Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR 436-060 – removal of SSN reporting boxes from claim reports

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Oct. 15, 2020, 9 a.m. to 12 p.m. PDT, telephone/computer attendance only: **Computer, tablet or smartphone:** https://global.gotomeeting.com/join/447784405 **By phone:** U.S. (Toll Free): 1 877 309 2073 **Access Code:** 447-784-405
Facilitator:	Fred Bruyns and Katie Bruns, Workers' Compensation Division
9:00 to 9:10	Welcome and introductions; meeting objectives
9:10 to 10:30	Discussion of issues
10:30 to 10:45	Break
10:45 to 11:45	Discussion of issues continued
11:45 to 12:00	Summing up – next steps – thank you!

Attached: **Issues document** | **Draft rules**

OAR 436-060
Claims Administration
Rulemaking Advisory Committee (RAC) 10/15/20
Proposed Rules effective January 1, 2021

ISSUE #1

Short Title: Deadline for using modified forms

Rule: OAR 436-060-0003(3)(c)

Issue: The deadline in current rule is no longer applicable.

Background: On April 1, 2020, OAR 436-060-0003 was amended to create a process for insurers to obtain approval for forms contained within the OAR 436 chapter 060 which they modified for their use. Rule language included a May 1, 2020 deadline, to allow time for insurers to comply with this new process by obtaining approval by the director to use any existing modified forms that had not been approved for use, or cease use. That deadline has passed, and this subsection of the rule can be removed. Currently, any insurer that uses a modified form must have director approval prior to using the form.

Options identified:
- Remove 436-060-0003(3)(c) as it is no longer applicable
- Other

Fiscal Impacts, including cost of compliance for small business: No impacts are expected, but the WCD invites input from the advisory committee members about costs, including costs to be borne by small businesses.

Recommendation:

ISSUE #2

Short Title: Social Security number (SSN) on workers' compensation report of injury form (Form 801)

Rule: OAR 436-060-0010(3)(a)

Issue: The rule requires an employer to submit a worker's SSN (if known) to the insurer. However, the division's business processes only require an SSN from the insurer, not the worker or employer.

Background: On July 20, 2020, the Management-Labor Advisory Committee (MLAC) wrote a letter to Governor Brown outlining six consensus recommendations related to workers' compensation system issues. The committee heard concerns that the use of a Social Security number (SSN) on the most common injury reporting form has a chilling effect on workers filing claims. Because the reporting form is used by many entities for a variety of purposes, the committee supported further discussion and recommended the Workers' Compensation Division (WCD) convene a stakeholder group to discuss the use of the SSN on the Form 801, "Report of Job Injury or Illness." The WCD expanded the discussion to include the Form 827, "Worker's and Physician's Report for Workers' Compensation Claims," used by medical providers to report a claim.
The WCD held a stakeholder meeting on September 15, 2020.

The WCD heard input that confirmed the mere presence of a box for the SSN on the forms deters some workers from filing a claim for an injury. Additionally, insurers and employers both expressed discomfort with the collection of a worker's SSN on the forms due to privacy concerns. Some of the solutions discussed were: moving the box for the SSN from the worker's portion of the form to the employer/provider portion; allowing an alternative identification number to be provided in place of the SSN; indicating on the form that providing an SSN is optional; and removing the box for the SSN from both forms. After reviewing all of the input received, the WCD decided to move forward with removing the SSN box from both the Form 801 and Form 827.

With the SSN box removed from the Form 801, employers may not be compliant with rule as it is currently written. The SSN (if known) reporting requirement for employers should be removed from rule to ensure employers are compliant with rule when they solely report a claim using the Form 801. The rule currently requires insurers to report the SSN to WCD, and requires insurers to obtain the SSN from the employer. Insurers also need to obtain the SSN for other purposes, including the requirements for reporting disabling claim status and requesting supplemental disability benefits.

The WCD is interested in hearing from stakeholders how much time they will need to change their processes to obtain the SSN, and ensure it is not included on the Form 801, or any modified Form 801.

Options identified:

- Remove the requirement for the SSN to be reported to the insurer as a part of the first report
- Other

Fiscal Impacts, including cost of compliance for small business: We do not expect any significant fiscal impact, but the WCD invites input from the advisory committee members about costs, including costs to be borne by small businesses.

Recommendation:

Claims Administration
Oregon Administrative Rules
Chapter 436, Division 060

DRAFT Proposed* – *projected effective date, Jan. 1, 2021

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Historical rules: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060

NOTE: Revisions are marked as follows: new text | ~~deleted text~~.

436-060-0003 Purpose, Applicability, Forms, and Bulletins

(1) Purpose.

The purpose of the rules in OAR 436-060 is to prescribe uniform standards for insurers to process workers' compensation claims under ORS chapter 656.

(2) Applicability.

(a) The rules are subject to the applicability provisions under ORS 656.202.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(3) Forms and bulletins.

(a) The forms and bulletins referenced in OAR 436-060 are available on the division's website at https://wcd.oregon.gov/forms/Pages/index.aspx.

(b) With the approval of the director, an insurer may modify the appearance, wording, or font size of a paper form referenced in OAR 436-060. Any insurer modified paper form must:

(A) Obtain information equivalent to the division's current form;

(B) Use the same form number as the division's current form;

(C) Have an appearance and format substantially similar to the division's current form; and

(D) Have an asterisk after the form name with the following statement at the bottom "*This form was modified by [INSERT INSURER'S NAME], and has been approved for use by the Oregon Workers' Compensation Division."

~~**(c)** An insurer may continue using a modified paper form that was in use prior to the effective date of these rules if the insurer requests, no later than May 1, 2020, approval by the director to continue using that form, subject to the following:~~

~~**(A)** If the insurer requests approval by the director to continue using a modified paper form, the director will either approve the form, specify changes to the form, or deny approval of the form. The director may require immediate removal of information that violates state or federal laws or otherwise may cause harm to any person. Otherwise, the insurer must comply with the director's determination within six months of the director's decision; or~~

~~**(B)** If the insurer fails to request approval by the director to continue using a modified paper form by May 1, 2020, or if the insurer fails to comply with the director's determination within six months of the determination in subparagraph (A) of this paragraph, the modified paper form can no longer be used by the insurer.~~

(c~~d~~) The director may revoke approval of an insurer modified paper form when the director determines the form does not comply with current federal or state law, or if the director finds the form no longer meets the requirements of (3)(b) of this rule.

(d~~e~~) To request approval of a modified paper form, the insurer must send or hand deliver the proposed form, along with a cover letter requesting approval to use the form, to the Forms and Bulletins Coordinator at WCD.FormsBulletins@oregon.gov or 350 Winter Street NE, P.O. Box 14480, Salem OR 97309-0405.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 84.013, 192.318, 192.355, 656.005, 656.126, 656.160, 656.202, 656.204, 656.206, 656.208, 656.210, 656.212, 656.214, 656.216, 656.228, 656.230, 656.234, 656.236, 656.245, 656.260, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.277, 656.278, 656.289, 656.307, 656.308, 656.313, 656.325, 656.331, 656.360, 656.362, 656.386, 656.605, 656.704, 656.726(4), and 656.745
Hist: Amended 12-1-2009 as WCD Admin. Order 09-057, eff. 1-1-2010
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf .

436-060-0010 Employer Responsibilities

(1) General.

A subject employer must accept notice of a claim for workers' compensation benefits from a worker or the worker's attorney under ORS 656.265.

(a) Form 801, "Report of Job Injury or Illness," must be readily available for workers to report their injuries. The employer must provide Form 801 to the worker:

(A) Immediately upon request by the worker or worker's attorney under ORS 656.265(6); or

(B) Upon receiving notice or knowledge of an accident that may involve a compensable injury under ORS 656.262(3)(a).

(b) Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," signed by the worker, is written notice of an accident that may involve a compensable injury. The signed Form 827 will start the claim process, but does not relieve the worker or employer of the responsibility of filing Form 801.

(c) Form 3283, "A Guide for Workers Recently Hurt on the Job," must be provided by the employer to the worker at the time a worker files a claim for workers' compensation benefits. Form 3283 may be printed on the back of Form 801.

(d) If a worker provides notice of a claim using an electronic form, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records necessary to process the claim under OAR 436-010-0240.

(2) Employer reporting time frame.

An employer, except a self-insured employer, must report a claim to its insurer no later than five days after the date the employer has notice or knowledge of any claim or accident that may result in a compensable injury. The date an employer has knowledge of an accident that may result in a compensable injury is the earliest date any supervisor or manager of the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.

(3) Reporting requirements.

The report must provide the information requested on Form 801, and include at least:

(a) The worker's name~~,~~ and address~~, and Social Security number (if known)~~;

(b) The employer's legal name and address; and

(c) The information required under ORS 656.262 and 656.265.

(4) Injuries not requiring medical services.

The employer is not required to notify the insurer of an accident that does not require the worker to seek treatment from a licensed medical service provider, subject to the following:

(a) The employer must report the claim to the insurer under section (2) of this rule, if:

(A) The worker chooses to file a claim;

(B) The worker signs a Form 801;

(C) The worker or employer is billed for treatment; or

(D) The employer learns that the injury has resulted in medical services, disability or death. For the purposes of this paragraph, the date of that knowledge under section (2) of this rule is the date the employer received notice or knowledge of the medical services, disability, or death; and

(b) If the employer does not give the insurer notice under this section:

(A) The employer must maintain records for five years showing the name of the worker, the date of the accident, the nature of the injury and treatment provided; and

(B) These records must be available for inspection by the director, the worker or the worker's attorney, if any, and the insurer.

(5) Civil penalty for failure to report claims.

The director may assess a civil penalty under OAR 436-060-0200 against an employer that:

(a) Is late in reporting more than ten percent of its total claims to its insurer during any quarter; or

(b) Intentionally or repeatedly pays compensation instead of reporting claims or accidents that may result in a compensable injury to its insurer.

(6) Worker's right to choose medical service provider.

The worker may choose a medical service provider, attending physician or authorized nurse practitioner under ORS 656.245, 656.260, OAR 436-010 and 436-015. Except as provided

under ORS 656.260 and OAR 436-015, if an employer restricts the worker's choice of medical service provider the director may impose a civil penalty of up to $2,000.

Statutory authority: ORS 656.265(6), 656.726(4), and 656.745
Statutes implemented: ORS 656.245, 656.260, 656.262, 656.265, and 656.745
Hist: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf .

436-060-0011 Insurer Reporting Requirements

(1) General.

The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, OAR chapter 436, and orders of the director.

(a) All forms must be legible and include all information required by this rule.

(b) The insurer may not submit forms, or their electronic equivalents, by email, facsimile, electronic data interchange (EDI), or other electronic means, without the director's prior authorization.

(c) Electronic forms, when allowed, must include the same fields and elements as their paper counterparts.

(2) Misdirected claims.

If an insurer receives a claim and did not provide coverage for the worker's employer on the date of injury, the insurer must forward the claim to either the correct insurer or the director within three days of the date it determined it was not responsible for the claim.

(3) Identification of insurer.

All workers' compensation forms generated by the insurer must include:

(a) The insurer's name;

(b) The service company's name, if applicable; and

(c) The mailing address and phone number of the location responsible for processing the claim.

(4) Claims status and activity reporting.

The insurer must report all disabling claims status and activity to the director using Form 1502, "Insurer's Report."

(a) The insurer must file a Form 1502 with the director within 14 days of:

(A) The date of the insurer's initial decision to accept or deny the claim;

(B) The date of any reopening of the claim, except voluntary reopening under ORS 656.278;

(C) The date of a change in the acceptance or classification of the claim following the initial Form 1502;

(D) The date of a litigation order or insurer's decision that changes the acceptance or classification of the claim, or causes the claim to be reopened;

(E) The date a worker is enrolled in a managed care organization that occurs after the initial Form 1502 has been filed;

(F) The date the insurer has knowledge that a previously filed Form 1502 contained erroneous information;

(G) The date of a denial that occurs after the initial Form 1502 has been filed; or

(H) The date first payment of temporary disability is issued, if the date was not included in the initial Form 1502.

(b) Each Form 1502 the insurer files must include the following information:

(A) The worker's legal name;

(B) The worker's Social Security number as provided by the worker or employer, or a statement that the insurer is unable to obtain the worker's Social Security number;

(C) The insurer's claim number;

(D) The date of injury;

(E) The employer's legal name;

(F) The employer's policy number, unless the employer is self-insured or the claim is a noncomplying employer claim;

(G) The status of the claim;

(H) The reason for filing; and

(I) The wrap-up project name, if the claim is from a wrap-up project.

(c) The Form 1502 reporting the insurer's initial decision to accept or deny a claim must also include:

(A) If the first payment of compensation was made within the time frame required under OAR 436-060-0150, if applicable;

(B) If the claim was accepted or denied within the time frame required under OAR 436-060-0140; and

(C) For a worker enrolled in a managed care organization:

(i) The date of enrollment; and

(ii) The managed care organization number, unless the number was reported on a prior Form 1502 on the claim.

(5) Filing the first Form 1502 on a claim.

The first Form 1502 the insurer files on a claim must be accompanied by:

(a) Copies of all acceptance and denial notices not previously submitted to the director; and

(b) A signed Form 801, or its electronic equivalent, except when a Form 801 is not available for timely filing.

(A) The Form 801 must be completed by the employer and worker, unless:

(i) The Form 801 cannot be obtained from the employer or worker because the employer or worker cannot be located, refuses to cooperate, or is physically unable to complete the form; or

(ii) The Form 801 was prepared using an electronic form that required it to be prepared by the insurer based upon information obtained from the employer and worker.

(B) If a Form 801 is not available for timely filing:

(i) The Form 1502 may be accompanied by a signed Form 827 to satisfy the initial reporting requirement; and

(ii) The Form 801 must be submitted within 30 days of the date the insurer filed the first Form 1502.

(6) Nondisabling claims.

The insurer is not required to report a nondisabling claim to the director, except:

(a) The insurer must report a nondisabling claim that is denied in part or whole to the director within 14 days of the date of denial; and

(b) The insurer must report a nondisabling claim that is reclassified as disabling to the director within 14 days of the date of the status change.

(7) Voluntarily reopened own motion claims.

The insurer must file a Form 3501, "Notice of Voluntary Reopening Own Motion Claim," with the director within 14 days of the date the insurer voluntarily reopens a qualified claim under ORS 656.278.

(8) New condition reopening.

If the insurer reopens a claim due to a new medical condition, and the claim:

(a) Is not closed within 14 days, the insurer must file Form 1502 with the director within 14 days of the earliest of:

(A) The date the new condition is accepted; or

(B) The date the insurer has knowledge that interim temporary disability compensation is due and payable; or

(b) Is closed within 14 days, the insurer must report the reopening on the Form 1503, "Insurer Notice of Closure Summary." Form 1503 must be filed with the director at the time the insurer closes the claim, and accompanied by the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" sent to the worker.

(9) Claim withdrawal.

The insurer must file a Form 1502 with the director if it receives written communication from the worker stating the worker never intended to file a claim and wants the claim withdrawn after the claim has been reported to the director. The Form 1502 must be accompanied by a copy of the worker's communication.

(10) Failure to report.

The director may issue a civil penalty against any insurer that does not file required notices and forms within the time frames of these rules.

(11) Reporting of legal service costs.

Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms provided by the director for that purpose. Reports for each calendar year must be filed by March 1 of the following year.

(12) Election of payment of supplemental disability.

If an insurer elects to not process and pay supplemental disability benefits under ORS 656.210(5)(a) and OAR 436-060-0035:

(a) The insurer must submit a Form 3530, "Supplemental Disability Election Notification," to the director. The insurer is not required to inform the director if it elects to process and pay supplemental disability unless the insurer has previously provided notice otherwise.

(b) The insurer must use a Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," to request reimbursement under OAR 436-060-0500 for each quarter the insurer processed and paid supplemental disability benefits.

Statutory authority: ORS 656.264, 656.265(6), 656.726(4), and 656.745
Statutes implemented: ORS 656.210, 656.262, 656.264, and 656.745
Hist: Adopted 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

436-060-0500 Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) General.

When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, the director will reimburse the supplemental amount quarterly, after receipt and approval of documentation of compensation paid by the insurer or service company. The director will reimburse the insurer, in care of the service company, if applicable.

(2) Requests for reimbursement.

Requests for reimbursement must be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include at least:

(a) Identification and address of the insurer responsible for processing the claim;

(b) The worker's name, WCD file number, date of injury, Social Security number (if known), and the insurer claim number;

(c) Whether the claim is disabling or nondisabling;

(d) The primary and secondary employers' legal names;

(e) The primary and secondary employers' policy numbers;

(f) The weekly wage of all jobs at the time of the injury separated by employer;

(g) The start and end dates for the periods of supplemental disability due and payable to the worker;

(h) The amount of supplemental disability paid for the periods in subsection (g);

(i) The quarter and year in which the payment was made;

(j) A signed payment certification statement verifying the payments; and

(k) Any other information the director requires.

(3) Administrative fee.

In addition to the supplemental disability reimbursement, the director will pay the insurer an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

(4) Repayment of invalid or incorrect payments.

The director may require the insurer to repay reimbursements made for invalid or incorrect payments.

(a) The director may periodically audit the insurer's files to validate the amount reimbursed.

(b) Invalid amounts include, but are not limited to:

(A) Payments exceeding statutory amounts due to the insurer, excluding reasonable overpayments, as determined by the director;

(B) Compensation paid as a result of untimely or inaccurate claims processing;

(C) Payments of compensation that were not documented as required by OAR 436-050; or

(D) Amounts in a third-party recovery that result in overpayment.

(5) Benefits due workers of a noncomplying employer.

Supplemental disability benefits due subject workers of a noncomplying employer as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(2).

(6) Claim disposition agreements and stipulated claims settlements.

Claim dispositions agreements or stipulated claims settlements, under ORS 656.236 or 656.289, that include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless they receive

written confirmation from the director before the disposition or settlement is approved by the Worker's Compensation Board.

(a) To receive written confirmation of a proposed disposition or settlement, the insurer must submit a request to the division. The request for written confirmation must include:

(A) A copy of the proposed disposition or settlement that specifies the exact amount of the proposed contribution to be made from the Workers' Benefit Fund;

(B) A statement from the insurer indicating how the amount of the contribution was calculated; and

(C) Any other information required by the director.

(b) The director will not confirm the disposition for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

Statutory authority: ORS 656.726(4)
Statutes implemented: ORS 656.210
Hist: Amended 10/12/15 as WCD Admin. Order 15-062, eff. 1/1/16
Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf