not treated with the attending physician or authorized nurse practitioner if the authorized provider is no longer able to provide care.

So, a little bit more background, Rule 34, again, kind of getting our bearings, the insurer has to close regardless of whether a worker med stat when a worker has not sought treatment for more than 30 days with a healthcare provider authorized under 005 or 245. To close the claim, they have to follow those requirements of Section 1. It says bug letters, and they have to inform the worker that the reason for the impending closure is because they failed to seek treatment with an authorized healthcare provider. So, we just previously talked about the date the claim qualifies for closure as related to Section 1 of the rule, and in that section, there is reason simply to not simply rely on the last treatment provided, but we talked about calculating the 30 days, using 30 days from the last treatment provided which was authorized by the attending physician or authorized nurse practitioner. Otherwise, it could be interpreted to say any treatment regardless of whether it was authorized or not. And so, there could be circumstances where the worker never establishes an attending physician or authorized nurse

practitioner.

So, an example would be maybe a worker just goes to seek treatment in the emergency room and then fails to follow up for additional care. In that circumstance, the claim would close under Section 2 of the rule. But Section 2 of the rule tells the insurer to follow the requirements of Section 1, and then you go to Section 1, you say what date does the claim qualify for closure, and there wouldn't be a way to apply that because there was no treatment with an attending physician or authorized nurse practitioner. So, it wouldn't be clear what date to use under what we had just discussed. There could also be circumstances where the worker treats with an authorized provider such as an authorized nurse practitioner or a type B attending and then that provider can lose authority to continue to provide compensable medical services. Maybe the chiropractor has used up all their visits, the time has passed for the authorized nurse practitioner to act as an attending physician on the claim, and in those circumstances, that could also fall under Section 2 when looking at what date the claim should qualify for closure in those circumstances.

And so, what we were looking at is modifying Section 2 to indicate that the qualified for closure date, it could either be 30 days from the last treatment provided with an authorized healthcare provider unless that authorized healthcare provider had told the worker to follow up more than 30 days from the last treatment in which case, you could use the date the provider authorized for a follow-up. But if that provider was no longer authorized to treat the worker, you could use 30 days from the last day the provider was authorized to treat the worker and that would articulate a qualified for

closure date kind of under all these other scenarios where what we had discussed in 1E wouldn't necessarily apply. Anybody have any thoughts? People still looking or do you want me to move on?

25:49: This is Dan with SAIF Corporation. I think that this proposal muddies the water on the timeframe. It's clear in my opinion if the worker seeks treatment with, again, the authorized attending physician at that point in time or follows up, PT, MRI, whatever, and if they abandon treatment for more than 30 days, we have the right to send a bug letter. The way I'm reading this, and I think the way I heard it is this throws in another caveat into that, where if the worker treated for 45 days with a chiropractor and then type B provider and stopped treating at that point in time, because their authorization to treat ends at 60 days, we couldn't just wait 30 days and say, okay, 30 days from last treatment, we can send the bug letter. It's like, oh no, because the authorization to treat with any type B provider ended at 60, so we need to go to the 60 days and then count 30 days forward of that, so now we're at 45 days when -- and maybe I'm not -- I'm reading more into this. To me, it should be clear that when the worker abandons treatment and hasn't treated for more than 30 days, unless they have direction from an AP to wait longer than 30 days, for consistency, that's when you should be able to send out the bug letter, and this seems to add a wrinkle into that whether it's an ER, and we're saying well, they never qualified as the attending, or they're treating with a type B and they can treat for up to 60 days, so now we have to wait until the end of that time period before we start the 30-day clock. So, this adds more complexity I think than what's already there.

27:49: So, I'm wondering if we need to maybe clarify what this is asking. So, let's talk about what we see more often would be you're treating with a type B as any provider or a nurse practitioner. The worker, their time period expires and the worker continues to treat with a non-authorized person. Where do you think the 30 days should start from? Do you think it's any treatment, so the non-authorized provider if they continue to treat? You have to wait for all those treatments to be done, or do you think it's 30 days from the last treatment with this provider when they were authorized, or do you need to wait for that to expire and go with 30 days from the last date they were authorized? So, the question really is what do people think should be -- the 30 days should draw from when you're no longer auth -- seeking treatment from an authorized provider?

28:47: I guess in that situation I would think that it would be appropriate to use the admin closure process to close the claim if the worker is continuing to treat with the type B provider even if we're saying, hey, they're not qualified.

29:05: Well, under 003(4)(2), there is an allowance to close a claim when the worker is not treating with a qualified authorized attending. So, if the worker did choose to continue, the insurer can close their claim.

29:20: Are you seeing insurers --

29:22: Yes.

29:23: -- closing in that matter?

29:24: Yes.

29:25: Closing in --

29:26: Yes. Yes.

29:30: Does that include us?

29:33: Yes. Well, I would think adjusters -- come on.

29:35: How else -- Dan, how else would you close a claim in that scenario if a worker didn't -- if say the worker didn't want to change attendings? How do you close it? You can't schedule closing with some other doctor that is not the worker's attending.

29:49: Yeah.

29:50: The worker gets to choose who's their --

29:52: Yeah.

29:52: -- attending physician. So yes, you are closing under that.

29:56: I mean you know I would have -- I'd have to basically ask an adjuster. I mean we wouldn't be paying time loss after that time period because we would say it's not qualify -- or you know, you can't authorize. We may be -- I would think we would let that play out and simply say we're not going to pay for the medical treatment. We're not paying for the time loss, and yeah, we're kind of caught in a little bit of a catch 22, and if we want to close the claim, hmm.

30:30: So, is it SAIF's position that 003(4) should be eradicated?

30:35: If --

30:35: Sub 2.

30:37: I would agree.

30:39: If that's the reason, then okay. I view this as when a worker abandons

treatment, like they're not treating anymore, that we have to then wait for that 60 days to run before we can send the bug letter.

30:56: When they -- okay, when they abandon treatment with the non-authorized provider or the authorized provider?

31:02: So, they're treating with a chiropractic physician.

31:04: Okay.

31:05: They treat for 45 days, and they just stopped treating, so then we would normally wait 30 days to send the bug letter out.

31:13: Yes, and that -- this rule would say that.

31:16: Okay. The way I was reading this was we would have to wait until the end of the 60th day because they could still treat with any type B within that, so you'd have to wait for the end of the authorization before you could send the bug letter.

31:32: It may be that it's worded incorrectly or confusing. The intent of this rule would be that you wait. The worker's treating with the chiropractor. He treats on the 45th day. You have to wait 30 days from the 45th day --

31:47: Yeah.

31:47: -- to send your bug letter.

31:48: And if they're continuing to treat outside of the 60, we could send the bug letter.

31:52: Yeah, so you wouldn't have to wait for the time period to be expired to send your bug letter. What was the scenario where they might want to use the 30 -- that the 30 days would be from the time period expired? I can't think of a good

example.

32:12: Thirty days from the last treatment.

32:14: It would help me -- this is Elaine -- if we could get a little more clarification because I guess I'm getting hung up on the unless and then there's another unless.

32:24: Okay, so --

32:24: And so, that the double, like an exception exception exception, it's --

32:28: Okay, so --

32:29: -- muddled in my mind.

32:29: Like these are the two scenarios. One is you have a worker who's treating with a chiropractor and within their 60 days, they have not recommended treatment, you have to wait the 30 days to send the bug letter. The second option is the worker is treating with them within -- like, day 59, they're still authorized --

32:56: And they recommend --

32:57: So, a physician assistant ,59th day, recommends one month of physical therapy, then are you going to wait 30 days from whenever that physical therapy ends that is no longer within the type B physician's authorization period, or?

33:15: So, on day 59 -- let's say the last day, day 60, they say you need three months of physical therapy. Do you need to wait for the three months of physical therapy to expire before the notification letter can go out? They were authorized on day 60, but day 61 through three months, they're not.

33:35: Just off the top of my head now, sitting down with an adjuster and

saying, what would you do here, I would say if the physician's assistant recommended, you know, and I'm not going to say three months of physical therapy but if it was four weeks of physical therapy, I would say let's wait until the end of the physical therapy runs, and then we can send the bug letter because that -- the recommended treatment was within that 60-day timeframe. Now, we're also going to be communicating to the worker, hey, you can no longer treat with that type B provider. You need to change care too.

34:09: So, as long as a provider's within their allowable time period, if they authorize something, you would want to wait for that authorized -- authorization and it would be difficult. You can't say, well, if it was four weeks, we'd want to wait, but if it was three months, we wouldn't. So we're -- that's the period that we're looking for.

34:26: And I guess if they said okay, six -- or three months of physical therapy, each time there's -- each time you have a physical therapy appointment, theoretically the 30-day clock starts ticking because it's not follow-up with me, the attending physician, in this amount of time. Okay, you have three months of physical therapy. You have two appointments the first week. You have one appointment the next week. To me, each time, the clock starts ticking 30 days, and if that worker doesn't follow up with physical therapy for 30 days, we could send the bug letter because there's been a gap of 30 days in medical treatment. Even though the doctor said -- AP said three months of physical therapy, there's a gap. It's been abandoned. It's -- the bug is a reminder of, hey worker, you haven't sought any treatment for 30 days without the direction of the attending physician. I see the follow-up in more than 30 days as

follow-up with me, the attending physician. Follow up with me in six weeks, we would need to wait the six weeks. But if it was go to six weeks of physical therapy and after the first week of physical therapy, the worker abandons physical therapy, it's not follow up with the doctor in six weeks. You're supposed to be following up with the doctor. Now, there's no treatment, so I would wait 30 days from the end of that physical therapy last appointment and say, here's the bug letter and, hey worker, just let us know what's going on. Are you going to commence the physical therapy again and schedule an appointment?

36:12: Nathan Goin from -- oh, I apologize.

36:14: Oh, go ahead.

36:14: Are you sure?

36:15: Yeah.

36:15: Nathan from Reinisch. I see this more as a type B attending physician issue. And so, just like time loss authorization, time loss authorization technically ends after a type B attending physician can no longer prescribe it, regardless of whether or not the worker is actively treating. So, I think that this proposed rule change creates continuity between closure processing itself and the time loss rules and provides clarification for what an adjuster should be doing, so.

36:41: Yeah, this is just about when you can close and sometimes it will in fact impact time loss and sometimes it won't.

36:46: Exactly. So, I think a rule change makes sense. I think it makes sense in the context of what happens when workers treating with a type B attending physician

and doesn't transfer care over to a type A and what is appropriate in that circumstance, so I think the rule change is good.

37:07: I just wonder -- this is Elaine -- if you really need to change the rule because you're already referencing Subsection 1 that sets out the time period. And so, you're just applying it to a similar fact pattern, just the provider's authorization has at some point in time expired. But it would be the same as if they just didn't go back at all, and you would go from 30 days from the last visit with the chiropractor, you know.

37:34: Well, that would be the question. Would it be -- so right now, Sub 2 does refer up to 1 and says you close using that same statutory qualifies for closure date. That's talking about if you have an authorized attending physician, so it doesn't give expressed instructions on how you -- what would qualify you for closure if you aren't treating with an authorized provider. So, this would add just a one small exclusion to 2 that would say under this scenario when you don't have an authorized provider, you would use this as the qualifies for closure date, and the question would be 30 days from the last time this worker saw their type B provider, 30 days, or would it be three months from now because during the 60-day timeframe that doctor provided an authorization for continuing treatment.

38:28: Yeah. I guess I just -- it seems like it'd be the same, right?

38:33: Because it's --

38:33: If you're making -- if you're adjusting the time periods for Subsection 1 and you're just applying them to a private whose authorization has potentially expired and the worker either follows their treatment plan or not, and you'd still have the

practical application regardless of --

38:51: It may just be confusing because you're saying go up to 1 and use the last time he sought treatment with an authorized provider. I mean it's something we could think about, but.

39:02: Because they were authorized at that point in time. In your example, the 59th day, that chiropractor is still an authorized provider. They either go and get the physical therapy that's recommended or they don't, you still use that 59th day then for your -- if they don't treat per the recommendation, that's your 30-day period. Or they go and they start having the physical therapy appointments, then --

39:25: Provided you all agree --

39:25: -- you go from there.

39:26: -- that in the cases where they recommend further care, you keep in mind that as long as that authorization was in the timeframe. If you all agree that if they make -- you know, they make a recommendation on the 59th day, the worker can continue to treat for three months. This -- you'd have to agree, and we'd have to make a decision that an unauthorized provider we would treat the same way.

39:50: I guess I can -- maybe my hang-up's the last part of the last sentence where it says use 30 days after the last day the provider was authorized to treat the worker. That seems, to me, it's that 60-day timeframe, the 60th day.

40:08: So, the first part of the sentence says the qualify for closure date could be 30 days from the last treatment provided with an authorized healthcare unless the authorized healthcare authorized the worker to follow up more than 30 days. So, it is

30 days from the last treatment with the authorized healthcare unless they recommended more time than 30 days. And in that case, you're beyond your 30 days in that scenario. So, would you wait for the recommended treatment to expire or would you say that on the 60th day, when you gave it, he's no longer authorized to provide, so you would start the 30 days from the 60th day?

40:51: Right. And so, that's why I would make a distinction between treatment with who was the authorized physician and someone else. So, if was the type B provider, I would go to his or her last treatment date. If they said go to physical therapy, then I'd be tracking the physical therapy. And it could be the last treatment date, but if the physical therapy ends, I would still be going for -- even if it ended before the end of the 60th day, I would use that date. I wouldn't say, well, they could still authorize treatment until the 60th day, so I'm going to use the 60th day.

41:33: I guess that second part is referring to the situation where the worker is treating say with a chiropractor, the 60 days are up and then the worker still continues for another two, three months to see the chiropractor --

41:47: Well, I guess that's where I think I would need to see the administrative proposed draft to see the clarity there. I just --

41:56: I think what we need is an idea of when a worker is not treating with an authorized provider and they opt to continue that, what do you think the 30 days draws from? Does it draw from the last treatment with that provider? Do you have to wait for the -- any recommended treatment even if it was on the last day to extend before you start the 30 days? That's what we're looking for.

42:22: This is Nathan Goin from Reinisch. It was my understanding that after a type B attending physician's status expired, the ongoing prescription was essentially invalidated, and maybe that's incorrect. But I thought that at the point in which the chiropractor could no longer serve as the attending physician, they could no longer prescribe physical therapy, follow-up chiropractic services, diagnostics, what have you. So, I would say at that point, when they can no longer serve as a type B attending physician, that's when the 30-day clock starts regardless of whether or not physical therapy, diagnostics, or some other medical service has been prescribed because they are no longer lawfully entitled to act as a type B attending physician and prescribe those things.

43:04: Then I think we just say that if the treatment continues beyond the authorized period of time, you may use the 60th day as the timeframe.

43:15: And that's really why this question has come up because there's questions of are they actually authorized to prescribe additional treatment, or you were saying we would wait for the additional treatment. We're just kind of looking for what you guys think is the most reasonable approach to it.

43:32: And I guess we're not looking to force closure per se, as provide the treatment that's recommended, and if at one time where the worker abandons treatment, then say okay, you've abandoned treatment. Are you continuing to treat? If no, we're going to close your claim.

43:49: So, let's not talk about abandonment of treatment because that -- I think it gets a little confusing. So, we have a scenario. You last treated with an authorized

provider 45 days, and he doesn't recommend follow-up care. Does everyone agree it would be 30 days from -- the qualified for closure would be 30 days after that date?

44:06: Yes, I think so.

44:07: Yeah.

44:08: Okay.

44:08: So, I mean the -- you know, it's -- I agree with what Nathan said. Maybe that needs -- what needs to be clear is if three days before this physician's --

44:16: Yes.

44:16: -- no longer going to be qualified, they say, I want you to go get an MRI in a couple weeks or I want you to do a month worth of treatment, that was treatment prescribed while the doctor was still qualified, but then -- so, maybe the rule just needs to be made clearer, as well. Once the qualified period ends, if there's any pending treatment, does that continue or is that no longer?

44:42: Because that's how time loss is treated, right? I mean --

44:44: Yeah.

44:45: -- once their attending physician hits that 60-day mark, that's -- or the 18 visits, the worker can't receive time loss anymore. So, I understand why the treatment would be even different.

44:59: So, Nathan, if the injured worker -- if the doc -- if the physician, let's say the chiropractor, three days before says, I'm going to give you another four weeks of time loss or you're off work for the next four weeks, you're saying that the insurer would only have to pay time loss for those three days and then after that, they're not

obligated to pay time loss because that person wasn't authorized -- the doctor was no longer authorized to -- he didn't have the authority to provide time loss.

45:35: Correct. That would be my position. I wrote a blog article actually that you can read if you're interested in that.

45:42: Yes, that --

45:42: Cases and stuff, so.

45:43: That makes sense to me. I get the scenario that you were talking about, and that was going to be my question. So, in essence what you're saying is that the physicians even though they authorized it, they can only authorize it for the next three days. So, if you want to get the MRI in the next three days, great, but after that, they don't -- there's no authority for them to have granted that, that it --

46:03: Exactly.

46:03: That extra treatment.

46:04: More that they're -- yeah.

46:05: So, they've got to -- which makes it confusing and I totally can see how that would be really difficult for the injured worker to be like, how am I supposed to know that I need -- this guy told me to go.

46:16: Would you send them a warning?

46:17: Pardon me?

46:18: Would you send them a warning --

46:19: You do.

46:19: -- that their period is getting close to expiring?

46:23: We do.

46:24: Yeah, yeah. (unintelligible) does but not everyone may.

46:27: And I think that could be confusing, but it makes sense. Like, I under -- then you're -- it does seem like that's very confusing is, is that authorized or is it -- is it authorized when they were still allowed to authorize it? Does that survive the termination of their ability to treat or --

46:42: I would say it does not.

46:42: -- or does it terminate?

46:45: Or they say go get another three weeks of therapy until you go see the orthopedic surgeon, and then they don't go to see their orthopedic surgeon, but they're still beyond the -- it's a dynamic that's --

46:59: And they're required to send a copy of their treatment plan to the attending physician, then the attending physician is no longer then authorized probably to review the treatment plan or the MRI.

47:19: A lot of good stuff to think about. Any other comments or feedback on it?

47:27: As it's explained, we wouldn't -- we would support the change with the clarification that Nathan provided. I think just looking through some of the more internal stuff, we're probably looking more at our application of not at the 60th day of saying, hey, everything's done, now let's send a bug letter out. But having that clarification of the intent of this proposed change, okay.

47:59: Out of curiosity, how does that play out for the audit too? Because if you're being audited and the rule says, you know, if you close a claim within 14 days of

the day it qualifies for closure, you know, the worker is treating with a type B attending physician who then prescribed physical therapy and you say, well, we want to give this a chance. But if you have a state auditor that looks at it and says, well, qualified for closure at the expiration of a 60-day period, it kind of creates -- I think it's detrimental.

48:25: I'm not sure in the field we've ever seen that.

48:27: You've never had that issue? And maybe it's not an issue. I don't know, so.

48:32: We don't have a (unintelligible).

48:35: Troy, do you audit for whether they closed timely in that circumstance?

48:45: I don't remember coming across or ever hearing about anything across this area. I don't think so.

48:56: Okay. We're going to move to the next section that we're putting forth.

So, Section 3 and its language in Section 3 of the administrative claim closure rule does not explicitly state that the closure should occur regardless of whether the worker is medically stationary, which makes it inconsistent with 2 and 4 of the rule. And we're on Issue 12 for those following along on the phone.

The background, when an insurer pursues admin closure, the rule generally says they have to pursue the closure regardless of if the worker is medically stationary.

Under 1, they can close when the worker is not medically stationary and they fail to seek certain medical treatment. Two and 4, 2 is what we just discussed, they may close in certain situations regardless of whether the worker is medically stationary.

Section 3 of the rule requires an insurer to close the claim when the worker fails to

attend a mandatory closing exam for reasons within their control. That section of the rule is silent about their medically stationary status. 268(1)(c) of our statute requires the insurer to close the claim as prescribed by the director when the worker fails to attend a closing exam unless the worker affirmatively establishes that such failure is attributable to reasons beyond their control. So, we were looking at adding in a statement that the closure under 3 must occur regardless of whether the worker is medically stationary when they fail to attend that mandatory closing exam for reasons within their control.

And I haven't been commenting on the fiscals that we wrote up but, again, feel free to offer any fiscal impacts on all of these as well as we go along.

50:39: This is Nathan Goin from Reinisch. That sounds reasonable.

50:45: Any concerns?

50:46: No issues.

50:50: So, on with the Issue 13, which is also Section 3, same section. So, currently if the insurer is pursuing administrative closure for failing to attend a mandatory closing exam, this section of the rule requires the insurer to send a worker a certified letter 10 days before the exam. The letter has to include specific information including the worker's responsibility to provide information to the insurer regarding why the exam was not attended if the reasons were beyond their control. There is no timeframe for the worker to provide that information, but the rule does require -- there's no timeframe stated for the worker to provide that information, but the rule does require the insurer to wait seven days from the date of the missed exam to allow

the worker to demonstrate good cause prior to closing the claim. So, since the insurer may close the claim within seven days, it would seem appropriate to advise the worker that they have seven days to provide their reason for a missed exam. Jim Edwards, the Jim Edwards case is a board decision, and in that case, the Board had concluded that the letter that the insurer sent to the worker was not valid for the following reasons. One, the insurer improperly stated how long the worker had to notify the insurer of the reason for the missed exam, and two, the letter had failed to advise the worker that in the event he did not schedule the closing exam, he had seven days to demonstrate good cause. And so, we were looking at whether the rule should be revised to include the requirement that the insurer advise the worker of the worker's responsibility to provide the information to the insurer within seven days of the scheduled closing exam regarding why the exam was not attended if the reasons were beyond the worker's control. And we put some draft language in. Any thoughts?

52:55: Dan from SAIF Corporation. We agree with the change.

52:57: So, what -- I'm trying to follow along and reread this. And so, when is this information required to be given to the worker?

53:05: So, this is at least 10 days before the mandatory closing exam, the worker gets a letter saying here's all the details of the exam and here's what you need to do. And right now, the rule says that the letter, that letter that goes to the worker, has to inform the worker of their responsibility to provide information to the insurer regarding why the exam was not attended if the reason was beyond their control. But that part of the rule that says, insurer, your letter needs to say this, it does not currently say that

the worker has the responsibility to provide that information within seven days. It only just says, you need to give it to us. And the worker might think they have two weeks or maybe even longer. Yeah, so, they could get a closure before they realize that they were supposed to tell the insurer that information.

53:51: And this just makes it clear, it's spelled out in the letter --

53:54: Yes.

53:54: -- 10 days before the exam. If you don't attend, you have seven days.

53:58: Correct.

53:59: Right, yeah.

54:00: Yeah.

54:02: It makes it clear for the worker.

54:08: Okay? I'm going to move to Issue 14. So, this is about rating permanent disability after a missed mandatory exam. So, if an insurer closes the claim for failing to seek medical treatment, they have to rate all permanent disability apparent in the record at the time of claim closure, so that would include but not be limited to any irreversible findings. Oftentimes, that's surgical awards, is what I've seen most frequently. But an insurer may also administratively close a claim if a worker fails to attend a mandatory closing exam, and we've got that process under Section 3, which we've been talking about, of the Rule 34. In that case, the rule is silent on whether they have to rate impairment that's apparent in the record, so it's not stated one way or another if they'd have to rate that apparent disability. So, we were looking at revising the rule to require the insurer to rate all permanent disabilities apparent in the record at

the time of claim closure when the worker is failing to attend a mandatory closing exam, which would include but not be limited those irreversible findings.

55:13: So, if the record's apparent that there is reduced range of motion and other factors that would allow an impairment award in addition to their surgical findings, that would be made at the time of the closure.

55:30: I think if it was apparent that it was permanent disability.

55:32: Right.

55:32: So, if it wasn't --

55:33: Irreversible.

55:33: -- I guess it would depend if it's permanent versus they're still recovering, but yeah.

55:37: Right.

55:38: Yeah. And this is a mandatory closing exam, so you're talking about when they're hopefully determined to be around med stat.

55:55: Thanks for pointing out we've been doing it wrong all these years.

56:00: You guys don't have to change anything if we just align it all with the process, right?

56:04: Well, at least for the next few months we won't.

56:06: Right.

56:06: With an emphasis on sarcasm.

56:10: Yeah.

56:10: In our practices.

56:14: Okay. So, it sounds like no concerns around that issue? Okay. Issue 15, so it's still the admin closure rule. We're on Section 5 of the rule. This is with major -- with closing with major cause denials, combined conditions. So, that part of the rule says a claim may be closed when the worker is not medically stationary and a major contributing cause denial has been issued on an accepted combined condition. That major contributing cause denial must inform the worker that claim closure may result from the issuance of denial and provide all the information required by the rules. And when a major contributing cause denial has been issued following the acceptance of a combined condition, the date of the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability, under Rule 20 or the date of the denial, whichever is later. So, the intent of the rule is to apply it to closure of a combined condition when the worker's compensable injury is not medically stationary, but there's been some confusion because the way the rule currently reads under 5, it says a claim may be closed when the worker is not medically stationary, and we were looking at just changing that to a claim may be closed when the worker's otherwise compensable injury is not medically stationary for clarification.

58:06: And clarity is good.

58:12: Okay. Any concerns? Okay.

58:15: Am I supposed to object?

58:19: Okay. Issue 16, last one of our admin closure rules. So, this is Section 7. Section 7 of the rule says the attending physician or authorized nurse practitioner must be copied on all notification and denial letters applicable to this rule, and we were

looking at whether we should add in language, the attending physician or authorized nurse practitioner, if the worker has one, must be copied on all notification and denial letters applicable to the rule because occasionally workers may not have an authorized attending or an authorized nurse practitioner on their claim.

58:59: So, it would -- what if the worker is treating with an unauthorized attending physician or someone that doesn't qualify as -- so that provider would not be sent a copy, is that correct?

59:17: That would be correct, yeah. And the way the rule currently is, yeah, it doesn't say. It says the attending physician or authorized nurse practitioner.

59:48: Makes sense to me.

59:51: Alright. I'm going to go to 17. So, this one is in Rule 35. We're switching gears. Rule 35 talks about determining medically stationary status. There's two pieces to this. They kind of go hand in hand, which is why I wrote it up that way. So, again, we're -- the rule is titled determining medically stationary status. Section 1 of the rule talks about when a worker is determined medically stationary by certain opinions from the attending physician, authorized nurse practitioner or preponderance of medical opinion, so they can be med stat. Either the AP declares them that, the ANP, or there's a preponderance of medical opinion.

Section 5 of the rule, which is what we're discussing on this issue requires the insurer to request a concurrence or a comment from a type A attending on an IME report and, in certain circumstances, a closing exam report. So, I'll read the way the rule currently reads. It says the insurer must request the attending physician as

defined in 656.005(12)(b)(A) to concur or comment when the attending physician arranges or refers the worker for a closing exam with another physician to determine the extent of impairment or when the insurer refers a worker for an independent medical exam, and then it explains what concurrence means.

So, for Part 1, the issue in Part 1 is that it might be unnecessary to require the insurer to ask the attending physician to concur or comment when they have arranged or referred the worker to a closing exam with another physician to determine the extent of impairment, and that's because the attending physician arranged for the exam to take place, and the rules require the consulting physician to send the attending physician a copy of that closing report for concurrence or objections under our Division 10 rule, and I've provided a copy of what that rule states. Also, the insurer has to obtain sufficient information from the authorized nurse practitioner or the attending physician to close the claim, that includes clear documentation of their opinions when it comes to the issue of permanent disability. And so we're looking at whether we should remove the requirement for concurrence or comment from the attending physician or authorized nurse practitioner when they -- from the attending physician when they have arranged or referred the worker for a closing exam with another physician to determine the extent of impairment. Or we could -- there's a requirement for a concurrence or comment from the attending physician when the insurer refers for an IME. The closure is based on a preponderance of medical opinion declaring the relevant condition's med stat, and the preponderance of the opinions include the opinion of the IME. And I apologize, that part's for part 2. But so, the issue is whether we should remove the

requirement for concurrence or comment from the attending physician when they have arranged or referred the worker for a closing exam with another physician to determine the extent.

1:03:00 Also, you'd be assuming then that because the attending physician referred this worker to like, let's say, I don't know, what's a normal outfit, like --

1:03:11 Medical exams.

1:03:13 Well, so I'm trying to think of -- anyway, their attending physician says I want someone -- the worker to go somewhere else for a closing exam to rate findings because they'd done that, whatever. Wherever the worker went for this exam, because the attending physician said that I want it done, you're just assuming then that the attending physician would adopt the findings of the -- no? Well, I mean I'm trying to --

1:03:44 Well, hopefully not.

1:03:46 Well, if they -- I mean if the attending doesn't have a chance to review the report and comment on whether or not they agree, then we just assume that the report stands in the place of what the attending physician would think.

1:03:55 Okay, so this is talking -- it's under medically stationary, but it's requiring the report to be sent to the attending if -- to determine impairment. So, you're talking about impairment under a medically stationary rule. So, most people wouldn't be looking for impairment there. There's also other rules that are very specific including statute that says only the attending physician can give impairment or concur or ratify impairment. Those rules would remain in effect.

1:04:24 But is -- this rule is asking to remove the requirement for concurrence or

comment from the AP when the AP arranges or refers the worker for a closing exam with another physician to determine the extent of impairment. So, if the attending physician arranges and refers the worker somewhere else for a closing exam, then the place that does the report doesn't have to send it back to the attending physician for concurrence?

1:04:51 No, they still do because there's Division 10. So, there's the Division 10 rule, which is quoted at the top of Page 23. So, under Division 436.010.0280, Section 4, when the AP or ANP requests the consulting physician do to the closing exam, the consulting physician has seven days from the date of the exam to send the report to the AP for concurrence or objections. That's not part of -- that rule already exists somewhere else in our rules.

1:05:18 So, then why this -- why do we need this section then?

1:05:20 Well, that's the point, is that this -- so, then under this section, which is under determining medically stationary status in the Division 30 rules, it says that the insurer has to request the AP to concur or comment when there's a closing exam and they're determining extent of impairment. But our Division 10 rules already require the consulting physician to send that report to the attending, and as Jennifer had mentioned, the attending or the authorized nurse practitioner needs to give sufficient information, which includes information about permanent disability. And so, when the insurer closes, they need to have the opinions from the provider about -- from the attending about impairment. They can't rely on the IME for the impairment determination. They need the opinions from the attending.

1:06:15 So, under also Division 35 rules, under 007(5), it requires that the attending physician either provide or concur, ratify any impairment. Whether he recommends an IME, whether he recommends a consulting, it has to come back to the attending in order for them to use that for closure. This rule for some reason has just been there. It's not usually where people would look to address a PPD because it's under med stat. And so, the first issue is could we just remove it because it is very clear in other rules, Division 10, but -- and also specifically Division 35.

1:06:56 So, my only question, if it is in the med stat section, does that mean that - - because what I see all the time is IMEs changing the med stat date. If we removed this piece of the rule and the IME doctor on a closing exam changed the med stat date, would that be the new med stat date without the AP getting to comment?

1:07:19 This rule would -- we would not apply to a med stat --

1:07:22 Okay.

1:07:22 -- because it's really just applying to impairment. So, the second rule would be -- the second issue I believe is more --

1:07:29 Is that part of this rule?

1:07:30 The second part of --

1:07:31 Yeah.

1:07:31 -- this rule. So, the first issue is whether we could just eradicate the PPD piece. The second piece is the preponderance of med stat where an IME physician's opinion would be factored in.

1:07:46 Alright, so if we remove this, the AP would still have to concur on

medically stationary date and work disability, but not on the actual impairment findings.

1:08:00 If we removed 1, the AP would still have to comment on PPD based on other rules.

1:08:07 Okay.

1:08:08: And it's the only thing you would use 1 for. You wouldn't use it for med stat per se.

1:08:12 Jennifer, this is Dan from SAIF. Just to clarify, so if the attending physician doesn't want to do range of motion and they refer them to a physical therapist -- a PCD to do the range of motion, they've already declared the worker medically stationary, dealt with all the work restrictions, they just want the findings done, so this is saying that if the AP says, go to this provider for the impairment rating, that we the insurer may be able to say, okay, we don't have to get concurrence on just the rating portion of it because the AP sent them to that provider for the impairment findings.

1:08:55 No, you would always have to get either impairment findings directly from the attending or his concurrence or ratification of any impairment that you're going to use for closing, no matter whether he referred the worker or an IME, a consulting, you have to have the attending physician.

1:09:14 But option 1 says remove requirement for concurrence or comment from the attending when the attending physician arranges, refers worker for a closing exam.

1:09:23 Because it's under medically stationary, so it doesn't really have any relationship when you're --

1:09:30 This is just talking about that one rule, not talking about that you would never have to get --

1:09:34 So, it's removing this. It's not removing the requirement.

1:09:37 Correct.

1:09:38 It's a duplicate.

1:09:39 Yes.

1:09:40 Yeah.

1:09:41 In an odd place.

1:09:41 It says the same thing in two places.

1:09:47 I guess I -- when I looked at this, I assumed it was removing the requirement versus -- so --

1:09:53 No, Division 35 007(5) --

1:09:56 It wouldn't really change, so.

1:09:57 It's no change. It's just taking it out of med stat and leaving it over where you would look for PPD must come from or ratified by the AP.

1:10:05 I'm just happy I wasn't the only one on this one.

1:10:09 This is the only time at Section 5, Rule 35, which is in that part. So Division 10 does talk about needing to send the report. Rule 20 talks about what's sufficient information for closure and you need to have the opinions from the attending to be able to close for impairment and all that is unrelated to this piece, which is only talking about that Section 5 of the rule, that one sentence. Okay, make more sense?

1:10:41 Yes.

1:10:41 Sorry.

1:10:41 No, thank you. Appreciate your --

1:10:44 Okay.

1:10:44 -- clarity.

1:10:46 Sorry.

1:10:46 Yeah.

1:10:47 This is Elaine. To clarify, because at the end of this, it talks about concurrence with the report. Is that in agreement in every particular?

1:10:53 So, that's going to be part 2, which I'm going to go into right now, yeah. So, you're talking about in the part -- the rule, concurrence? You're reading the rule, concurrence is agreement in every particular? What was your question? Sorry.

1:11:07 So, you would take out that piece as well because I'm not sure that that appears in the Division 35 rules, that second part of Sub 5 where it says concurrence with the other physician's report is in agreement in every particular including the medically stationary impression, so it goes beyond that?

1:11:31 The second part of the sentence would remain. The first part would be gone.

1:11:35 So, just the first sentence?

1:11:37 The first sentence would be gone, but with respect to a concurrence with another physician's report and agreement in every particular including the medically stationary date would remain.

1:11:47 Okay.

1:11:50 And then Part 2 is dealing with the same rule, so but a different piece of it. So, the current rule requires the insurer to ask a type A attending physician for a concurrence or comment when the insurer refers the worker for an independent medical exam. So, in other words, the rule does not require the report to be sent to an authorized nurse practitioner or a type B attending. So, what we just talked about in Part 1 of this issue was the part of the rule that requires it to be sent for closing exams to determine the extent of impairment, but the other part of this rule requires the insurer to request the attending physician to concur or comment if they refer the worker for an IME. And so, that part we were looking to leave in. You know, if they're going to request -- if they're going to refer the worker for an IME, requesting concurrence or a comment there, but it only is, right now, talking about attending physician and it doesn't apply to authorized nurse practitioners or type B attending physicians. Under Rule 35, Section 1, a worker is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares the relevant conditions either medically stationary or medically stable or other language to mean the same thing. The current rule language in Rule 35, Section 5 suggests that the insurer must request concurrence or comment for all independent medical exams, but not all independent medical exams would be for the purpose of determining medically stationary status. And again, this is -- this rule is for the purpose of determining medically stationary status. And so, we were looking at whether we should only require the insurer to request concurrence or comment on the insurer-arranged IME from a type A attending if the insurer is closing the claim based

on a preponderance of medical opinion declaring the conditions medical stationary or also requiring the concurrence or comment to come from an authorized nurse practitioner or a type B attending as opposed to right now where it just limits it to only needing to send it to an attending physician. That's under statute, the type A attending physician.

So, I'll start with the first piece. Any thoughts on requiring the insurer to request concurrence or comment when the insurer is requesting an IME if they're closing based on a preponderance of medical opinion declaring the conditions med stat?

1:14:34 So, Ms. Patrick, this would be where they use an IME to close for medically stationary statuses, will continue to require that they at least ask the attending physician their opinion for comment.

1:14:45 Right.

1:14:46 That's where that would go.

1:14:47 Gotcha.

1:14:48 The type A attending physician.

1:14:50 Yes.

1:14:50 Right, and right now it's type A, and then the other piece is should it be brought in to also include type B and authorized nurse practitioners.

1:15:02 Well, and the biggest question for me, the authorized nurse practitioners I understand under general statute, they have 180 days, but are nurse practitioners or type B attending physicians allowed for extended periods under MCO authorization? I think that -- I feel like they are because I saw something about like --

1:15:22 They can.

1:15:23 They can be.

1:15:23 Right because then like, you can have an attending physician as your chiropractor the whole time.

1:15:27 Yes, you can.

1:15:28 But under this rule, if the MCO allowed that, that person would not get to comment on medically stationary status.

1:15:34 Well, if they allowed that, they would actually be kind of credentialing them into a type A. They'd be --

1:15:39 They would, okay.

1:15:39 -- saying you can act as an attending physician.

1:15:41 Okay.

1:15:42 But this currently doesn't allow for --

1:15:46 It doesn't require --

1:15:46 -- a chiropractor -- does not require a chiropractor who now can provide closing an opportunity to respond or even a PA or a nurse practitioner.

1:15:59 Well, I think that when we extended the time periods for nurse practitioners 180 days, I mean it's possible in that time period that someone could have an injury, have permanent impairment but get the claim closed within that time, and that person who's really their only doctor on the claim should have a chance to comment on it because they are authorized to provide those services.

1:16:18 And I think if it's within the period that they're still authorized, then they

should be the one commenting.

1:16:26 I'll just throw in, are some of these type B providers or authorized nurse practitioners not allowed to actually measure or do the closing exam and determine findings of impairment? So, would they be able to provide a concurrence?

1:16:44 There are some that cannot provide impairment, but there are no limitations that I'm aware of that would say that they can't provide an opinion regarding medically stationary status.

1:16:55 Okay.

1:17:07 Any other thoughts on that one? Okay. So, it's still -- yeah.

1:17:17 Can I --

1:17:17 Go for it.

1:17:18 I do have a question. So, I'm still trying to put all the pieces together, so I apologize. But does this -- can this give rise to WRME? So, the language that you have in there is initially under 35 Sub 5, is that they have to get concurrence from all independent medical examiners -- examinations, right, but you're saying, no. IMEs are for the purpose of medically stationary status. I'm just wondering if -- are these reasons for -- to request a WRME?

1:17:57 No.

1:17:58 No, no reasons if there's no concurrence because I -- WRME can only occur if -- there's a presumption now. We switched it through MLAC.

1:18:08 There would need to be a claim --

1:18:08 But that was the very first year I started on MLAC.

1:18:10 You only can get a WRME if there's a denial compensability --

1:18:14 Okay, so that's what it is.

1:18:14 -- based on the IME and the attending physician disagrees with the IME.

1:18:17 Right, because we switched it so that they had to -- it was -- there was a presumption that, if they didn't respond, it was that they didn't agree, but we switched it and made them -- made it, you know, that they have to affirmatively concur or disagree in order for --

1:18:32 Right, so the WRME's only in a limited circumstance of compensability denials.

1:18:36 So, okay. Thank you. Sorry.

1:18:39 And I guess the other piece of this too would be if you're going to require a concurrence or comment from the insurer-arranged IME if the closing's based on a preponderance of medical opinion, would that -- would it also have to have that preponderance of medical opinion be included in the IME? So, only when it's including the IME to require that it be forwarded or in all of those situations regardless of it's including the IME, for the preponderance?

1:19:10 I'm sorry. Where are you?

1:19:12 So, for Part 2, we talked about only require the insurer to request concurrence or comment on the insurer arranged IME from a type A attending, or we talked about broadening it, so from the provider, if the insurer is closing the claim based on a preponderance of medical opinion declaring the relevant conditions medically stationary, or the way the rule currently reads is all IMEs versus only IMEs

that are on a preponderance of medical opinion, which is what -- one other piece to this discussion. Should it be for all IMEs, or should it be for only those IMEs that are closing on a preponderance of medical opinion or maybe a preponderance that involves that IME itself?

1:19:55 How would you close a claim without the attending physician's concurrence other than a preponderance of evidence? Maybe I don't understand the dichotomy there. You're saying if you're closing on a preponderance of the evidence, we do have to send it to the AP, but if you're closing based on what -- and then you don't have to ask the AP?

1:20:17 Well, so right now, the rule reads the insurer must request the attending physician to concur or comment when the insurer refers the worker for an IME, so it just kind of has it as a general statement, but it's under that med stat rule. So, whether that should be further articulated on which IMEs we're talking about. Any thoughts? It is 2:30. Should we take a 15-minute break and then reconvene? And if anybody has any other thoughts, we can touch base on that. Otherwise, we'll hop into Issue 18 after the break. So, that sounds okay? Alright.

1:21:40 I have the backup one.

1:21:41 Okay.

1:21:41 So, we're back on record. We ended finishing Issue 17 going onto Issue 18, but if people have additional comments or questions on the Issue 17 before we move on, I want to pause there.

1:21:55 I just had a question. Does anything about this rule change anything

about like to close a claim under the regular way? The attending physician still has to declare their medically stationary and have impairment findings.

1:22:10 Correct, although there is a way to close a claim with a preponderance of evidence.

1:22:13 Right.

1:22:14 But this would require that if they're using an -- the thought is that if they're using the IME for the preponderance of evidence, they would have to send that over for concurrence.

1:22:24 Or a comment.

1:22:25 Or a comment.

1:22:26 Okay, so it's not as if they can just send the claim into an IME and the IME says they're med stat, they're good to go, and the claim gets closed?

1:22:32 No, because you still need the impairment findings. Correct me if I'm wrong, Jennifer. You still need the impairment findings from the attending to be able to close.

1:22:42 Okay.

1:22:42 You would be required to get that. And additionally, on a preponderance, you're going to have a hard time proving a preponderance if you didn't even ask the attending physician for their --

1:22:50 Right.

1:22:51 -- comment, so it won't change any of that.

1:22:53 Okay, thank you.

1:22:56 Okay. Should we move onto Issue 18? So this is Rule 35 still. Again, so it's determining medically stationary of the rule. And Section 6, if a claim closes based on the worker being deemed medically stationary, the insurer has to identify the date the worker became medically stationary, and usually, we're talking about a date of an exam, but occasionally providers do conclude other evidence led to a determination that the worker was medically stationary, not specifically on a date of an examination. And the rules currently aren't clear on whether a date other than the date of an examination may be used. And we're looking at Section 6 where it currently says a worker is medically stationary on the date of the examination when so specified by a physician. I think historically the dates are dependent upon the medical evidence, and so if the doctor concludes that the medically stationary date is some other date other than a date of an exam because of whatever evidence they're looking that, that that historically has been used. And so, in maintaining kind of the current practice would be to eliminate "of the examination when." So, basically a worker is medically stationary on the date so specified by a physician. Any thoughts?

1:24:25 Nathan Goin with Reinisch. I think that this is a positive change that also will clarify the rule, and it's a good modification.

1:24:35 Okay. Rule 65 is the Form 1644P is used to rate permanent total disability reduction, so we're shifting gears here. The form is not referenced in the rule currently. So, the rule explains when an insurer reduces a permanent total disability claim, the insurer must, based on sufficient information to determine the extent of PPD, issue a notice of closure that reduces the PTD, permanent total disability, and awards PPD,

permanent partial disability, if any. There's a specific notice of closure form that we have, a Form 1644P, that's related to permanent total disability reduction, and the form is published within Bulletin 139, but the rule does not make a reference to that form or the bulletin. And so, we were looking to modify the rule to reference both the form and the bulletin. That's part of a housekeeping change that we discussed later, but basically reference the form and have reference to the bulletin at some point as well.

Okay. Issue 21 is about lost wages to attend an arbiter exam. So, a stakeholder had been looking for a rule that stated a worker must receive net lost wages --

1:26:08 Julia.

1:26:09 Yes.

1:26:09 You skipped 20.

1:26:10 Oh, sorry.

1:26:11 Yeah, 20 and 21, yeah.

1:26:12 Nice try.

1:26:13 Is that how you're going to get done to quickly?

1:26:16 I flipped instead of -- I turned instead of flipped, sorry.

1:26:20 Okay.

1:26:20 Yeah.

1:26:21 Okay, Issue 20, obtaining relevant claim notes in administrative closures.

So, when reconsideration of a notice of closure begins, Rule 135, Section 1 requires the insurer to provide the director and the parties with copies of all documents pertaining to the claim. And the rule explains that that includes but is not limited to the complete

medical record and all official actions and notices on the claim. There is a concern that ARU might not be receiving all relevant information on administrative claim closures. So for example, the worker may have contacted the insurer about their treatment or a scheduled exam, which should be documented in some claim notes. Those claim notes often are not submitted into the reconsideration record, so unless a worker or their attorney obtains and submits that information, ARU would be missing pertinent information related to administrative claim closures. They're trying to look at contact that the worker had about their treatment. And so, a couple options that we had identified was, when listing out what is included in the documents that pertain to the claim, add a requirement for any documentation related to contact made between the worker and the insurer pertaining to the worker's failure to seek treatment or attend the exam, if closure occurred under Rule 35, that administrative closure rule for failure to seek treatment or attend an exam. Another option would be have an insurer certify that the worker made no contact with the insurer pertaining to their failure to seek treatment or their failure to attend an exam which lead to closure or, if there was contact, have them give details of the same or no change or something else. And if --

1:28:05 Nathan -- oh, I apologize.

1:28:06 Oh, go for it.

1:28:07 I was going to say -- Nathan Goin with Reinisch. I would recommend option 2, have the insurer certify if this is something that's necessary needed by ARU to appropriately review what's going on. I'm worried about confidentiality and privilege issues with, you know, just producing claim reference in notes and there may be

instances in which you receive copies that are heavily redacted or we have other kind of medical issues that arise, and I think the easiest way around that is just with the certification of having to make sure that it's needed.

1:28:40 Elaine Schooler with SAIF Corporation. We have the same concerns, and these administrative closures, often legal advice has been sought on the process and steps that are -- the adjuster has taken or if they followed it properly, so there is that concern, as well as the scope of information that's in there and the process of redacting it all. It's just not something that we provide. In addition, the information is something that the worker already has, so the worker should have told their attorney then that they called the insurer or they spoke with the claims adjuster or they didn't receive the notice. And so, the worker representative have that information already available. We can submit a letter to that effect to the Division for consideration, so our preference would be that there's no change.

1:29:31 That's assuming the worker has an attorney with that last one, right.

1:29:36 Sure.

1:29:36 I mean, so it seems the second option you're saying the insurer would require the worker made no contact with the insurer or, if there was contact, to provide some details of what the contact was.

1:29:50 Yeah.

1:29:50 I mean, I think at a minimum if the question of the conduct of the worker attending or not attending an exam or getting or not getting treatment if the worker contacted the insurer and there's discussions of that or the worker provided reasoning

for their attendance or nonattendance, I think that's certainly information that ought to be put into the record of a closure reconsideration.

1:30:19 It seems like though that, if the worker has requested reconsideration, that they would be the party to provide that information, so if it is required, the Division could send a letter to the worker asking them what steps they took or what responses they provided to the insurer, and then the Division could take that into consideration and, of course, copy the carrier who can also respond.

1:30:46 I just have a question about your concerns about confidentiality, and we're not talking about like emails between the adjuster and the worker, right, which would be not confidential and should be shared, but you're more talking about like internal claim notes where the adjuster might have written down, you know -- I don't know what the claim notes look like but, you know, left a message for a worker, a worker didn't call me back or something. You're more worried about the claim notes --

1:31:08 Correct.

1:31:09 -- than actual claims, yeah.

1:31:11 Yeah. No, the correspondence between the worker and the adjuster. If the adjuster emails or is like, I scheduled this examination for you, and the worker writes back, oh, I can't go because I have a family trip planned. No, we would still send that out.

1:31:23 Yeah.

1:31:23 We're not going to withhold that.

1:31:26 Okay. Well, with that information, I don't have that much of an issue with

a certified copy, only that I've had it come up in hearings for noncooperation denials where there was a dispute on whether the worker called and left a message, and it wasn't clear from the information we got whether that was something that would be tracked, meaning if there was a phone call in from a certain number, you know, whether they left a message or not, if that would be tracked in a system. So, it became relevant then. So, I think there are situations where if there's disagreement about no contact that the insurer may need to provide some documentation, not just a certification, but as a general matter, I wouldn't have an issue with the certification.

1:32:12 Any other thoughts? Okay, so now we're on Issue 21. So, this is the lost wage for an arbiter exam. So, our rule requires the insurer to pay for costs related to the medical arbiter exam. What constitute cost of the exam is not described in the rule, but 325(1)(f) does explain some information. It says the insurer or self-insured employer shall pay the costs of the medical examination and related services which are reasonably necessary to allow the worker to submit to any exam requested under this section and, as used in that paragraph, related services includes child care, travel, meals, lodging, and an equivalent amount to the worker's net lost wages for the period which the worker is absent if they do not receive benefits under 210, Section 4 during the period of absence and a claim for related services is made in the manner prescribed by the director.

So, costs are also described in the brochure titled What Is A Medical Arbiter Exam, and that description's consistent with what is described in the statute that I just provided. And so, the issue is whether our rule should be modified to further explain

what the costs are. Currently, the rule just says the insurer must pay all costs related to the completion of the medical arbiter process in this rule. And so, the option identified is to amend the rule to further explain what those costs may include and say they may include but not be limited to costs for child care, travel, meals, lodging, and equivalent amount of the net lost wages during the time that the worker is absent if the worker does not receive benefits pursuant to 656.210(4) during the period of absence, and that's just mimicking the statutory language that I described in 325(1)(f). Other options identified, no change or something else and we think of the interpretation's consistent with the statute and rules, so we don't anticipate any fiscal impact, but welcome that feedback as well. Any thoughts?

1:34:32 I think clarity is good.

1:34:35 Okay. Issue 22 is whether the rule is too prescriptive in describing how an insurer must use an updated notice of acceptance at closure to indicate when it's indicating it's a corrected document. So, this is kind of rewinding to Rule 15. Under Rule 15, it talks about the insurer's responsibilities and so, when an omission or error requires a corrected updated notice of acceptance at closure, the word corrected has to appear in capital letters adjacent to the word updated. The specificity about the title and the need for the term corrected to be in all capital letters and adjacent to the word updated could become a point of dispute even when the document's clearly labeled as a corrected updated notice of acceptance. We also have our Division 60 rule that provides that corrected omission or error in an updated notice of acceptance at closure they have to word -- add the word corrected to the notice. In that rule, there's no

mention about corrected being in capital letters or adjacent to the word updated. And so, it raised the question of whether we should remove the prescriptiveness in this rule about the title of the document, the title of the corrected updated notice of acceptance at closure.

And so, what we had thought was to -- an option that we had identified is to amend the rule so that it indicates that when there's this omission or error requiring a corrected updated notice of acceptance at closure, the document must be clearly identified as a corrected updated notice of acceptance at closure, and this may be accomplished by including the word corrected in capital letters. The thought is that by maintaining that information in there about continuing to allow that it wouldn't require a process change for an insurer. So, if they're doing it correctly now, they can keep doing it that way and that would continue to be acceptable, but it would also add a little bit more wiggle room to just say that it could be clearly identified instead of having to have it be so prescriptive. So, we're looking for feedback or not changing the rule at all, something else, and we didn't identify any impacts since we're going to continue to allow the process to be as is, just add a little bit more wiggle room in how that's labeled.

1:37:01 This is Dan from SAIF. I think that prescriptive doesn't need -- being too prescriptive is still going too far. Throughout the rest of the administrative rules, Division 60 and that, and all the documents I found are all titled. Let's say notice of acceptance, that "notice" is capitalized and "acceptance" is capitalized, but the "of" isn't. And throughout -- you need a style guide to say corrected updated notice of

acceptance at closure, the "corrected" has to be in all caps and then going to our next issues document of notice of refusal to close, that has to be all, all in caps. There are two notice requirements, but one doesn't jive with the other one. And again when we're going to our IT department, we're saying, okay, here's the titles that we have to put on these letters, and sometimes they listen to us, sometimes they don't.

Sometimes they capitalize what we ask for, sometimes they don't. And if there was consistency throughout all the rules that you capitalize all the words that aren't "of" and "the" and "and," then it would be a lot easier to be in strict compliance with the administrative rules because there'd be a consistent style throughout all the divisions of the rules instead of, oh, this is all caps and this all caps is everything in the title. So, that's my suggestion, is corrected should be capital C lowercase the rest of it, and then the next issue, the notice of refusal to close should be capitalized notice refusal and close and everything else should be lowercase.

1:38:52 But are you saying that if it wasn't lowercase, that that somehow should invalidate a closure if an insurer put all big letters? This rule would be giving a little more flexibility. You could do it the way you said it, or it could be in all caps, or it could be part in caps.

1:39:14 Well, it says -- as I'm reading it, it says the word corrected in capital letters.

1:39:20 So, maybe that it could include that.

1:39:21 So the may --

1:39:22 It's --

1:39:23 May instead of it being a requirement.

1:39:23 Or it would be a requirement. Now, we're saying we don't want to require everything, but it can include that.

1:39:29 It's saying it must clearly identify corrected updated and this may be accomplished by putting it all in caps. It's just an example I think of --

1:39:37 Of a requirement.

1:39:39 So currently, the rule requires that it must. So we'd change -- basically changing it to a may, and just say you have to clearly identify it.

1:39:46 Just put a period at the end of corrected updated notice of acceptance at closure period.

1:39:55 But then does it have to be capital C, the rest lowercase?

1:39:59 Well, that's what I'm getting at is if you put an example and it's all in caps, people are going to assume it has to all be in caps.

1:40:06 I think this example was for SAIF adding that because --

1:40:11 Well, I think that --

1:40:12 So, it wouldn't require a programming issue so you could still do it without reprogramming by saying corrected in all caps.

1:40:20 Okay. And then I'll throw myself under the bus. In the notice of refusal to close, we capitalize the R in refusal and nothing else is capitalized, so we're not even in strict compliance with the current rules or the proposed. So, I guess what I'm getting at is just have a consistent style, so that we know that notice of acceptance, claim -- any type of document that we're required to send out that has a title to it has a

consistent style of what you capitalize and what you don't capitalize.

1:40:57 I think we're saying it doesn't have to -- it doesn't -- you don't have to have any of them in capitalized if you don't want to. That's the proposal.

1:41:03 It must be titled that, but it could be any form and formats of capitalization.

1:41:08 So, as long as we agree that the word corrected, it doesn't mean that it has to be capitalized corrected even though it says including the word corrected in all capitals.

1:41:19 Dan, are you focusing on the fact that it's in quotes?

1:41:23 Yeah.

1:41:23 It's surrounded by quotations, so it says that's the title of the document. That's how I read it also, so.

1:41:31 If you think we could take that part out because was that added for a programming issue?

1:41:36 Yeah. You know, currently, the rule has that in all quotes. I think that it's just maintaining the current rule language. But I mean we could take -- I think -- let me just rewind a second for -- concept-wise, are people's feelings that if the document is clearly identified as whatever the document is, it should be okay? If you're clearly labeling it, we shouldn't be -- right? Are people comfortable with that? I see nodding heads.

1:42:00 Nathan Goin, that would be my position.

1:42:07 Okay. So then, where we're left is right now our rule is very prescriptive.

It has corrected has to be in all capital letters, it has to be adjacent to the word updated, and what we are looking to do is modify it to just say if it's clearly identified as a corrected updated notice of acceptance, we're good, and then you could do that by keeping corrected in all caps, or you could do it some other way. And I think that was added more with the idea that that's what's currently being done and so making clear that what's currently being done is still allowed, but it's not that we're trying to change the current process. We're just trying to change some of the technicality behind it so that there's not arguments about whether -- you know, what should happen on that document where everybody agrees it's a corrected updated notice of acceptance and it's labeled that way.

1:42:59 We don't want a style guide, Dan.

1:43:00 I'm for that. We've just had instances where we've been told that letter's not in strict compliance, and then we have to go in. So, when I read this and I say word corrected in parens and it's all capitalized in capital letters, to me that implies that it has to be in all capital letters or it's not in strict compliance. But if what I'm hearing is that it's not what it says, okay.

1:43:32 Yeah.

1:43:33 It's saying that you may do it this way, but it's not saying you must do it this way.

1:43:39 Okay.

1:43:39 Yeah.

1:43:40 I think you're bitter.

1:43:43 I guess I'm missing the "may" in there.

1:43:45 It's there.

1:43:46 Okay. Any other thoughts or feedback? And Jen touched on it a bit. The next issue is very closely related, but I'll go through it in case people have more thoughts or something specific that's related to the notice of refusal to close. So, this is also -- or this is in Rule 17, our next rule, Section 2 and whether the prescriptiveness of notices of refusal to close. So, if an insurer issues this document, they have to identify it in cap -- according to the rule, it has to be in capital letters, says notice of refusal to close, and it must include specific information and appeal letter language. The requirement for the title to appear in all capital again might be too prescriptive. And in addition within that rule, there's a couple of housekeeping items that we're looking at. Capitalizing the title. Normally we capitalize titles within the rule language, not talking about what has to go in the document and then to eliminate some duplicative language, so I included that within this description.

And so, some options to identify to try to address whether to modify the prescriptiveness of this notice of refusal to close title, we could revise the rule to state that if an insurer issues a notice of refusal to close, the notice must be clearly titled notice of refusal to close and must include and then we've got the list of what has to be in there. Or it could be revised to say that if an insurer issues a notice of refusal to close, the notice must be identified in all capital letters or boldface type as a notice of refusal to close, so it would give either capitals or bold because I think we tend to see both often because, like Dan mentioned, there's different rules that require different

things and different contexts and some rules require bolding, some rules require capitals, and that kind of gives to either or. Or we could just make the housekeeping changes that were articulated or something else with other ideas. Any other thoughts?

1:46:00 I mean however it's written out I think as with the prior Issue No. 22, whatever makes it clearly identified that's what the document is. I mean I think -- I mean it's the critical things for the injured worker to understand what they're receiving.

1:46:15 Okay.

1:46:16 So, whether it's all in caps, it's all bolded, whatever just as long as it clearly identifies this is what you're being sent.

1:46:24 Right. Okay. Alright, I'm going to move to Issue 24. This is under our reconsideration record rule. When a claim is closed for failure to treat with an authorized provider, we do not always get documentation demonstrating that the treating provider lacked authority to treat the worker. So, an insurer has to provide, like I said before, the director and all parties with a copy of all documents contained in the record at claim closure. Under Section 5 of Rule 155, it also explains that for workers enrolled in an MCO the insurer must provide documentation of the healthcare provider's authority to act as an attending physician. Occasionally, a claim could close under Section 2 of Rule 34 for failure to treat with an authorized provider. When that occurs, the insurer may not automatically provide documentation to the director or the parties that that provider lacked authority to act as an attending physician whether it's because their time period expired or if they're not authorized by the MCO or something else.

And so, we were looking at whether we should modify Section 5 of Rule 155 to explain that if the claim did close under a rule or administrative closure rule for failure to treat with an authorized provider, the insurer must also provide documentation that the healthcare provider lacked authority to act as the attending physician or no change or something else and no impacts expected.

1:47:59 What exactly is this documentation that you're not getting because the rule requires all documents to be sent up to the point of claim closure to the Division, so is there missing things, or is there some like certification you need from the adjuster?

1:48:16 Do you guys want to comment on what you've seen lack?

1:48:20 We generally don't get anything MCO related. We don't see a lot of documents saying the MCO says, no, you can't treat, or we're not going to credential you or those sorts of things.

1:48:25 That would be --

1:48:27 We also don't get a lot of letters where the insurer tells the worker that a chiropractic physician no longer qualifies or this or that, so we don't get a ton of that information.

1:48:54 Well, when we MCO enroll a claim, we send out a notification to the worker that their claim is enrolled, and we also notify them in that enrollment --

1:49:02 And we get that.

1:49:02 -- whether or not the physician is a member and if they need to change providers or not because the rules --

1:49:08 Is it usually that on the original acceptance, like right as you accept it, and then it kind of goes on for maybe six months, a year, and there's not any future notifications. Would you agree with that?

1:49:21 Yeah, or I guess the other situation would be when they then are trying to change physicians. If the worker maybe calls the adjuster and says, I want to treat with Dr. Y, there's nothing in the record that tells us if this provider was or was not in the MCO. It's usually we don't get anything that says that this doctor the worker wanted to go to would be or wouldn't be.

1:49:46 Well, wouldn't the adjuster be sending the letter that they have failed to treat with an MCO provider prior to going through the administrative closure process, and that failure to seek treatment with an authorized provider will result in claim closure?

1:50:03 They general -- yeah. Are you saying would they have sent the bug letter under 003, 4(2)?

1:50:07 Right, yeah. When we send these letters, we give the adjuster notice that they're seeking treatment with a provider who's not authorized under the MCO to treat them and that their claim may be closed if they don't find an authorized provider, so if that -- are you saying that documentation is insufficient then?

1:50:26 That -- if the worker isn't trying -- attempting to change or go to someone aside from that provider, that notice would be fine. If that's the only provider that they're actually naming and they're attending, that would be fine. But if the worker's verbally saying, I'm changing to someone else, and we still don't know if that provider

is authorized either in the MCO or --

1:50:49 But if a worker is just -- I'm just trying to think of all like -- but you're -- and a -- and if a worker says, I want to see this doctor, the adjuster probably wouldn't send a letter to them. They would just tell them, that's not an authorized MCO provider --

1:51:04 And telling a worker is not an authorized provider --

1:51:04 -- and if the worker does -- but if the worker does go and seek treatment, at that point, the adjuster would then send something in writing that says not an MCO provider and something goes out from the MCO too, and then again, that would be -- trigger the bug letter that they're not treating with an MCO provider.

1:51:20 That might be SAIF's office.

1:51:23 Yeah.

1:51:23 It's not necessarily all insurers or processors that we -- we don't see a lot of that information on cases that are not SAIF related, so and we need to.

1:51:36 For these situations where the insurer is not doing what they should be doing, so requiring them to provide something that they're not doing in the first place, they can't comply with this rule to provide the documentation that they're not even sending out in the first place.

1:51:54 Is not doing.

1:51:57 Repeat that question, Dan?

1:51:59 If the information doesn't exist, they can't provide it. So, if they're not sending out the information to the worker saying --

1:52:07 What do you mean the information doesn't exist?

1:52:09 A letter.

1:52:11 In the example where the worker is treating or is seeking treatment with a non-MCO provider, if the insurer is not notifying them that they're seeking treatment with an unauthorized provider but yet they're going through the administrative process to close the claim, this rule -- that seems to conflict then --

1:52:35 So, they might not have sent a notice that tells the worker you -- a type B physician can treat for this long. The first thing that we see is just a notification, a bug letter, saying you're not seeking treatment with an authorized provider. It does not go into why that provider is not authorized and it's the only notice that we have in the record. Is that usually something we would see from SAIF?

1:53:01 So, that's what I'm getting at, is the insurer in that situation can't provide the documentation because they never sent it in the first place.

1:53:08 Oh, okay.

1:53:09 Yeah. They don't generate -- they don't need to generate the documentation.

1:53:12 Yeah, true. Well, maybe. We don't -- we didn't have it and they didn't send it.

1:53:15 We don't, no.

1:53:16 And see, I think that's what we're saying, is when the reconsideration request is made and you guys send your request for documents, we send you everything that we're required to send you, but if we didn't -- we or an insurer didn't do

something in a claim, having a rule that says well, you must provide the documentation, they can't provide what they don't have. So, unless they're deliberately holding it back as opposed to --

1:53:46 Well one, they need to start generating that document, so there needs to be a rule that requires that you do generate and then at least submit it as part of the reconsideration process.

1:53:57 Not if the letter -- before the bug letter.

1:54:00 Yeah, and there are rules that the division --

1:54:03 Fifteen, 15 probably.

1:54:05 Fifteen?

1:54:06 Maybe 10 too.

1:54:08 And sorry, this rule is about providing additional documentation when the insurer is already required to provide all documents in the claim record. So, they should be providing everything already in the record.

1:54:24 So right now, some insurers only provide the medical records and any what they consider official actions is and there's an acceptance, a denial. They don't provide any of the other stuff, just medical records, just the official denials, acceptances, that type of documentation.

1:54:43 So, they're not providing any other communication with the worker?

Okay.

1:54:48 Well, it's going to be -- that seems to be a noncompliance --

1:54:50 We have a choice?

1:54:50 -- with the rule then.

1:54:53 Do we have a choice.

1:54:56 Well, you know.

1:54:56 Didn't know you had a choice.

1:54:57 Guess we were just supposed to find out.

1:55:04 Well, it seems if the insurer doesn't provide that information, that may be grounds to rescind the closure in and of itself, isn't it, if there's no information containing that the worker's not treating with an unauthorized attending physician. So, it behooves the insurer providing they haven't and they don't or they haven't sent out the appropriate letters or they're not sending information, hey, this is not an authorized attending physician, but the records show that the worker is still getting treatment, isn't that -- I mean that -- I mean it's kind of the insurer's problem then, isn't it, and the claim get -- the closure gets rescinded or kicked aside.

1:55:48 Possibly.

1:55:56 And I think one other -- like, that -- the one other piece of background for this is within Section 5. It does state that for cases involving healthcare provider have to meet criteria as an attending for an MCO, the insurer has to provide that documentation on their authority to act as an attending physician. And so, it's just kind of the flip side of that, so the rule does state that you need to provide the documentation on authority to act as attending. It's silent right now on if it would need to provide documentation for authority not to act as the attending.

1:56:36 In the 30s.

1:56:37 Correct.

1:56:42 I just -- I don't see the need for the change because we're already required to provide a copy of all documents in the record. My other concern is that the way this is worded, must provide documentation of healthcare (inaudible 1:56:58) authority. I guess I just don't know. Like, does that mean there's going to be some sort of procedural review as to whether or not that provider had authority? And I'm not sure like beyond us putting the worker on notice like we do, and we provide all that documentation pursuant to the rule, that should be sufficient, and it raises a specter in my mind that somehow their authority to act as the attending physician would be under scrutiny.

1:57:37 Okay. Any other thoughts? Alright. Issue 25, so currently addresses are not always inserted in the notice to worker, beneficiary, estate. So, when an insurer sends certain information to the worker or the beneficiary or an estate, they have to include specific language. Within that language is an area to insert the current address of the board or the division, and that language is not always inserted by the insurer, so some people might have seen notices that come out, and it says, insert here, insert address, and it's just -- it goes that way to the worker without it actually inserted. So, we were looking at whether in the rules we should go ahead and spell out the addresses for mailing rather than asking the insurer or self-insured employer to insert to current address. I think it's almost a housekeeping issue, but it would require a change if our address is spelled out differently than is in current forms that could require a modification, so we went ahead and put it here. But it relates to Rule 15 and

Rule 17 where there's those kind of blocked-out insert-address-type statements. Any concerns? Okay. Yes.

1:59:06 Nathan Goin from Reinisch. I think this is a fantastic idea.

1:59:12 Okay. Issue 26 we've kind of already talked about, but this is in the Division 30 rules, so we want to point it out here and see if there's any other thoughts as to what we discussed. So, you might remember one of the first things we discussed today was the rating of impairment in the Division 35 rules referencing in any part and we talked about should that be material part, should that be due to, should that be something else. So, there is some of that language in Rule 20 within the Division 30 rules. A closing report must identify permanent impairment and permanent work restrictions that is caused in any part by the accepted condition, new omitted, directed medical sequelae, blah, blah, blah. So, in Caren, like we talked about, it advised that the rating of impairment must be based on what is caused in material part of the injury or disease. We talked back in the Division 35 about what that should be modified and people's thoughts on modifying that, and our thought is wherever the Division 35 rules land on the phrase in any part and whether it would also be appropriate to modify the phrase in any part in this Division 30 rule. And so, our option identified is to update this rule in conjunction with the language that goes into Division 35 or something else if people have a thought or no change and looking. Any thoughts on that one?

2:00:42 It seems like they should be consistent, so whatever is used in the 35 rule should be mirror whatever you use.

2:00:51 Okay. So, we're in housekeeping. There's 46 housekeeping items. I

think they're all housekeeping. I'd be happy to read through them all if people want or we can also -- we thought we would give people until the end of the day on Monday, December 2, which is the Monday after Thanksgiving, if people have additional thoughts after leaving today to provide feedback or comments or anything. If you leave this room and think of something else that you wish you had mentioned, then we -- you can feel free to provide that information to -- Fred can get it to everybody that needs to know. And so, would anybody like me to go through any particular housekeeping items or read through them so that we can go through those or would people like to read through them on their own and provide comment at some point later if there is feedback on it? People good with reading through them and letting us know?

2:01:58 And I would just like to say that if you -- I think I have all your contact information, but there's some business cards at the back of the room and so, get in touch with me if I haven't been in touch with you. If you kind of received the invitation that was forwarded by somebody else for instance, then I may not have your contact information. I want to keep you informed. Like, when we file proposed rules, we'll post it to our website and then I'll notify everybody that I have on my list. So, if you're on the telephone as well, I may not have your contact information, so be sure to give me a call after the meeting 503-947-7717 and just let me know what your contact information is so I can keep you in the loop going forward.

2:02:43 Great. Thank you, guys. We said at the beginning, but we really do appreciate everybody coming and providing feedback and input on all of these issues. I

know it was a long day, so thank you for spending your Tuesday with us and we appreciate it.

2:02:56 Yes, goodbye everybody.

2:02:58 Thank you.

2:02:59 Thank you. Bye-bye.

2:03:00 Bye.