Rulemaking advisory committee meeting
Subject: Claims for COVID-19 or Exposure to SARS-CoV-2
Oct. 28, 2020, 9 a.m.

Location: Virtual meeting - GoToMeeting

Committee members attending:

Kirsten Adams	AGC
Kevin Anderson	Sather Byerly Holloway LLP
Ronald Atwood	Ronald W. Atwood, PC
Dave Barenberg	SAIF Corporation
Steven Bennett	APCIA
Karen Betka	Farmers Insurance
Rebecca Borchers	Zenith Insurance Company
Bob Brandkamp	AVISTA
Daedra Buntin	Portland Public Schools
Constantine Gean, MD	Liberty Mutual Insurance Co. | MAC
Olivia Geidl	Gallagher Bassett
Ben Johnson PA-C	Oregon Society of Physician Assistants
Shanalee Kuikahi	Kaiser Permanente
Tanya Miller	CCMSI
Kathy Nishimoto	Duckwall Pooley | MLAC
Jennifer Olson	Government Relations Strategies
John Powell	John Powell and Associates
Sue Quinones	City of Portland
Denneile Ritter	American Property Casualty Insurance Association
Dan Schmelling	SAIF Corporation
Elaine Schooler	SAIF Corporation
Keith Semple	Johnson Johnson Lucas & Middleton PC | OTLA
Paloma Sparks	OBI
Craig Stone	Intermountain Claims
Kate Suisman	NWJP
Virginia Walker	DAVACO Inc.
Jenny Walsh	Providence Health Plan
Gina Wescott	S | D | A | O
Diana Winther	IBEW Local 48 | MLAC
Kimberly Wood	Perlo Construction | MLAC

- Fred Bruyns, Workers' Compensation Division, welcomed the committee members and asked the members to provide advice about fiscal impacts during review of the issues.
- Sally Coen, Workers' Compensation Division administrator, provided an update on Covid-19-related claim filing and the division's audit activities. Sally first noted that all denied claims are reported to the division, and accepted disabling claims are reported, but accepted nondisabling claims are not reported. As of Oct. 26, the division has received 31 claims that were post-Oct. 1, 2020. All 31 were from SAIF Corporation and all were accepted.
- Sally then explained that the temporary rule effective Oct. 1, laid out which companies and claims would be subject to an audit to determine whether the insurer conducted a reasonable investigation of the claim before issuing a denial. As noted in section (3) of the rule, if as of

Oct. 1, an insurer had reported five or more claims for Covid-19 or exposure to the SARS virus, regardless of whether those claims were accepted or denied, all of the denied claims would be subject to audit if final by operation of law as of the date of the audit.

- As of Oct. 1, there were 11 companies subject to the audit, eight insurers and three self-insured employers. Those claims are processed at seven different processing locations. Many companies hire a service company to process their claims, so we audit at the service company where the claims are processed. The 11 companies had reported about 260 denied claims as of Oct. 1, but the number to be audited is smaller, as we can only audit denials that are final as of the date of the audit. We started a performance audit the week of Oct. 12, and we started with a service company, Sedgwick, that processes claims for multiple insurers and self-insured employers. We reviewed four companies' claims there – a total of about 55 claims. We completed the audit of these claims and are reaching out to other companies. It does require some time for companies to get us access to their records. We want to get these up and running as quickly as possible.
- We are tracking for a number of items in the claims we are reviewing, including the employer's date of knowledge and whether the claim was for illness or exposure. We are checking to see if there was three-point contact made – employer, worker, medical provider. We are checking whether the worker lost time or wages from work and whether there was medical treatment in the claim, whether there was a Covid-19 test and what the results were. That is the type of information we will be tracking in the claims we are auditing.
- When we complete an audit at a location, we follow the process for all of our performance audits, which are guided by the governmental auditing standards that are put out by the federal government. Part of that is that we provide a draft report to the processor, to give them a chance to answer questions or respond to our questions or areas where we believe there were violations. The final report will go to the company that is ultimately responsible – the insurer or self-insured employer. For this Covid-19 claim audit, we do plan on doing a summary report for the processing location as well.
- We anticipate the other smaller processing locations will go fairly quickly, depending on how quickly the company can accommodate our request for access to the records. To clarify, we are auditing based on standards for reasonable investigation of a claim that were in the rule prior to Oct. 1. Claims filed after that are not subject to audit yet, because they are not final, and we do need to make sure the denial is final before we start auditing.
- Sally asked if anyone has questions or comments.
- Kate Suisman asked if the audit reports become publicly available.
- Sally replied that we plan on posting some summary information. We cannot publish the reports that contain specific claim and worker information. We will make a summary report public.
- Fred then explained that Cathy Ostrand-Ponsioen, the division's legal issues coordinator, will take us through the agenda. A summary of the discussion has been added below the following agenda items:

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.

Minutes:

- No input

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?

Minutes:

- Daedra Buntin said they are interested in revising the wording to language to focus on the investigation as recommended.
- Cathy Ostrand-Ponsioen asked if Daedra meant the language used in the first option.
- Daedra confirmed that was her intent.
- Diana Winther asked if the division had considered the impact of telemedicine. It does eliminate some concerns about in-person exams. Diana added that she understands the intent is to get folks to investigate, but she has concerns that we are now requiring something we did not previously, and workers may not have the option to respond in some way.
- Cathy noted that the Workers' Compensation Board has said IMEs must be in-person exams (in order for the worker to be eligible for a WRME), but she does not know if there have been cases where exams were done by telemedicine rather than in person. Cathy asked if anyone has thoughts about this.
- Elaine Schooler said it is SAIF's position that a telemedicine exam using video conferencing would qualify as an in-person evaluation. They do use virtual IMEs to develop medical opinion to address compensability and comply with the rule. Elaine added they would support revision of the rule to reflect that virtual IMEs are considered to be in-person exams. These would entitle the worker to a WRME if the attending physician does not concur with the IME or offers no comment.
- Kimberly Wood said she prefers the language as written in the temporary rule. All claims are dealing with the same thing. This is not unique to Covid-19. Presently in our system an insurer can use a medical opinion that is based on medical records instead of in-person reviews. That happens all the time, and a WRME would not be available to a worker at that point in time. They do have their own provider. The IME allows the insurer to have a provider's opinion as well as the opinion of the worker's provider. Kimberly added that she doesn't see this issue as specific to these types of claims, so she does not think it is appropriate for us to change it.
- Diana replied that she appreciates the perspective, but we have created a rule that redefines what a reasonable investigation is and now requires this under certain circumstances. Diana added that she thinks the rule makes things different enough that

adjusting the language does feel appropriate. Clarifying that a telemedicine exam is "in person" is very different from a record review situation. There is an opportunity to ask questions.

- Kate Suisman explained that she is an attorney who handles workers' compensation retaliation cases and she often works with the workers' compensation attorney. She said she appreciates what the SAIF representative said about virtual visits. Kate said most of her clients are immigrants and that there is a well founded concern in her clients' community that filing for workers' compensation is risky, mostly due to retaliation she sees many of her clients suffer. Kate added that whatever we can do to lessen the barrier to filing a claim, and to have the claim proceed in a way that benefits the worker, we should do. Medical review on paper by a doctor who may not have cultural competency and may not have talked to the worker about how much time they spent at work or at the store – all those types of things. We have just seen through the MLAC process that there is a lot of doubt cast on workplace exposure and a lot of focus on a barbeque social event that might have happened. That is a cultural competency issue. Kate said her clients are harmed by this and she wants us to do whatever we can to make this process work for them. She is very much in favor of revising the language to make it err on the side of more access for workers and more review if the worker asks for a WRME.
- Steve Bennett said regarding the options presented on the agenda, their position is that in some cases a medical opinion is not necessary. What we really want to know is the source of the worker's exposure. Steve said he believes the suggested language in option #1 leads to a better investigation of the claim.
- Ron Atwood said he seconds the last comments, and that we should remember the purpose of the rule is to try to define what a reasonable investigation is, for the purpose of the audit by the department to make sure claims are processed properly. Ron added that he likes this language because it gives flexibility to the investigation, but also makes sure that they look at the source of the exposure.
- Kimberly said she recalls that the reason for the language being added regarding a medical opinion, was to some degree done to slow down the process, so that for those individuals who just had time off work without significant medical expenses, there was time added to process that claim appropriately so you didn't have the denial so quickly. If you change this you go back to just investigation of the cause. You might have insurers that abuse that, though we hope not.
- Elaine confirmed that the intent was to ensure a thorough review of the claim, and that when the exposure is unclear that the insurer obtain a medical opinion to determine whether the claim is compensable, and to prevent a knee-jerk denial without that medical opinion. As part of the review, obtaining the complete history may involve the doctor asking questions that may lead to an answer that either party hadn't considered in the overall compensability determination. That medical review is an important piece of a robust process.
- Daedra Buntin said her only concern was that she found from her history as an examiner that you don't consistently get a thorough history from medical providers. Some are better than others. Daedra added that she does not disagree that a medical opinion has value.
- Cathy asked Kimberly Wood about her concern about potential abuse if we focus on exposure and not the medical opinion.

- Kimberly said the concern was that insurers might quickly make decisions and deny Covid-19 claims. They might ask them some questions about whether they were exposed at work or at home but not do an in-depth investigation and then deny the claim quickly. So that employee who would have their 14-day quarantine covered now has a denied claim. Versus a situation where you require a medical opinion – that takes some time. In all likelihood the 14 days will have expired and they would get paid up to the point in time when they get the medical opinion. In the alternative, because IMEs are somewhat expensive, an insurer might decide it is only 14 days of time loss so it is cheaper just to accept the claim and pay the time loss. So the intent was to slow the process down.
- Elaine Schooler confirmed Kimberly's description of the intent – to prevent a quick denial where the exposure is unclear and the worker has either a positive diagnosis or a presumptive case of Covid-19. It is part of the overall investigation of the claim, where questions may be asked – can you point to a specific source at work or off work? And, if the worker could not point to a specific source there would be a quick denial issued without further investigating other parts of the worker's history that may not have been gleaned from discussion.
- Ben Johnson asked who has the burden of proof. Does the employee have to show an exposure, or the other way around?
- Elaine Schooler replied that the worker has the burden of proving the compensability of their claim. This rule goes into, not the worker's burden, but rather the insurer's claim processing obligations before issuing a compensability decision when they have a claim where the worker has a presumptive diagnosis or a positive Covid-19 test diagnosis.
- Cathy said we would look into the telemedicine question. It sounds like that might address concerns to an extent.
- Steve Bennett said that investigating the source seems to be the most reasonable method. If you are looking at what the insurer did you should look at whether they did an investigation of the Covid-19. Like Option #1 says, that could well involve a medical or expert opinion. Sometimes it might not require a medical opinion because it is assumed that the person has Covid-19. You can have a very good claim investigation if you investigate the source and find the source was not the workplace. Option #1 gets to the issue of whether the insurer conducted a good, reasonable claim investigation. It is better than the language that is in there right now that says you need a medical opinion in every case even if it does not progress the claim investigation.
- Tanya Miller said they have seen a few mostly nondisabling claims, but the workers did not necessarily even seek medical treatment. They call their doctors with their symptoms, do the drive through, get tested, whether negative or positive, are told to go home and rest, take Tylenol, etc. They file the claim. Having to get a medical opinion on someone who was not treated technically – we are processing as if it was medical treatment. It does make it harder to get medical opinions if there has not been in-person treatment. Tanya added she is more positive about some of the telemedicine so there is communication between the worker and the provider.

ISSUE 3: No medical/expert opinion for procedural denials

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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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Minutes:

- Steve Bennett said that claims should be handled well if an injured worker has Covid-19 from a workplace, and they should get paid and get good quality medical care. The claim investigation should be reasonable, a requirement even under current rules But, if you have a black-letter rule that says you need a medical opinion before you deny a claim, or it's an unreasonable claim investigation, that's going too far, because sometimes a medical opinion is not needed – for procedural reasons. If a worker files a claim against the wrong workers' compensation insurer, that claim can most efficiently be denied so they can file it against the correct insurer. There is no sense in spending money on a medical review when there is another reason to deny the claim. The wording in Issue #2, Option #1 may be alright, where it says a medical opinion ***may*** be necessary. Or, we can say a medical opinion is not needed if the claim is denied for other than medical reasons – if there are procedural or other reasons to deny the claim.
- Elaine Schooler said the rule already refers to a compensability decision, so in the case of a responsibility denial, that could already be issued. For a subjectivity denial, their recommendation is to amend subsection (2), second sentence, and say "for all claims filed by a subject worker for Covid-19 …" Then for those nonsubject workers whose employer receives a claim in error, the employer could deny them without going through the steps of procuring a medical opinion.
- Kimberly Wood said she echoed what Elaine said. If we can keep in the language she recommended, that would stay with the intent of MLAC's recommendations. As an alternative if that is not possible, Kimberly recommended we leave the language as is but create an exception to address situations where the denial is not related to Covid-19 but there are other issues that would allow a denial.
- Cathy noted that we want to cover all of the bases. In addition to referring to compensability, if we add subjectivity, are there other situations we should address?
- Steve Bennett said that what Kimberly and Elaine said makes sense.
- Daedra Buntin said she concurs with that opinion.
- Keith Semple said they are fine with changing the language a little to clarify the intent. He added he is not sure denying for medical reasons is the best way to describe it. "Medical causation" might be a better way.
- Cathy asked if it would read something like, "Before a denial is issued for reasons based on medical causation"?
- Keith replied that he would just want it to be clear that what we mean when we say medical reasons is not only whether they were positive or not, but also whether it was caused from work. It's just something to consider with the terminology. There might be a way to make that a little bit more clear.
- Kimberly noted she didn't hear anyone support adding in language "before a compensable denial is issued based upon medical reasons." Kimberly said she would be concerned about medical compensability as well, and doesn't want to change the nature of their intent. Elaine's suggestion to add "subject worker" does seem to address the concerns. An insurer could deny a claim when the issue is not Covid-19 but they filed the claim with the wrong insurer or they are not a subject worker. That is the least amount of change that addresses the issue without changing MLAC's intent. Kimberly said she has concerns about adding additional language other than just subject worker.

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

Minutes:

- Cathy Ostrand-Ponsioen asked Ron Atwood (who raised the issue in advance of the temporary rule) if the wording of the temporary rule addressed his concerns.
- Ron said he likes this language; remember the purpose is to give us some guidance on what a presumptive case is, so we know one when we see one, so we actually do a complete investigation. If OHA's definition changes at some time in the future and is significantly different, we can correct that. Ron added that the definition is not too detailed but does get the point across.
- Steve Bennett strongly prefers OHA's wording to the wording of the temporary rule, because it is more specific and more accurate. If there is concern with changes to OHA's definition, can we just say as defined by OHA and give the citation to that definition?
- Cathy Ostrand-Ponsioen at first said she doesn't know if we are able to do that. She will have to look into it. Cathy then said that if we refer to something else, it has to be a specific version. We cannot adopt a definition that doesn't yet exist. It has to be what is in effect at the time we adopt it.
- Ron said that is correct. It is a bit unworkable if your rule says "see page 45 of xyz documents." The idea is to make sure we do a good investigation. What you put together tells us what a presumptive diagnosis is. We don't want to go into the middle of an audit and try to determine whether "x" test or "y" test was actually done. The purpose is to provide guidance. We don't want to hamstring with excessive detail. I would object strongly to referring to tests in here. Over the last ten months we have heard about one test after another that is either good or bad or indifferent. Nobody can agree on which test is good or not. The intent is to provide guidance so one can say, that looks like a presumptive diagnosis, we need to take extra steps. If we load the definition with too much detail, there are claimants that won't fit but should if we are going to do a reasonable investigation.
- Elaine Schooler said that SAIF agrees with Ron and his reasoning for keeping the rule as is. She added that SAIF also agrees with the division's comment that they cannot refer to a rule that is not in existence. So far, to their knowledge, there has not been an issue with the current definition. If an issue does arise in the future, we can do what we are doing right now and talk about it and see if an adjustment needs to be made.
- Keith Semple said he agrees with Ron and Elaine.
- Kimberly Wood said her recollection is that they did not get into a definition like we have here. Kimberly asked if Ron and Keith and Elaine are saying to leave the definition as is. Kimberly added that she is concerned with the definition from OHA, just because under the last section it talks about "lived in the same household or congregate setting or had close contact with a confirmed case is identified as having been exposed in an outbreak." None of that may have occurred for someone you know has a confirmed case or was involved in an outbreak, and she wouldn't want that to disqualify someone from getting their claim approved. Kimberly would like to remain with the more general definition that came out in the original draft.
- Cathy Ostrand-Ponsioen referred the committee to the wording of the temporary rule, which is a hybrid between OHA's and what the division published in an earlier draft.
- Kimberly thanked Cathy for the clarification, and she said she is on the same page as Ron and Elaine and Keith.

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

Minutes:

- Cathy Ostrand-Ponsioen noted that given the discussion of the last issue, we may have already addressed this issue, but asked the committee if anyone would like to discuss this issue.
- Daedra Buntin said that she was asked by her district, for issues #4 and #5, to report that they were inclined to be more consistent with the OHA rule, maybe not the specific language but more consistent with it. With regard to the Covid-19 testing, they have folks who think a positive finding must be pursuant to the PCR test. Daedra added that listening to the feedback today, she certainly understands just keeping it broad so as not to have to touch the rules over and over again.
- Cathy said we don't want to be inconsistent with OHA in any way. It is that balance between being specific enough but not being so specific that we are unintentionally binding ourselves.
- Ron Atwood said the purpose of this is to cast a broad net, not to argue whether it is a good test or a bad test – he thinks it adds some costs to the system that we might not want to do, so he would not want that changed. It may be the favored test today. A month from now it may not, and we are working with a rule that doesn't have current science attached to it. I'm not sure it adds anything to the goal here, which is to make sure that people do a reasonable investigation before they make an accept/deny decision.

- Steve Bennett said issue #5 is somewhat different from #4, as #5 goes into the issue of testing as opposed to how we are going to define it. Steve added that we should not lose sight of the fact that what we are trying to do is have high quality care for injured workers. Basically, everybody says a PCR test is a state of the art, correct test. Other tests have a lot of false positives. Steve said he doesn't support the position that it is okay if workers do not get the best test and get a lot of false positives and a lot of treatment that they don't need, that is potentially dangerous to them. Steve added that a PCR is much better than an antibody test, and he thinks we should have a requirement for the PCR test.
- Constantine Gean said that typically how this has been handled in other policy discussions he has participated in – it is *PCR or other accepted test defined by CDC or other authorities to be definitive*. You are not having to rewrite it if things change. Over the last nine months things have changed enormously. Constantine added that he doesn't disagree with specific language but we can broaden it by acknowledging in the language that things may change.
- Elaine Schooler said SAIF's feelings are similar to Ron Atwood's, that the language as is achieves the intent, when we talked about this prior to the temporary rule and also before MLAC. It does give that flexibility, which is important because the testing can change. For purposes of SAIF's claims processing, we haven't encountered a problem where the testing being performed is impacting the investigation of the claim and the processing of it. SAIF's preference is for the rule to stay as is. There is also the concern about the rule directing care for injured workers and insurers having to enforce that direction as part of initial claims processing.
- Cathy said she thinks the test results come into play in terms of when the insurer would be required to obtain a medical or other expert opinion. If the original test results might be questionable, then that might be part of the investigation – maybe we want to test again – just putting that out there (for the committee).
- Steve said he agrees that has happened in a lot of cases – a positive antibody test, but that doesn't show that they actually have the disease, and then a PCR test shows whether or not they have the disease. A PCR test is state of the art, the best one, and the one that ensures workers receive the best care and are not possibly being treated with drugs when they don't have Covid-19. It is true that what many insurers would do is to require a PCR test. That can be part of the investigation.

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

Minutes:

- Daedra Buntin said PPS's prefer "resulted in an exposure to." Consider the wording, "investigating whether there was confirmed exposure" as opposed to "likely exposure."
- Keith Semple said it makes sense not to use the phrase "nature of employment." It is vague.
- Daedra said she agreed.
- Cathy Ostrand-Ponsioen asked Keith if he thought arising our of and in the course of employment is better wording.
- Keith said he thinks it is.
- Steve Bennett said they had a couple of members question what nature of employment meant, so he thinks the proposed new language would be better in terms of their being an exposure in the course of employment.
- Diana Winther said the proposed wording seems more in line with workers' compensation law and the courts. In developing the rule we have tried to avoid creating more questions, more potential opportunity for litigation, so sticking with language that is familiar and less vague would make more sense.

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

Minutes:

- Daedra Buntin said PPS's preference is to change "did not work" to "lost time or wages."
- Elaine Schooler said SAIF's preference is to keep it as is. The rule is about whether a reasonable investigation was done, and SAIF's concern is that this might get into a benefits determination rather than what really happened with the worker, potentially excluding some workers if changed to "lost time or wages."
- Ron Atwood said his concern with the change is that it would only apply to someone receiving TTD (temporary total disability). If someone isn't ill but is sent home as a precaution because of potential exposure, at some point someone is going to have to rule whether that person will get benefits for the time that they are gone. The revision may not cover that type of person. Ron added that he likes the more flexible language in the current rule. Remember we are talking about the definition of what a reasonable investigation is.
- Steve Bennett said he prefers the language in the rule now; it is a close call but he more or less agrees with what Ron said. Steve added that he can see both sides for this one.

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)."

Minutes:

- Daedra Buntin said that because the division already has the ability to complete audits, there doesn't seem to be a need to adopt an additional section in the permanent rule; just maintain the current ability to audit.
- Cathy Ostrand-Ponsioen noted that this rule is in division 060, and in division 060 near the end there is a rule that talks about the division's authority to audit and enforce the claims processing standards, which this rule would fall under.
- Ron Atwood said he doesn't read the rule to mean the division can only do audits for cases existing on Oct. 1, 2020; if the division doesn't think the rule will allow ongoing audits, then why are we talking about a rule here? Ron added that if he looks at section (3), it anticipates further audits, and the rule we are talking about sets the standard for claims filed after Oct. 1, 2020.
- Cathy explained that the introduction to section (3) defines the initial pool that the division is auditing right now; as of Oct. 1, if an insurer had reported to the director under the claim reporting rules five or more Covid-19 claims, regardless of whether the claims have been accepted or denied, the director will audit all of that insurer's denied claims. But, if an insurer did not have as of Oct. 1, five or more Covid-19 claims reported, then they are not included under this rule. The division still has authority to audit them, but they are not included in this initial pool.
- Ron replied that subsection (a) says that for claims filed before Oct. 1, the director's audits will focus on whether the insurer conducted a reasonable investigation, and that's exactly what we talked about when we discussed the temporary rule. (b) says for claims filed on or after Oct. 1, the director's audit will focus on whether the insurer complied with section (2) of this rule. So, if you are reading the beginning of (3), you only can look at cases filed as of Oct. 1, then subsection (b) is surplus language and is meaningless.
- Keith Semple said he agrees with Ron. Keith added that if we are going to take the requirements of this audit rule and change that, what is the point of this rule; there is no point if the division already could have done this before; now we are codifying exactly when and how we are going to do this, but we are saying it sunsets. Keith said he doesn't follow this.
- Ron said it was made quite clear at the time the temporary rule was adopted that the department had jurisdiction to look at a reasonableness of investigations filed before Oct. 1, but they were to use this new standard for claims filed after Oct. 1. Ron added that the courts don't like language that doesn't seem to fit someplace. You can't interpret this rule to be a limited pool and have subsection (b) present. He can't imagine any judge would limit the ability of the division to conduct audits.

- Cathy replied that (a), (b), (c), and (d) are true and are going to be true moving forward. It is the first introductory section up above in section (3) that defines what group of insurers the division will look at in the first phase of auditing. Insurers and self-insured employers are required to report to the division accepted disabling claims and denied claims within a certain period of time from the compensability decision. What this says is that as of Oct. 1, if an insurer or self-insured employer had not reported five or more Covid-19 claims, then they are not included in this initial pool. The division has authority to audit on an ongoing basis.
- Ron responded that the operative word is "initial," and (a), (b), and (c) say you are going to continue. So this is about adding language that says the division gets to look at more claims – Ron said he thinks it is already there. If greater certainty is wanted, then the division can add some language. The idea that the division has limited its ability to audit using this rule doesn't make sense.
- Cathy replied that the division has the ability to audit any claim at any time the division determines it is necessary. The division's concern is not to inadvertently limit that by having something in rule. As information comes in and things change, the division does want to have authority to go out and audit.
- Elaine Schooler said SAIF agrees with Ron's and Keith's comments, and it sounds as though a solution could be to say at the start of (3), "In addition to its existing authority to audit claims," and then go into more specifics. That might address the division's concerns that it might be unable to audit smaller insurers or claims processors that don't meet the threshold.
- Cathy replied that Elaine's wording does address the issue in part.
- Elaine said she agrees that the audit was part of a specific agreement amongst the parties to ensure compliance and a uniform review of claim decisions to ensure reasonable investigations for these types of claims. Removing it is problematic for the concerns that were expressed prior to adoption of this temporary rule.
- Keith said he agrees with Elaine's proposed language that gets at the concerns.
- Kimberly Wood said she is concerned that the intent is to remove this language entirely. MLAC wanted to hold insurers accountable and for these audits to be a priority for the department so issues are addressed appropriately and quickly. Kimberly noted she is opposed to removing the language in section (3) entirely. She added that she thinks Elaine made a good suggestion on how to modify it, so the language remains requiring the department to conduct those audits. Removing section (3) would defeat what MLAC's purpose was in creating this language. MLAC heard from the department that they had authority to conduct audits, but the committee felt it was important for them to identify how and what the parameters were for the department to conduct those audits.
- Jennifer Flood said she was not sure whether there was an intended threshold for future audits. Is the suggestion not to remove audit provisions and that there should be a threshold before the Workers' Compensation Division could audit?
- Kimberly said she thinks MLAC's initial intention was that when an insurer reaches a point they have five or more claims, this provision applies to them. From that point forward they are subject to audit on their denied claims. Kimberly added that the reason they chose five – some insurers had fewer than five claims and their intent was not that they be audited – for whatever reason they chose five as the golden number.

- Jennifer replied that her concern is that does limit the department's authority in auditing, because if the division suddenly said that three claims is too many to have not processed correctly, if the rule was in place then one might believe that the division could not audit those claims. Jennifer added that she doesn't believe the division intended that five-claim threshold to carry forward into the future, but she said she might be mistaken.
- Kimberly responded that she believes the department still has other reasons why they can audit; they just wouldn't be able to use these particular criteria to audit somebody that only has three claims. If the division felt that a denial was reached inappropriately just as they could in a non-Covid-19 claim, they still the ability to address that.
- Jennifer said she doesn't think the department's current rule applies that five-claim threshold to future audits, but she invited others to advise about that.
- Elaine replied that the rule does serve as a threshold for the department to do a mandatory investigation. The department retains it ability to review any claim at its discretion. The suggestion to put in "In addition to," may address Jennifer's concerns that some claims may go unreviewed if the insurer only has two. The department could still audit those under its existing authority and also under this rule.
- Jennifer says that some anecdotal information is that someone may have said that as long as they do not have five claims that are reported, they don't have to worry about the rule.
- Diana Winther said that, regarding what Jennifer has shared, the goal is to get folks into alignment about reasonable investigations. Diana added that she would definitely be concerned if there was the idea out there that if someone didn't report five claims, they wouldn't be affected by this and they don't have anything to worry about; she doesn't want anyone to think the division isn't paying attention. MLAC will be consistently monitoring and asking for reports. We want everyone to understand this is an expectation for everybody. The automatic requirement is in line with MLAC's intent for the rule that everyone is doing these things in a consistent fashion.
- Kimberly asked what insurer said they don't have to follow the rule; or is this just someone who might feel that way?
- Jennifer replied that the information was anecdotal.
- Kimberly added that if somebody actually said it I guess you report that to the department and let the department audit under other reasons. Kimberly continued that if an insurer has under five claims at the moment, eventually they are probably going to have more than five so will have to worry about the future of having to be audited. The division has the ability to go back and look at any of the claims that were denied once they qualify. If they are under five and remain under five, we are talking about such a small number. Remember we only have as of Oct. 19, 318 claims that were denied, and a very few companies had the bulk of those.
- Jennifer said this is not so much about that statement, the point is not tying the division's hands as to when they can audit, and she is not certain why there is a concern that the trust is put in the division in doing the audits. There was the concern – what if they don't audit – well they are auditing. By still having a threshold in place, that puts an unnecessary restraint on the department from taking actions.
- Daedra Buntin said she understands what Jennifer is getting at here; we have discussed in other parts of the rules where to be more specific and where to be more broad. Maybe this is another area were we look at not being so specific, to provide the department flexibility by leaving the language broad.

- Paloma Sparks said this provision of the rules is about when audits are required, not about limiting the department's other abilities to do audits. The agency would still have the ability to do audits.
- Kimberly said that Paloma said it very well. Kimberly added that MLAC didn't want to require the department to do that on every claim; they set a threshold but their intent was not to restrict the department, and she doesn't think they did so.
- Elaine said she agrees, and reminded that we can introduce section (3) with "In addition to the division's ability to audit claims" (or something to that effect), then that would capture those instances if the division or others are reading this rule to exclude them, which was not the intent. The intent was to create that threshold, but (other) claims are still subject to audit under the division's broader authority.
- Diana said she appreciates Elaine's suggestion and thinks it will address the concerns. At the end of the day we want to be sure we are not creating unintended consequences. Diana added that she would hate for anyone to have to review the transcript of this meeting to find out what we intended, rather than just adding a simple phrase at the beginning of section (3).

ISSUE 9: Other issue

- Are there other issues not identified above that we should discuss?

- Were there issues raised during MLAC's review that were not addressed in the temporary rule, that should be addressed in the permanent rule?

Minutes:

- Daedra Buntin said PPS had a few additional ideas that didn't fit elsewhere:
    - Regarding what an expert opinion is, with Covid-19 the county health department is considered to be the expert. They are conducting the contact tracing and determining if a positive case is linked to exposure to a known case or community acquired, with the latter meaning not associated with any known source, untraceable, or not work related.
    - There was feeling that there needed to be clarity that a presumptive case doesn't have anything to do with presumptive workplace causation.
    - There was concern about having clarity regarding delineation between just having Covid-19 at the time of death and Covid-19 being the cause of the death.

Closing:

- Fred Bruyns said the division may file rules in November for a hearing in December. The earliest that rules could be made effective is Jan. 1, 2020. Fred asked if committee members have additional thoughts to send them to him by the end of next week (Friday, Nov. 6).