Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR 436-060:
Claims for COVID-19 or Exposure to SARS-CoV-2

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Oct. 28, 2020, 9 a.m. to 12 p.m. PDT, telephone/computer attendance only: Join meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/668131629 By phone, U.S. (Toll free): 1 877 309 2073 Access Code: 668-131-629
Facilitator:	Cathy Ostrand-Ponsioen and Fred Bruyns, 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** | **Temporary rule (current)**

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OAR 436-060-0141
Claims for COVID-19 or Exposure to SARS-CoV-2
Issues Document
For 10/28/20 Rulemaking Advisory Committee Meeting

On June 23, 2020, Governor Brown asked the Management-Labor Advisory Committee (MLAC) to review the current workers' compensation system and the impact of the COVID-19 pandemic. After several public meetings, MLAC made recommendations to the Governor. Management members proposed that (1) clear and consistent rules for processing COVID-19 claims be adopted and (2) the department audit claims of insurers with high numbers of COVID claim denials to determine whether the denials were reasonable and proper. A draft rule was included with the management members' proposal.

MLAC reconvened on August 26. The Workers' Compensation Division (WCD) advised the committee that some parts of the draft rule proposal were beyond WCD's statutory authority. After the September 18 meeting of MLAC's subcommittee on COVID-19, WCD prepared a draft rule. WCD's draft was reviewed at the September 24 subcommittee meeting, and revised based on that discussion.

After soliciting further public comment, WCD adopted OAR 436-060-0141 as a temporary rule, effective Oct. 1, 2020. The rule will expire on March 29, 2021. If WCD is going to replace it with a permanent rule, WCD needs to begin the rulemaking process immediately.

ISSUE 1: Implementation of temporary rule

Rule: 436-060-0141

Discussion: Before discussing the specific issues below, WCD would like to hear from stakeholders about their experience, if any, with the rule so far.

Feedback:

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ISSUE 2: Worker-requested medical exam (WRME)

Rule: 436-060-0141(2)(c)

Discussion: A worker is eligible for a WRME if the worker has made a timely request for hearing on a compensability denial, the denial is based on one or more independent medical examination (IME) reports, and the attending physician or authorized nurse practitioner does not concur with the report or reports. ORS 656.325(1)(e), OAR 436-060-0147(1). The Workers' Compensation Board has held that the worker is not eligible for a WRME if the IME report is based on a record review and not an in-person exam. *Lorinda L. Gauthier*, 70 Van Natta 96 (2018).

OAR 436-060-0141(2)(c) requires the insurer to obtain a medical or other expert opinion if, before a compensability denial is issued, the worker tests positive for COVID-19 or has a presumptive diagnosis, the insurer is aware of the test results or diagnosis, and the source of the exposure is unclear. If the insurer obtains an independent medical opinion that is based on a record review, and denies the claim based on that review, the worker would not be eligible for a WRME. Some stakeholders have raised concerns about fairness to the worker, if the intent of the rule is to protect workers from unreasonable denials.

The purpose of the requirement to obtain a medical or expert opinion is to help determine the source of the worker's exposure to COVID-19 or SARS-CoV-2 if it is not clear whether the exposure happened at work or away from work. An in-person exam – whether an IME or a WRME – may be of limited value in helping to identify the source of the exposure. Moreover, requiring a worker who has tested positive for COVID-19 to attend an in-person exam is problematic.

Below are possible options identified by WCD. WCD looks forward to hearing stakeholder feedback on how to address the concerns that have been raised.

Options:

- Revise the language in (2)(c) so the focus is on investigating the source of the exposure. For example:

  "[A] reasonable investigation must include:

  "* * * * *

  "(c) Investigating the source of the worker's exposure to COVID-19 or SARS-CoV-2, which may involve obtaining a medical or expert opinion, if, before a compensability denial is issued, the worker tests positive for COVID-19 or a medical service provider diagnoses a presumptive case of COVID-19, the insurer is aware of the test results or presumptive diagnosis, and the source of the exposure is unclear."

- Leave the language as it is written in the temporary rule.
- Remove (2)(c) altogether.
- Other options?
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ISSUE 3: No medical/expert opinion for procedural denials

Rule: 436-060-0141(2)(c)

Discussion: The temporary rule requires a medical or expert opinion before a compensability denial is issued, in certain circumstances. WCD received feedback questioning the necessity and effectiveness of a medical opinion when the denial is for non-medical or other procedural reasons. The suggestion was to change the wording to, "before a compensability denial is issued **based upon medical reasons**."

WCD agrees that a medical or expert opinion is not needed when there is a basis to deny the claim such as the claim was filed with the wrong insurer, the insurer did not provide coverage for the period in question, or the worker is nonsubject. However, WCD is concerned that the suggested language may be too narrow.

As discussed above in Issue 2, the purpose of obtaining the medical or expert opinion is to help determine the source of the worker's exposure to COVID-19 or SARS-CoV-2 if it is not clear whether the exposure happened at work or away from work. A denial based on no workplace exposure is not necessarily "based upon medical reasons."

Revising the language in (2)(c), as listed as an option for Issue 2, may address, in part, the concern raised by the feedback:

> "Investigating the source of the worker's exposure to COVID-19 or SARS-CoV-2, which may involve obtaining a medical or expert opinion, if, before a compensability denial is issued, the worker tests positive for COVID-19 or a medical service provider diagnoses a presumptive case of COVID-19, the insurer is aware of the test results or presumptive diagnosis, and the source of the exposure is unclear."

WCD could also develop language that creates an exception to this requirement when the insurer has a reason to deny the claim based on subjectivity, responsibility, or another reason not tied to the source of the worker's exposure.

WCD would like stakeholder feedback on this issue.

Options:

- Revise the language in (2)(c) to focus on investigating the source of the exposure rather than obtaining a medical or expert opinion, as discussed above in Issue 2.
- Create an exception to the requirement in (2)(c) when the insurer has other reasons to deny the claim, as discussed above.
- A combination of the above two options.
- Leave the language as it is written in the temporary rule.
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ISSUE 4: Definition of "presumptive case"

Rule: 436-060-0141(1)(d)

Discussion: WCD's revised draft rule defined "presumptive diagnosis" as "the individual has COVID-19-like symptoms and close contact with a confirmed case of COVID-19, but does not have a positive diagnostic test." This language was pulled from the Oregon Health Authority (OHA) website, but was not a formal definition. WCD received feedback that we should use OHA's definition of "presumptive case," from its Sept. 18, 2020, Interim Investigative Guidelines (https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/REPORTINGCOMMUNICABLEDISEASE/REPORTINGGUIDELINES/Documents/Novel-Coronavirus-2019.pdf). That definition is:

> A presumptive case is a person without a positive COVID-19 RT-PCR, NAAT, or antigen test result, with:
> • An acute illness featuring at least two of the following: shortness of breath, cough, fever, new loss of smell or taste, radiographic evidence of viral pneumonia;
> AND
> • No more likely alternative diagnosis;
> AND
> • Within the 14 days before illness onset, lived in the same household or congregate setting, had close contact with a confirmed case, or is identified as having been exposed in an outbreak.
>
> OR

> • A COVID-19-specific ICD-10 code listed as a primary or contributing cause of death on a death certificate.

WCD agrees that its definition should be consistent with OHA's. WCD is hesitant to refer to specific types of tests in the rule, however, as they are likely to change over time, making the rule out-of-date. In the temporary rule, WCD adopted language intended to be consistent with the OHA definition but without the specific detail. WCD would like stakeholder feedback on whether its definition works, or if there are other ways to make sure the language in the rule stays current.

Options:

- Leave the language as it is written in the temporary rule
- Adopt the specific OHA definition
- Adopt alternative language
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ISSUE 5: COVID testing

Rule: 436-060-0141(2)(c)

Discussion: The temporary rule refers to positive test results, but does not specify the type of test that should be administered. WCD received a comment that the most reliable laboratory test for determining whether a person has COVID-19 is a nucleic acid detection test, such as a positive polymerase chain reaction ("PCR") test, and not antibody tests. It was recommended that (2)(c) specify that the positive test result be pursuant to a PCR test:

> "***if, before a compensability denial is issued, the worker tests positive for COVID-19 **pursuant to a polymerase chain reaction ("PCR") test** ***."

As discussed above in Issue 4, WCD is hesitant to refer to specific types of tests in the rule, as they are likely to change over time, making the rule out-of-date. However, WCD would like stakeholder input on whether specifying the type of test is necessary for the purposes of (2)(c).

Options:

- Leave the language as it is written in the temporary rule
- Specify that the positive results must be pursuant to a PCR test

- Adopt alternative language
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ISSUE 6: Consistency in terminology

Rule: 436-060-0141(2)(a)

Discussion: The management members' proposed draft rule contained the following language in 436-060-0141(2)(a): "Determining whether the nature of the worker's employment resulted in an exposure to coronavirus." The temporary rule has slightly different wording, but still refers to "the nature of the worker's employment."

A question has been raised about what is meant by "the nature of the worker's employment," since the inquiry into compensability typically refers to whether the worker's disability or need for treatment arose out of or in the course of employment. The suggestion was to change the language to:

> "Investigating whether there was likely exposure to COVID-19 or SARS-CoV-2 that arose out of and in the course of employment."

WCD would like stakeholder feedback on this wording.

Options:

- Change the wording as suggested above
- Leave the language as it is written in the temporary rule
- Adopt alternative language
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ISSUE 7: Consistency in terminology

Rule: 436-060-0141(2)(b)

Discussion: The temporary rule requires the insurer to determine if the worker "did not work for a period of quarantine or isolation." A suggestion was made to change "did not work" to "lost time or wages." This phrasing is more consistent with other statutes and rules, and would cover situations when a worker was able to work part-time (at home) but lost wages or was off work but paid full wages.

Options:

- Change "did not work" to "lost time or wages"
- Leave the language as it is written in the temporary rule
- Adopt alternative language
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ISSUE 8: Ongoing audits

Rule: 436-060-0141(3)

Discussion: The temporary rule defined an initial audit pool as of Oct. 1, 2020. If, as of that date, an insurer had reported five or more COVID claims, all of that insurer's denied COVID claims will be audited, provided the denials are final by operation of law by the date of audit. WCD began auditing this group of insurers the week of October 12. If an insurer had not reported five or more COVID claims by Oct. 1, 2020, that insurer's denied claims are not included in the initial audit pool.

The rule as written is temporary in nature and will not be adopted permanently. The rule was intended to capture a snapshot of insurer processing of COVID claims at a point in time. It was not intended to establish an ongoing audit process, nor was it intended to limit future audits of COVID claims under the new reasonable investigation standards.

WCD has authority to audit an insurer's claim files without a rule. On an ongoing basis, WCD could rely on its general authority to initiate and conduct future audits, without having a rule specific to auditing COVID claims, which could inadvertently limit WCD's ability to address performance issues. Without a rule, WCD has more flexibility to adapt as information is learned.

Options:

- Not adopt section (3) as part of the permanent rule.
- Not adopt the introductory paragraph and subsections (a) and (b), but keep modified versions of subsections (c) and (d). For example:

  "(3)(a) All claims for COVID-19, symptoms of COVID-19, or exposure to SARS-CoV-2 are subject to audit by the director.

  "(b) Failure to comply with requirements in ORS chapter 656, OAR chapter 436, or orders of the director subjects the insurer to civil penalties under ORS 656.745(2)."
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ISSUE 9: Other issues

- Are there other issues not identified above that we should discuss?
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- Were there issues raised during MLAC's review that were not addressed in the temporary rule, that should be addressed in the permanent rule?
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436-060-0141 Claims for COVID-19 or Exposure to SARS-CoV-2 ***(New temporary rule)***

(1) For the purpose of this rule:

(a) "COVID-19" means a disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(b) "Isolation" means the physical separation and confinement of a person who is infected or reasonably believed to be infected with COVID-19 from nonisolated persons to prevent or limit the transmission of COVID-19 to nonisolated persons.

(c) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.

(d) "Presumptive case" means:

(A) The person has not tested positive for COVID-19;

(B) The person has an acute illness with at least two of the following symptoms: shortness of breath, cough, fever, new loss of smell or taste, or radiographic evidence of viral pneumonia;

(C) There is no more likely alternative diagnosis; and

(D) The person, within the 14 days before illness onset, had close contact with a confirmed case of COVID-19.

(e) "Quarantine" means the physical separation and confinement of a person who has been or may have been exposed to COVID-19 or SARS-CoV-2 and who does not show signs or symptoms of COVID-19, from persons who have not been exposed to COVID-19 or SARS-CoV-2, to prevent or limit the transmission of COVID-19 to other persons.

(f) "SARS-CoV-2" means the strain of coronavirus that causes COVID-19.

(2) Under OAR 436-060-0140(1), insurers must conduct a "reasonable investigation" before denying any claim. For all claims filed for COVID-19 or exposure to SARS-CoV-2 on and after Oct. 1, 2020, in addition to the requirements of OAR 436-060-0140(1), a reasonable investigation must include:

(a) Investigating whether or not the nature of the worker's employment resulted in a likely exposure to COVID-19 or SARS-CoV-2;

(b) Determining whether the worker did not work for a period of quarantine or isolation at the direction of a medical service provider, the Oregon Health Authority Public Health Division, a local public health authority as defined in ORS 431.003, or the employer, for purposes of discovering information that may be relevant to the compensability determination;

(c) Obtaining a medical or other expert opinion if, before a compensability denial is issued, the worker tests positive for COVID-19 or a medical service provider diagnoses a presumptive case of COVID-19, the insurer is aware of the test results or presumptive diagnosis, and the source of the exposure is unclear; and

(d) Determining whether medical services were required as a result of potential workplace exposure to COVID-19 or SARS-CoV-2, even if the worker ultimately did not test positive for COVID-19.

(3) If, as of Oct. 1, 2020, an insurer has reported to the director, as required by OAR 436-060-0011, five or more claims for COVID-19 or exposure to SARS-CoV-2, regardless of whether those claims have been accepted or denied, the director will audit the insurer's files for all denied claims for COVID-19 or exposure to SARS-CoV-2, for which the denial has become final by operation of law by the date of audit.

(a) For claims filed before Oct. 1, 2020, the director's audit will focus on whether the insurer conducted a reasonable investigation as required by OAR 436-060-0140(1).

(b) For claims filed on and after Oct. 1, 2020, the director's audit will focus on whether the insurer complied with section (2) of this rule.

(c) The director retains the authority to audit additional insurers and claim files as the director determines appropriate.

(d) Failure to comply with requirements in ORS chapter 656, OAR chapter 436, or orders of the director subjects the insurer to civil penalties under ORS 656.745(2).

436-060-0140 Acceptance or Denial of a Claim ***(partial)***

(1) Claim investigations.

The insurer is required to conduct a "reasonable" investigation based on all available information in determining whether to deny a claim.

(a) A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(b) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.