OAR Chapter 436-060, 436-030, 436-120
Implementation of House Bill 2040 (2021), House Bill 4138 (2022)

Minutes
Stakeholder Advisory Committee Meeting
September 7, 2022

Stakeholders attending:

Adison Covey	Gallagher Bassett
Amanda Horn	Marion County
Ashley Willard	Travelers Insurance
Catherine Shaw	Sedgwick
Dan Schmelling	SAIF Corporation
David Barenberg	SAIF Corporation
David Pyle	CareMark Comp MCO
Elaine Schooler	SAIF Corporation
Eric Boling	TRISTAR Insurance Group
Jennifer Flood	Ombuds for Oregon Workers
Jovanna Patrick	Hollander Lebenbaum & Gannicott
Karen Betka	Farmers Insurance
Keith Semple	Oregon Trial Lawyers Association
Kelli Ianke	Farmers Insurance
Kevin Barrett	SAIF Corporation
Kirsten Adams	AGC
Lauren Rolater	Farmers Insurance
Linh Vu	City of Portland
Marcy Grail	IBEW Local 125 | MLAC
Monica Nassar	Reinisch Wilson Weier PC
Rod Ewing	Travelers Insurance
Sonya Powers	Strategic Comp
Sue Quinones	City of Portland
Susan Lavier	TriMet
Tara Hutchinson	Farmers Insurance
Thais Lomax	Sedgwick
Tricia Jones	Clackamas County Risk and Benefits
Virginia Jones	Strategic Comp

Department staff members attending:

Adam Breitenstein
Barb Anderson
Barbara Belcher
Carrie Van Handel
Daneka Karma
Don Gallogly
Fred Bruyns
Jenni Bertels
Jennifer Flood
Kirsten Schrock
Matt West
Sally Coen
Stan Fields
Steve Passantino
Summer Tucker
Tasha Fisher
Troy Painter
Yesenia Gonzalez

Minutes: Fred Bruyns welcomed the committee members, asked the members to provide advice about any fiscal impacts of possible rule changes, and also to advise about effects on racial equity in Oregon. After calling a roll of attendees, Fred turned the conduct of the meeting over to Summer Tucker, the division's policy analyst responsible for the subject rules.

NOTE: Additional summary minutes are included below each issue.

ISSUE #: 1

Rule: OAR 436-060-0011 Insurer Reporting Requirements
OAR 436-030-0015 Insurer Responsibility

Issue: If rulemaking is needed at this time to implement House Bill 2040 (2021).

Background:
Currently, insurers are only required by statute to report denied claims, accepted disabling claims, and notices of closure to the division. Insurers do not currently report accepted nondisabling claims. Insurers are required by statute to submit certain claim documents to the division, generally in paper form, either through mail, fax, or other electronic means with the director's permission.

Effective July 1, 2023, House Bill 2040 (2021) made three changes to statute:

- ORS 656.262(9) was changed from requiring that the insurer send a copy of the denial notice to the director, to notifying the director of the denial in the manner the director prescribes by rule.
- ORS 656.268(5)(b) was changed from requiring that the insurer send a notice of closure of the claim to the director, to notifying the director of the closure in the manner the director prescribes by rule.
- ORS 656.277(3) was changed from not requiring nondisabling claims being reported to the director (except for denials and reclassified claims), to requiring insurers to report nondisabling claims in the manner the director prescribes in rule.

These changes were requested to allow the department to eventually receive claim information electronically through Electronic Data Interchange (EDI), instead of providing paper claim documents via mail, fax, or other previously allowed electronic means.

With future implementation of Claims EDI, reporting requirements will shift to requiring certain data elements instead of document copies. The division will undergo specific rulemaking to implement the EDI process, and will revise the reporting rules accordingly.

However, EDI claim reporting will not be implemented by July 1, 2023, and the current paper-based reporting, manual data entry work processes, and claims information system are not prepared to accept the expanded claim information (i.e., accepted nondisabling claims) as specified by the legislation.

The legislation allows the director to adopt rules regarding what and how claim information must be reported. Currently, OAR 436-060-0011 and OAR 436-030-0015(1) require insurers to provide a variety of documents to the division, including:

- Copy of acceptance or denial notice
- Form 1502 for all disabling and denied claims
- Notice of closure documents (Forms 1503, 1644, 2807, and Updated Notice of Acceptance at Closure)

Additionally, OAR 436-060-0011(6) specifies that insurers are not required to report nondisabling claims, with two exceptions: denied claims and claims that are reclassified to disabling.

The division believes the current rules would be sufficient to continue the current (status quo) claim reporting requirements when the law changes on July 1, 2023. However, the division would like input on if minor rule adjustments for clarity are needed. The options below include rules that may be beneficial to update for clarity.

The division seeks stakeholder advice on the following:

- Whether the proposed options would help clarify that reporting requirements will remain the same until the division is ready to implement Claims EDI.

- Whether the current rule language is clear enough with no rule changes needed to implement the bill and inform insurers that reporting requirements will remain the same until the division is ready to implement Claims EDI.

- Whether other rule changes are needed to continue the current reporting requirements until the division is closer to implementation of Claims EDI.

Options

1) Add a rule note to OAR 436-060-0011(5)(a) stating:
With future implementation of Claims EDI, this reporting requirement will change from requiring copies of these documents to sending required data elements electronically.

2) Revise OAR 436-030-0015(1) to separate out insurer reporting requirements into its own subsection. This option is being presented to make changes to this rule easier in the future by being able to easily change what is reported to the director, yet keeping the requirements the same for copies of documents to be sent to the parties when claim closure occurs.

(1) When an insurer issues a Notice of Closure (Form 1644), the insurer is responsible for:

(a) Providing ~~the director,~~ the parties, and the worker's attorney if the worker is represented:

(A) ~~a~~A copy of the Notice of Closure,

(B) ~~a~~A copy of the Notice of Closure Worksheet (Form 2807) upon which the Notice is based,

(C) ~~a~~A completed Insurer Notice of Closure Summary (Form 1503), and

(D) ~~a~~An Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

(b) Providing the director:

(A) A copy of the Notice of Closure,

(B) A copy of the Notice of Closure Worksheet (Form 2807) upon which the Notice is based,

(C) A completed Insurer Notice of Closure Summary (Form 1503), and

(D) An Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in OAR 436-030-0020;

Current subsections b and c would need to be revised to "c" and "d", respectively.

3) Add a rule note to OAR 436-030-0015(1) stating:
With future implementation of Claims EDI, this reporting requirement will change from requiring copies of these documents to sending required data elements electronically.

4) Revise OAR 436-060-0011(6) to clarify which nondisabling claims are to be reported to the division. This option is being presented to clarify what nondisabling claims at this time the director expects to be reported. This will change in the future with Claims EDI reporting; however, at this time the following is what will be required by the director.

(6) Nondisabling claims.

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

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

5) Add a rule note to OAR 436-060-0011(6) stating:
With future implementation of Claims EDI, this reporting requirement will change to require all nondisabling claims be reported to the division.

6) No change to the rules is needed at this time in order to implement the bill and continue current reporting requirements, with the understanding that the division will undergo specific rulemaking to implement the EDI process in the future, and will revise the reporting rules before implementation.

7) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice. Summer also asked Jenni Bertels, the division's EDI coordinator, if the issue needed additional explanation.
- Jenni Bertels said the overview was great but welcomed questions.
- No additional discussion.

ISSUE #: 2

Rule: OAR 436-060-0150 (9) Request for reimbursement

Issue: There are two separate rules addressing insurer response to worker request for reimbursement.

Background:
OAR 436-009-0025 (1) states that when a worker requests reimbursement for claim-related services, the insurer must respond with a written explanation for each type of expense being paid or denied. Additionally, the rule provides a time limit for requesting reimbursement, and specifies content and format requirements for the insurer's response.

OAR 436-060-0150 (9) contains similar language stating that:

> "If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for nonpayment or reduction of each item."

Having two rules on this topic appears to be redundant and could be confusing. The division requests input on whether OAR 436-060-0150(9) needs to be removed or updated for clarity.

Options:

1) Remove OAR 436-060-0150 (9).

2) Add a cross reference to OAR 436-009-0025 (1) in OAR 436-060-0150 (9).

3) No changes.

4) Other?

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Thais Lomax said their team would prefer a cross reference. They often go to division 060 initially, and it would be helpful to have the reminder.
- Dan Schmelling agreed with the comment that a cross reference in division 060 to the division 009 rules would be helpful, just for those folks who are not as familiar with the rules and where to look.

ISSUE #: 3

Rule: OAR 436-060-0153 (1)(d) Electronic Payment of Compensation

Issue: The rule does not state the requirements for self-insured employers when paying compensation through direct deposit.

Background:

OAR 436-060-0153 specifies requirements for electronic payment of compensation. For insurers, subsections (1) (a) – (b) allows use of direct deposit to pay benefits to workers, with consent from the worker. For employers, subsection (1)(d) states that if the employer is making payments under OAR 436-060-0020 (1), they may assume the worker consents to payments through direct deposit, if that is the method the employer usually uses to pay the worker's wages.

Self-insured employers fulfill both the role of insurer and employer, so they appear to fall under both (a) and (d) of the rule, which may cause confusion on the requirements for self-insured employers regarding electronic payment of compensation.

A stakeholder identified that the rule does not clearly address what self-insured employers must do in regards to paying through direct deposit. The division requests feedback on whether to reword the rule to directly state the requirements for self-insured employers.

Options:

1) State in OAR 436-060-0153 that self-insured employers may pay benefits through direct deposit, without first obtaining the worker's consent, when the worker's wages are normally paid that way.

(1) General.
~~An insurer may pay b~~Benefits may be paid through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the worker voluntarily consents.

(a) Except as provided under subsection (c), an insurer must obtain t~~T~~he worker's consent ~~must be obtained~~ before initiating electronic payments.
~~(b)~~The consent may be written or verbal. The insurer must provide the worker a written confirmation when consent is obtained verbally.
~~(c) The worker may discontinue receiving electronic payments by notifying the insurer in writing.~~
(b~~d~~) An employer making payments under OAR 436-060-0020(1) may assume the worker consents to having benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages.
(c) A self-insured employer may assume the worker consents to having benefits paid through a direct deposit system if that is the method the employer usually uses to pay the worker's wages.
(d) The worker may discontinue receiving electronic payments by notifying the insurer in writing.

2) No change.

3) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- No discussion.

ISSUE #: 4

Rule: OAR 436-060-0200 (1) Penalties for inducing failure to report claims

Issue: The rule language on when a civil penalty under ORS 656.745 (1) can be issued may be confusing.

Background:

OAR 436-060-0200 (1) states that the director will assess a civil penalty under ORS 656.745(1) against an employer or insurer that intentionally or repeatedly:

1) Induces workers to fail to report accidental injuries,
2) Causes employees to collect accidental injury claims as off-the-job injury claims,
3) Persuades workers to accept less than the compensation due, or
4) Makes it necessary for workers to resort to proceedings against the employer to secure compensation due.

The rule also specifies in (1)(a) that "A penalty under this section will only be assessed after all litigation on the matter has become final by operation of the law."

The division has identified that the rule may be confusing in regards to what litigation must be final in order to issue a penalty. As currently written, the rule language states that a penalty will not be issued until litigation for one of the four items listed in section (1) is final. However, the division's civil penalty order (for violation of the rule) is often the first division action upon which an employer or insurer could initiate litigation. Additionally, ORS 656.745 (1) states that the director "shall assess" a civil penalty, but does not state that litigation must be final to assess the penalty.

Other OAR chapter 436 rules on civil penalties do not specify that a penalty will only be assessed after litigation is final.

The division would like input on whether it is necessary to state in rule that a penalty under OAR 436-060-0200 (1) will not be assessed until litigation is final.

Options

1) Remove (1)(a) as follows:

(1) Penalties for inducing failure to report claims.
The director will assess a civil penalty under ORS 656.745(1) against an employer or insurer that intentionally or repeatedly induces workers to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades workers to accept less than the compensation due or makes it necessary for workers to resort to proceedings against the employer to secure compensation due.

~~(a) A penalty under this section will only be assessed after all litigation on the matter has become final by operation of the law.~~

(~~b~~) For the purpose of this section:

(a~~A~~) "Intentionally" means the employer or insurer acted with a conscious objective to engage in the conduct or cause any result described in this section; and

(b~~B~~) "Repeatedly" means more than once in any 12-month period.

2) No change.

3) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- No discussion.

ISSUE #: 5

Rule: OAR 436-060-0095 Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice

Issue: The rule addresses suspension of worker benefits due to failure to attend an independent medical examination, but does not state that a monetary penalty may also be imposed under OAR 436-010-0265.

Background:
OAR 436-060-0095 (6) allows an insurer to request that the division suspend the worker's benefits, if the worker does not attend an independent medical examination.

Under the medical rules in OAR 436-010-0265 (10), if the worker fails to attend an independent medical examination, and does not notify the insurer before the date of the exam, or does not have sufficient reason for not attending the exam, the director may impose a monetary penalty against the worker. The amount of the penalty is specified in OAR 436-010-0340 (10).

Together, these rules establish that if a worker misses an independent medical exam, the worker's benefits may be suspended, and the worker may also be subject to a monetary penalty under Division 10 rules. However, if only referring to the Division 60 rule, a stakeholder might not be aware of the monetary penalty. The division requests input on whether it would be beneficial to add a reference to OAR 436-010-0265 in Division 60.

Options:
1) Add a statement to OAR 436-060-0095 (1) to cross reference OAR 436-010-0265 as follows:

(1) General.

A worker must submit to independent medical examinations reasonably requested by the insurer or the director.

(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.

(b) If the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1), the director may suspend compensation by order:

(A) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and

(B) Compensation will be suspended until the examination has been completed. The worker is not entitled to compensation during or for the period of suspension.

(c) Any action of a worker's observer allowed under OAR 436-010-0265(6) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.

(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(e) The director may also impose a monetary penalty against the worker under OAR 436-010-0265.

2) No changes.

3) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- No discussion.

House Bill 4138 Background for Issues # 6 – 8

House Bill 4138 (2022) states that the insurer or self-insured employer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and worker's attorney. This notice must include the reason temporary disability is no longer due and payable.

ISSUE #: 6

Rule: OAR 436-060-0015 Required Notice and Information
OAR 436-120-0443 Training - General

Issue: House Bill 4138 (2022) adds a notice regarding temporary disability that is not in the current rule language.

Background:
Currently, insurers generally are not required to send notice explaining why temporary disability is ending.

OAR Chapter 436 includes rules that address when the worker is no longer entitled to temporary disability. OAR 436-060-0020 (Payment of Temporary Total Disability Compensation) and OAR 436-060-0030 (Payment of Temporary Partial Disability Compensation) state when temporary disability is no longer due and payable. OAR 436-120-0443 (Training – General) states that the insurer must pay temporary disability specifically when the worker is actively engaged in an approved training plan, but that temporary disability compensation may not be paid for more than 21 months.

Insurers must continue to meet any current statute and rule requirements for ending temporary disability, *and* beginning January 1, 2024, provide the notice required by House Bill 4138.

To ensure it is clear what insurers must do to be compliant with statute, the division believes it may be beneficial to add the notice requirement to rule.

Options

1) Add the following language to OAR 436-060-0015 as a new section:
   In addition to other requirements in OAR Chapter 436, the insurer or self-insured employer may not end temporary disability benefits until written notice has been mailed or delivered to the worker and the worker's attorney, if the worker is represented. The notice must state the reason that temporary disability benefits are no longer due and payable.

2) Add the following language to OAR 436-120-0443 as a new section:
   In addition to other requirements in OAR Chapter 436, the insurer or self-insured employer may not end temporary disability benefits until written notice under OAR 436-060-0015 has been mailed or delivered to the worker and the worker's attorney, if the worker is represented.

3) No change to the rule.

4) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.

- Keith Semple said they are fine with either of the options. It makes sense.
- Elaine Schooler said they are in agreement with the trial lawyers that it makes sense to add this to rule language.
- Thais Lomax said it would be really helpful to have a cross reference, similar to what we discussed earlier.

ISSUE #: 7

Rule: OAR 436-060-0020 (4) Lack of verification of inability to work

Issue: Current rule language allows the insurer to send the worker an explanation for stopping temporary disability "in place" of a scheduled temporary disability payment, which may not meet the intent of the House Bill 4138.

Background:
OAR 436-060-0020 (4) provides steps the insurer must complete to end temporary disability when the worker's attending physician or authorized nurse practitioner cannot verify the worker's inability to work. After completing those steps, the rule states that the insurer "…may stop temporary disability payments and, in place of a scheduled payment, send the worker an explanation for stopping the temporary disability payments."

It is unclear if the language of House Bill 4138 means that the insurer may stop temporary disability payments once notice is provided – i.e., issue no further payments, or if the bill requires payment of temporary disability to or through the date of the notice. Testimony during the legislative session indicated that the intent of the notice provision was to ensure that workers are notified when their temporary disability payments are going to stop, and give workers a reasonable amount of time to correct mistakes.

The division identified that sending notice "in place of" a scheduled temporary disability payment may not meet the intent of House Bill 4138.

Options

1) Revise OAR 436-060-0020 (4) as follows:

(4) Lack of verification of inability to work.
No temporary disability is due and payable for any period of time during which the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it, unless the worker has been unable to receive treatment for reasons beyond the worker's control.
(a) Before withholding temporary disability under this section, the insurer must ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment.
(A) If no valid reason is found or the worker does not respond or cannot be located, the insurer must document its file regarding those findings.
(B) The insurer must provide the director a copy of the documentation within 20 days, if requested.
(b) If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may not end ~~stop~~ temporary disability benefits ~~payments~~ until written notice is provided

under OAR 436-060-0015. ~~and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments.~~

2) No change to the rule.

3) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Elaine Schooler said the change makes sense to align this with the notice requirement. One item that came up was whether notice was "provided" versus "mailed or delivered"; the statutory wording is preferred. But, agreed, the notice needs to be mailed or delivered prior to the time-loss benefit ending.
- Keith Semple said they agree.
- Kirsten Adams agreed with Keith and Elaine that it makes sense to have a little more specificity.

ISSUE #: 8

Rule: OAR 436-030-0015 (7)(b) Insurer Responsibility

Issue: A worker may receive two different notices about the end of their temporary disability benefits (just prior to claim closure and the House Bill 4138 notice).

Background:
Under House Bill 4138, the worker will receive a notice regarding temporary disability that informs the worker the reason temporary disability is no longer due and payable.

OAR 436-030-0015 (7) requires that an insurer send a written notice to the worker and worker's attorney when the insurer receives information that the worker's claim qualifies for closure. This notice must advise the worker of impending claim closure and that "any temporary disability payments will end soon."

The division identified that it may be confusing if the worker is informed that benefits "will end soon" after receiving the notice required by House Bill 4138. The division seeks input on whether the proposed revision would help better clarify the status of the temporary disability benefits.

Options:

1) Revise OAR 436-030-0015 (7) as follows:

(7) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of impending claim closure and that any temporary disability ~~payments~~ currently being paid will end soon.

2) No changes.

3) Other.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Keith Semple said the option proposed makes sense. They have no objections.
- Elaine Schooler said they are in agreement with the change.

ISSUE #: 9

Rule: OAR 436-030-0015 Insurer Responsibility
OAR 436-060-0015 Required Notice and Information

Issue: House Bill 4138 (2022) adds a medically stationary status notice requirement that is not in current rule.

Background:
House Bill 4138 includes a requirement that "An insurer must mail or deliver a written notice to the worker and the worker's attorney within seven days following receipt of information that the worker is medically stationary."

Currently, insurers are not required to send a notice to the worker and their attorney solely to let the worker know they are in receipt of information the worker is medically stationary. To ensure it is clear what insurers must do to be compliant with the statute, the division believes it may be beneficial to add the House Bill 4138 notice requirement to the rule.

Options:

1) Amend OAR 436-060-0015 to include "An insurer or self-insured employer must mail or deliver a written notice to the worker and worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary."

Amend OAR 436-030-0015 to include: "An insurer or self-insured employer must provide the notice required under OAR 436-060-0015."

2) Make no changes.

3) Other?

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Elaine Schooler said they agree with the change and think it makes sense.
- Keith Semple said they agree also.
- Summer read some chat input from Ashley Willard, "How would HB 4138 impact OAR 436-060-0030(2)(a) and OAR 436-060-0030(2)b)?"
- Ashley Willard explained that this provision basically tells the insurer when to stop paying temporary total disability and start paying temporary partial disability. If the worker is with a new employer, it is up to the worker to provide that information in order for the insurer to pay them. It goes on to say if the worker fails to provide that documentation, the insurer may assume that post-injury wages are the same or higher, which would mean they would not pay them. That conflicts with having to provide them written notice of having to stop temporary disability under HB 4138.
- Thais Lomax said the rule to stop paying doesn't change, so if the insurer sends the notice saying it will not pay because the worker did not reply, then they have met both standards.
- Ashley said if the worker switches to a new employer, the insurer will have to continue paying until they send the worker this [new] information, even if the worker has the responsibility to provide the information.
- Thais replied that instead of just unilaterally stopping, the insurer would have to send the notice saying they are stopping temporary disability.
- Summer asked Ashley if the question has been addressed.
- Ashley said it has been.

ISSUE #: 10

Rule: OAR 436-030-0035 Determining Medically Stationary Status.

Issue: Currently, attending physicians and nurse practitioners can retroactively declare a medically stationary date for a worker with no time limit. House Bill 4138 (2022) adds a time limit for a physician or nurse practitioner to retroactively date a worker's medically stationary status.

Background:
Currently, neither statute or rule limit on how far back a medically stationary date can be set.

House Bill 4138 (2022) limits a physician or nurse practitioner from retroactively determining a worker to be medically stationary more than 60 days prior to the date of the determination.

In OAR 436-030-0035, there are provisions related to determining the date the worker becomes medically stationary. When House Bill 4138 is effective, those provisions will still be appropriate, but subject to the new 60-day limit. To ensure it is clear that there has been a change, the division identified that it would be beneficial to state in rule that when a worker is determined medically stationary, the medically stationary date cannot be more than 60 days prior.

Options:

1) Amend OAR 436-030-0035 to add a section that states:

   "A physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination except in the case of claims that are subject to ORS 656.268(13)."

2) Make no changes.

3) Other?

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Thais Lomax said there is a concern about clarification on that 60-day retroactive aspect. They still receive chart notes from physicians and nurse practitioners that include everything needed for closure, but they won't say the words "medically stationary." So, does that 60 days apply to them commenting on that prior note? Or, will they have to set additional exams? Thais added that they can provide examples of where they are caught in the loop of trying to get those words from the doctor.
- Summer said the division would welcome examples.
- Keith Semple said Option #1 makes sense and looks fine to them. In terms of the question that was asked, the question becomes then what was the date of the determination. Was that the date the doctor put vaguely in the chart note or the date of the determination when it is ultimately clarified? That is a case and fact-specific question: what day did they determine the worker stationary – was that the intent in the chart note – that is how this would be analyzed.
- Elaine Schooler said they agree it makes sense to add these changes to the rules.

ISSUE # 11

Rule: OAR 436-030-0035 Determining Medically Stationary Status

Issue: HB 4138 (2022) adds a 60-day time limit for a physician or nurse practitioner to retroactively date a worker's medically stationary status. It is unclear what the medically stationary date should be if the physician or nurse practitioner retroactively dates the medically stationary status more than 60 days prior.

Background:
Currently, neither statute or rule have any limit on how far back a medically stationary date can be set.

House Bill 4138 (2022) limits a physician or nurse practitioner from retroactively determining a worker to be medically stationary more than 60 days prior to the date of the determination. The bill does not state what should be done when a medically stationary date is declared more than 60 days prior. It is unclear if the doctor must revise the medically stationary date, or if insurers must close the claim using a date that is within the 60-day limit.

Some scenarios where a medically stationary date is determined to be more than 60 days prior could include:

- An attending physician might concur with an independent medical exam that found the worker was medically stationary more than 60 days prior.

- There is a conflict as to the date the worker became medically stationary. OAR 436-030-0035 (3) states in that case, the medically stationary date is the earliest date a preponderance is established. However, the earliest date may be more than 60 days prior.

- The physician did not indicate a specific date when determining the worker medically stationary. OAR 436-030-0035 (6) states that if that occurs, the worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. However, the date of the last examination may be more than 60 days prior.

The division seeks stakeholder input on how the medically stationary date should be determined if a physician or nurse practitioner declares the worker medically stationary more than 60 days prior.

Options:
Pending stakeholder input.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Keith Semple said they think OTLA's intent on this was to limit the effects of a backdated medically stationary date on creating an overpayment by agreeing to a date that is long in the past, not to affect so much when and how it is given. If a doctor puts a medically stationary date more than 60 days in the past, the effective medically stationary date would be no more than 60 days prior to when it is being set and determined and agreed to.
- Elaine Schooler said that is also their understanding. This is meant to address the situation where an independent medical evaluation sets a medically stationary date six months prior and then the

treating doctor concurs with that determination – to limit that determination to 60 days from when it's made, so that an extended period of overpaid time-loss isn't happening.
- Kirsten Adams agreed with Keith and Elaine that this is consistent with negotiations around the bill during the legislative session.
- Summer described the input as saying that the intent was to limit the effect on the payment of temporary disability, but not on other areas. Summer asked if that is correct.
- Keith confirmed that the intent was to address the effect on overpayments, not necessarily how or when the opinion on medically stationary is given.
- Elaine Schooler agreed with Keith.

ISSUE #12

Rule: OAR 436-030-0020 (14)(b)

Issue: The rule requires a "current (within three months before closure)" determination of medically stationary status when a claim is being closed after a vocational training plan. This rule may conflict with the House Bill 4138 limit on retroactive declaration of the medically stationary date.

Background:
OAR 436-030-0020(14)(b) requires that if, after claim closure, a worker enrolls in an authorized vocational training plan, the insurer must again close the claim when the worker is no longer enrolled and actively engaged in the training plan. The rule specifies that if the worker is medically stationary, there must be a "…current (within three months before closure) determination of medically stationary status."

House Bill 4138 (2022) limits a physician or nurse practitioner from retroactively determining a worker to be medically stationary more than 60 days prior to the date of the determination.

The division identified that the three-month timeframe specified by rule may conflict with the 60-day limitation from House Bill 4138. When redetermining the medically stationary date, the physician or nurse practitioner may not be able use the medically stationary date established when the claim was closed for the first time, if that medically stationary date was more than 60 days prior.

The division seeks stakeholder input on whether the rule conflicts with House Bill 4138, and whether clarification is needed regarding redetermination of medically stationary status as required by this rule.

Options:
Pending stakeholder input.

Recommendation:

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in this state?

Minutes:

- Summer Tucker described the issue – see above – and asked the committee for advice.
- Keith Semple said that for OTLA, they would just reiterate what they said about the last rule regarding the effective date of medically stationary, as opposed to the date it was assigned. It

appears this would not change things after a vocational plan. The focus was on the effects, not on the date given, which obviously would be far in the past.

- Elaine Schooler agreed with Keith. A claim closure after a vocational plan was not on their radar, and there was no intent to impact that closure process. Regarding the medically stationary date in the vocational realm, when they have ended training, they are re-rating the work disability that was awarded in the prior closure. They are interested in how the division thinks this may create a conflict, maybe with a specific example, and if there is a way to modify the current wording, so if the worker "remains medically stationary" – or something that removes the word "determination," that we are using as part of the change in HB 4138 – something to set this apart as a separate piece that is not impacted. There does not appear to be an impact.
- Thais Lomax said that from a practical standpoint, most examiners who are setting a mandatory closing exam for a post-vocational closure are not setting the appointment 90 plus days before they are finished with the vocational program, so it likely will have little to no impact, in general.
- Summer said, in terms of the request for an example, we were thinking, as described in the issue, that the physician will have to redetermine the medically stationary status, and we have to stay to that 60-day timeframe and cannot just go back and restate that medically stationary status. That may be the issue. But it is helpful to know that people may not think there will be a practical impact, given that the focus of this 60-day provision had more to do with time-loss. To our understanding, the redetermination provision came from a court decision some time in the last 10 years.
- Summer relayed some chat input from Thais Lomax: "post-voc closure: Used to be if a worker did not treat during their voc we could issue closure based on MD statement that they "remained stationary". Now, there is an exam needed in almost all cases to verify current status for new stationary declaration and work disability rating confirmation." Summer added that Thais is pointing out something that the Court of Appeals decision addressed and why there is an additional exam requirement.

House Bill 4138 - Housekeeping issue

OAR 436-060-0170(1) Recovery of Overpayment of Benefits
Updating the rule's reference to statute to add ORS 656.268 (16). The rule currently states "*An insurer may only recover overpayments paid to a worker as specified by ORS 656.268 (14), unless authority is granted by an administrative law judge or the board.*" House Bill 4138 adds some additional limits on recovery of overpayments that will be in ORS 656.268 (16), so the rule should be updated to state ORS 656.268 (14) and ORS 656.268 (16).

Other Housekeeping issues

OAR 436-060-0005 (6) Definitions
Updating the definition of "dependent" by replacing the language "relatives of a worker listed under OAR 656.005(10)" with "individuals listed under ORS 656.005(10)." House Bill 4086 (2022) expanded the definition of dependent to include individuals beyond the worker's relatives.

OAR 436-060-0025 (5)(d) Calculation of regular wages
Moving the provision regarding calculation of average weekly wage for workers employed through a union hiring hall from section (5) (Calculation of regular wages) to section (3) (Rate of compensation, generally). When a worker is employed through a union hiring hall, the average weekly wage is not calculated as a regular wage. Rather, a specific method of calculation is prescribed, and none of the other

provisions for regular wages apply. Section (3) appears to be a more appropriate location for the union hiring hall provision.

Minutes:

- Kirsten Adams noted that there had not been confusion about this, and wondered what the impetus was for moving the provision at this point.
- Summer Tucker explained that the division thought it might make more sense in the general section of the rule, just to make sure it is not confused with being a regular wage, that this is a special situation. That was the only impetus, and we were not trying to shake anything up significantly.
- Kirsten added that there was a concern about down-the-road consequences of having it here versus the section it has been in – wanted to make sure that had been looked into and that there would not be unintended consequences of the move.
- Summer noted the concern and said the intent was not to make a significant change to how people approach that particular situation.

OAR 436-060-0060 (5) Denied Requests
Correcting punctuation in the rule language by inserting a missing comma in OAR 436-060-0060(5): "…the insurer must respond to the requestor within 14 days of receiving the request, explaining the reason for denying the lump sum request."

OAR 436-060-0105 (4)(b)(D) Request for suspension of benefits
Clarifying that the rule's reference to the "worker's failure or refusal" is referring to failure to comply, or refusal to comply. This rule provides that the insurer may request that the division suspend the worker's benefits when the worker commits insanitary or injurious acts that imperil or delay recovery, refuses to submit to medical or surgical treatment, or fails or refuses to participate in a physical rehabilitation program. When the insurer submits a request that the division suspend the worker's benefits, the request must include "(D) How, when, and with whom the worker's failure or refusal was verified;"

OAR 436-060-0135 (2)(b)(E)(iv) Request to suspend compensation
Updating the reference to section (2) to instead reference section (2), subsection (a), so it is easier for the reader to find the relevant information. The rule requires that the insurer's request for suspension must include "A copy of the notice required in section (2) of this rule…" Section (2) covers a wide variety of topics, while section (2), subsection (a) specifically addresses the notice.

OAR 436-060-0150 (1)-(2) Timely Payment of Compensation
Removing the list of legal holidays from section (2) of this rule. The list of holidays is duplicative of ORS 187.010 and 187.020, which define the current state legal holidays, and are already referenced in this rule under section 1. Additionally, changing reference to "weekend" to "Saturday or Sunday."

OAR 436-060-0005 (4) Definitions
Updating the definition of "Business days" to reference the list of state holidays in ORS 187.010 and 187.020 instead of the list in OAR 436-060-0150(2).

OAR 436-060-0015 (3)(e)(b) Information provided to worker
Specifying that legal holidays are the state legal holidays defined under ORS 187.010 and 187.020.

OAR 436-030-0020 (6)(k) Requirements for Claim Closure
OAR 436-060-0147 (6) Scheduling the exam

OAR 436-060-0147 (8) Exam questions
Updating references to "Ombudsman for Injured Workers" to new title "Ombuds Office for Oregon Workers."

Minutes:

- Summer Tucker and Fred Bruyns asked the committee members to send in any additional input they may have. Fred asked that advice be sent to his attention.
- Dave Barenberg thanked the division for its early start on rulemaking.