WORKERS' COMPENSATION DIVISION
STAKEHOLDER ADVISORY COMMITTEE

Implementation of Enrolled House Bill 4138 (2022)

Location of meeting:
Virtual Zoomgov meeting and Room F, Labor & Industries Building, Salem, Oregon

Date & time: May 3, 2022, 2 p.m.

Committee members attending:

Adison Covey	Gallagher Bassett
Allison Miller	Farmers Insurance
Amanda Brown	Marion County
Amber McMurry	Multnomah County
Andrea Bates	The Hartford
Andrew Davis	Sedgwick CMS
Arthur Towers	Oregon Trial Lawyers Association
Ashley Willard	Travelers Insurance
Catherine Shaw	Sedgwick
Cdavid Cottrill	I.A.T.S.E. Local 488
Dan Schmelling	SAIF Corporation
Dave Boyd	Associated Oregon Loggers, Inc.
David Barenberg	SAIF Corporation
David Pyle	CareMark Comp MCO
David Waki	Small Business Ombudsman
Dawne Novinger	Providence
Elaine Schooler	SAIF Corporation
Eric Boling	TRISTAR Insurance Group
Gina Wescott	S | D | A | O
Heidi Lively Melton	Oregon State University
Janet Jennings	Sierra Pacific Industries
Jason Hansen	Liberty Mutual Insurance
Jaye Fraser	SAIF Corporation
Jennifer Flood	Ombuds for Oregon Workers
Jessica McCune	Slocum Orthopedics
John McKenzie	JE Dunn
Jovanna Patrick	Hollander Lebenbaum & Gannicott
Julie Riddle	The Hartford
Karen Betka	Farmers Insurance
Keith Semple	Johnson Johnson Lucas & Middleton PC
Kelli Ianke	Farmers Insurance
Kellie Dial	Sierra Pacific Industries
Kerry Tambara	Gallagher Bassett
Kevin Anderson	SBH Legal
Kevin Barrett	SAIF Corporation
Kirsten Adams	AGC
Laura Grossenbacher	Broadspire
Lisa Johnson	Majoris Health Systems

Lloyd Cawley	Farmers Insurance
Maureen Farran	Comprehensive Claims Consulting LLC
Olivia Geidl	Gallagher Bassett
Paloma Sparks	OBI
Patrick Priest	CIS | MLAC Co-chair
Rod Ewing	Travelers Insurance
Scott Strickland	MLAC Co-chair
Sherrie Giggers	Cascade Corporation
Sue Quinones	City of Portland
Talya Armstead	Sedgwick CMS
Tara Hutchinson	Farmers Insurance
Thais Lomax	Sedgwick
Todd Johnson	NCCI
Tony Myers	Tristar Risk Management
Tricia Jones	Clackamas County Risk and Benefits
Vicki Graves	Oregon Insurance Guaranty Association
Virginia Jones	Strategic Comp

Department of Consumer and Business Services staff present:

Summer Tucker	Scott Alto
Sally Coen	Troy Painter
Matt West	Barb Belcher
Steve Passantino	Theresa Van Winkle
Fred Bruyns	

Meeting summary:

Fred Bruyns welcomed the committee members. After introductions, Fred turned the conduct of the meeting over to Summer Tucker.

Summer guided the committee through the agenda, which has been copied in below. "Minutes" have been added below agenda item and at the end. Most of the recorded conversation is paraphrased, though quotation marks are used for some verbatim comments.

Background

Effective January 1, 2024, HB 4138 (2022) will make various changes to workers' compensation law related to temporary disability, recovery of overpayments, and medically stationary status. These changes will have direct impact on worker benefits and claim processing procedures.

The division wants input on how stakeholders will be impacted by these changes and if there are areas of the new law that require further clarification. This meeting is intended to be a preliminary conversation. Though the division anticipates rulemaking will be required in the future, specific rule language is not the primary focus of this meeting.

Any stakeholders who cannot attend the May 3 meeting are still welcome to provide input via email before or after the meeting. Please send any written input to wcd.policy@dcbs.oregon.gov.

Minutes:

Summer Tucker explained the purpose of the meeting, including that HB 4138 will be effective Jan. 1, 2024.

Issues for discussion

New notices to the worker – ORS 656.262(4)(j)(A) and ORS 656.268(1)(a)

There will be two new written notice requirements.

- The insurer may not end temporary disability benefits until written notice is issued to the worker and worker's attorney. This notice must state the reason temporary disability benefits are no longer due and payable.
- If the worker is declared medically stationary, the insurer must mail or deliver written notice to the worker and the worker's attorney within seven days following receipt of information that the worker is medically stationary.

1. Does additional information need to be included in the notices to ensure workers understand what is happening on their claim? If so, what kinds of information would be helpful to have included on the notices?

Minutes:
Summer Tucker explained that HB 4138 includes two new notice requirements, one related to temporary disability benefits, and another related to medically stationary status. See shaded box above.

Julie Riddle said that, from the perspective of injured workers, it might be good to have something about next steps, to improve understanding of what comes next in their claim. Julie continued that the notice is issued before temporary disability has ended; is that even when the injured worker has returned to work? It seems a little broad there.

Summer said that is a good point and probably something we will touch on further down on our agenda.

Ashley Willard said that regarding when a person is declared medically stationary, insurers are required to issue the notice within seven days, but they are also required to submit within five days that someone is released for full duty or put on permanent restrictions. If they are still trying to get clarification on the work status, and they are sending the medically stationary letter, the worker might be confused. It would be nice if it was all in one document, but they are on different timeframes, five and seven days.

Summer asked, regarding the five-day requirement, is this one that goes with the Notice of Closure?

Ashley said no, it is the one issued when the worker is released to full duty or released with permanent restrictions – must include reinstatement rights, explanation of wage subsidy, job site modifications. It is a five-day turnaround on those. It is confusing for the worker. A lot of the time the doctor will declare them medically stationary, but there are outstanding questions that might not be resolved until after the medically stationary determination.

Keith Semple said they (OTLA) discussed the bill with SAIF yesterday. One thing that came up was to make sure that the multilingual form would be included in what is sent to the worker, and maybe refer to the Ombuds Office as a resource, and include the right to have counsel. Regarding temporary disability benefits being terminated, they wanted to be sure there is sufficient information so the worker can figure out what the problem is – as when the attending physician isn't a valid attending physician or the insurer didn't receive the work restrictions – without having to make an additional phone call to the adjuster. Keith added that one of the questions was whether notice would go out when all conditions are medically stationary or when each condition was medically stationary. What they had in mind was when there was sufficient information to close the claim, so that would mean all conditions are medically stationary.

Ashley Willard said, regarding multiple conditions, if the claimant's attorney requests additional conditions within that five-day timeframe, what effect would that have, because they have to determine whether the additional conditions are related and if they are medically stationary – would they send out two medically stationary statuses or one, and at what point?

Keith Semple replied that there will be times when there will be duplicate notices, and they think more notice is better. They don't want to confuse workers, but they do want them to get these notices so they know what is going on in their claims. If the medically stationary notice has gone out and then something changes, a second notice may be warranted.

Thais Lomax said the claims processor would need a lot of clarification on who declaring someone medically stationary would trigger this timeframe, and specifically, is it all of the currently accepted conditions? Would it include a claimed new condition under review? Do they need to send it out when an IME doctor says the accepted conditions are stationary but they don't have the attending physician's response yet? There is so much confusion already, not just for the processor but for the worker, possibly getting multiple notices.

2. How customized or standardized should the notices be? Some options include:
    - Insurers creating a custom letter that meets rule requirements
    - Using a standard template created by the division
    - Using standardized language that is required by rule
    - Other?

Minutes:

Ashley Willard said Washington has templates for notices and envisions this being provided by the state (Oregon), with an option to show the reason, but otherwise standard language. That would eliminate much confusion on the injured worker's part, especially if they have multiple claims with multiple carriers.

Cdavid Cottrill agreed with Ashley that there should be some standardization for the general message and then some flexibility to add in some specifics. Standard language will be really helpful for those who help workers navigate the system.

Keith Semple said that was their feeling as well.

Kirsten Adams said it would make sense to have a standard notice from the division, but also a run down of what should be included, so an insurer that wants to do its own notices has the option of to do that, but with all of the same information. Seems to be the best of both worlds.

Elaine Schooler said their preference would be to have the option to have a more customizable process, so they can include specific criteria but can incorporate some standardized language as well. They would like the opportunity to have their own form that they can then automate.

3. What is the minimum amount of time insurers and claims processors need to adjust processes and computer systems to implement these notices?

Minutes:

Julie Riddle said they need a minimum of 30 days, though 90 would be better.

Allison Miller agreed with Julie Riddle – a minimum of 90 days is ideal.

Jaye Fraser referred to the 2024 effective date. This is a major IT lift for SAIF, and they have other IT projects going on. To the extent systems need to be adjusted, their preference would be to implement down the road.

Summer noted that in the chat, Sue Quinones said 90 days; Lloyd Cawley said at least 90 days [additional from chat – at least 90 days: Ashley Willard, "LSELLI," and Virginia Jones].

Changes to retroactive authorization – ORS 656.262(4)(g) and (j)

The current 14 day limit on retroactive authorization of temporary disability will change as follows:

- Temporary disability cannot be retroactively authorized for more than 45 days before the date the authorization is issued.
- When the required written notice has not been provided, there will be no limit on retroactive authorization.
- Temporary disability may be authorized up to 45 days prior to the date of the notice.
- If the written notice was given more than 45 days after the worker was no longer eligible for benefits, temporary disability may be authorized back to that end of eligibility date. However, the provider must issue that authorization within 30 days following the earlier of the mailing or delivery of the written notice.

Minutes:

Summer Tucker described the changes to retroactive authorization – see shaded box above.

Jennifer Millemann asked if everyone agreed on what it means to "end temporary disability" and that it is no longer due and payable? Meaning, you have a worker whose benefits are being prorated to zero in a two-week period, and the following two weeks their benefits are not prorated to zero – do people have a feel for what it means to end the benefits? Will notices need to go out based on prorated benefits every couple of weeks?

Summer said that is a good question, and one that will come up with some subsequent questions on the agenda. We will be happy to discuss in the next section.

Ashley Willard said there is a question whether this changes any of the rules regarding type B attending physicians. If a chiropractor is going back 45 days, the insurer would still only owe for 30 days, based on the current rules for type B attending physicians? That may be confusing for an injured worker. There should be some clarification in the rule regarding type B attending physicians.

Ashley asked, regarding when the insurer does not provide written notice, how would that apply in claims in which they do not get a notice of the claims for perhaps six or eight months? Maybe it is paid under short term disability or private insurance and then changes over to workers' compensation. Would they then pay that time-loss all of the way back, even though the worker received short term disability? Delays occur quite often in occupational disability claims. Maybe

they initially don't know it is related to work. In these situations, the insurer would not have issued the required notice, because they did not have the claim.

Summer Tucker replied that we don't have exact answers for some questions, but we are noting them so we can look into them. These changes are related to the amount of time you can go backwards, and situations where a worker is going from private insurance to workers' compensation might not be different.

Jovanna Patrick said, regarding claims that are not timely filed, we should look at the purpose of the law, which is to make sure workers know what is expected of them and that they are given a meaningful chance to go out and get that. Workers don't know what they are supposed to get until they are told and what is wrong with what they have until they are told they are not going to get paid. In the examples about delayed filing, the worker doesn't know what they need to do to obtain workers' compensation benefits. The notice is the notice, and until they have that information, they don't have what they need to go back and fix something. This is all dependent on doctors. It is unlikely that a worker who hasn't been treating or who hasn't been treating with the right doctors will be able to get a new doctor of the right type to go back and authorize six months or a year in the past. But, if they are able to do that and it is medically appropriate, then the worker did what they are supposed to do when they knew what they were supposed to do. This might result in a worker getting time-loss during the period of time before the claim was filed. That was the intent.

Julie Riddle said the agenda is very clear that this is when the insurer is ending benefits. As it is right now, if a claim came in as short-term disability and then comes in as a workers' compensation claim, they are not sure how this would apply.

Summer apologized if the presentation of the issue caused any confusion, but noted that this agenda item is primarily about retroactive authorization, though it is affected by the timeliness of written notice about ending temporary disability benefits.

Keith Semple said, regarding when the claim is received late, the written notice would not be required unless the benefits were being cut off. Upon late receipt of the claim, the worker would still have 45 days to get backdated restrictions. Probably offsets for benefits such as short-term disability would then come into play. Keith added that the worker might not be able to go back indefinitely, but would have an increased ability to go back. This may be more of a notable effect of the law, but not necessarily something for a rule to address.

4. Do insurers and claims processors need to adjust processes or computer systems to implement these changes? If so, what is the minimum amount of time needed to make adjustments?

Minutes:

Jaye Fraser said that any time there is a process change, it takes time – adjusters to retrain and systems that have to be adjusted. They need as much as they can have.

Elaine Schooler added that when they were discussing these changes during the Session, a concern for SAIF Corporation was a major overhaul in progress affecting IT and the Claims Division. They are in the process of doing that right now and it affects their resources substantially. Looking ahead, if we can have as much time as possible, that would be helpful. They appreciate that we are starting this conversation early, so they can adjust their expectations for 2024.

Dave Barenberg said the minimum necessary is not necessarily the optimum amount of time.

Dave Boyd asked if the minimum time referenced is the time before the 1/1/2024 effective date for everything to be decided. Or, is it a grace period after the effective date?

Fred Bruyns said the question gets to the timing of the Workers' Compensation Division's rulemaking. If we do it sooner rather than later, and we actually adopt something – that gives everyone a clear idea of what the expectations are. If we are just in the process of rulemaking going into 2023, and stakeholders didn't know the final disposition, it is hard to program for that.

Summer Tucker added that we do have time to do rulemaking. How soon will affect how much lead time people have to make adjustments. On Jan. 1, 2024, these requirements will be the law. Probably the sooner you have notice, the easier it will be to meet that requirement. We didn't have a clear understanding of how much time is needed, and this input is helpful.

Fred Bruyns read some chat from Amber McMurry, related to retroactivity, "to clarify - this is not meant to say that the AP can authorize prior to the date of first treatment with them, correct?"

Summer Tucker said retroactive authorization probably was not meant to go back before the attending physician was actually seeing the worker, but we can certainly look into that.

5. In general, how should attending physicians be informed of the written notice or the authorization limits?

Minutes:

Thais Lomax asked what they can do to get physicians in Oregon to actually look at the WCD website and read about their rights and responsibilities and to participate. Dozens of times each week their adjusters try to get basic information from doctors' offices – to get time-loss authorization or an 827 for taking over treatment. It would be very good for adjusters and processors if we could get providers to participate fully and to read the requirements – so if we can adjust the WCD website and enforce their participation as an AP under the rules, that would be helpful in general and especially if we are expanding their ability to backdate.

Summer Tucker read some chat input from Ashley Willard: "agree- due to staffing shortages being told 827 being sent out to carriers is around 30-45 days."

Keith Semple said in terms of additional information, they are not sure what is given to the doctors about the rules on 14-day authorization, but it would be a similar amount of information

to give them. It might not be helpful to give doctors too much detail, such as a list of all of the exceptions.

Jaye Fraser said SAIF would agree with what Keith said.

Elaine Schooler said MCOs could assist with this – in notifying their providers.

Jaye added that they (MCOs) will do that.

Summer Tucker relayed some chat input from Amber McMurry about backdating beyond the date of first treatment, and from Jennifer Flood, Ombuds for Oregon Workers, that there are times when the worker has to wait to get in to see the attending physician, and time-loss is retroactively authorized. Keith Semple also had a comment that an attending could authorize prior to the date of first treatment, currently for 14 days, but under the revised law for 45 days with some exceptions to that limit.

6. To confirm stakeholder understanding of the intent of this provision, we seek input on the date temporary disability should be paid through once the notice is mailed or delivered. Possible scenarios:

    - Written notice is issued *before* the event that ends temporary disability.
      Example: The worker signs a modified job offer (for full wages) that starts in two weeks. The insurer sends written notice to the worker before the modified duty starts.

    - Written notice is issued *on the same date* as the ending event.
      Example: The insurer negotiates a verbal release to work with the attending physician, and sends the written notice the same day.

    - Written notice is issued *after* the ending event.
      Example: The worker is released to regular work on March 1, and the insurer receives the regular work release on March 5. The insurer sends the written notice on March 6.

    - Other?
      Example: The worker is performing modified work, but the amount they earn each week varies. As a result, for some weeks, temporary partial disability (TPD) is payable, and in other weeks, no TPD is payable. The insurer provides written notice after each week where no TPD is payable.

Minutes:

Summer said that with issue #6 we are shifting gears to focus on the payment of temporary disability. HB 4138 states "…the insurer or self-insured employer may not end temporary disability until written notice has been mailed or delivered to the worker and the worker's attorney…." Written notice is going to be a new requirement that insurers must fulfil before ending temporary disability. We anticipate there is going to be some variation in when the notice is issued and for how long temporary disability is paid, depending on the circumstances. We would like to understand expectations regarding the intent of this provision, and especially on

how long temporary disability should be paid through, once the notice is mailed or delivered. We have listed some scenarios, but these are not the only scenarios. We would like input on how long temporary disability should be paid in these scenarios – and other scenarios.

Ashley Willard said, regarding bulletin point #3, if an injured worker is not providing us their releases and not providing it to their employer, and they have an attending physician who is not responding to our requests for records or for work status notes, they could be paying time-loss way past a full duty release. So, in that scenario, if they are released to regular work and they don't get the work note for weeks or months, they are going to be paying months of time-loss past the full duty release. How will that impact them when they issue the Notice of Closure, because they are released to full duty? Technically no time-loss is owed past the full duty release, but this rule is saying they have to continue to pay.

Rod Ewing said it would seem that if it has to be sent when temporary disability is ending, there will be times when the worker is back at work. Now the insurer has to pay them temporary disability even though they did return to work?

Ashley Willard said the insurer would offset it. One of the other issues you will run into is not just when they are released, but when you are getting a claim late, and the worker is already back at work – we didn't send the written notice, so would we still owe all of that? We would be able to offset, but based on the rule, we still have to pay it – and in some circumstances will not know how much to pay.

Thais Lomax added that (the same concern applies to) those workers who no longer work for the employer at injury and are not providing you with the time-loss slips – post-exam.

Jovanna Patrick said they did talk about this. As written, payment must continue through the date of the notice. They understand concerns about claims that are not brought right away. Ideally these notices would be sent at or before the time that time-loss is going to end, so the worker has notice, and if they disagree they would have time to go back and fix that. Regarding scenario #3, certainly there will be times when time-loss is paid past an authorization date, but that is not really different from where we are now. If this scenario #3 happens now, and the worker was released on March 1, and the insurer received the regular work release on March 5, they potentially would have paid for those additional days. What is different here is that we are adding a notice provision, so the worker is notified that payment will end and why.

Elaine Schooler commented (similar to Keith's and Jovanna's input) that the intent was that the notice is provided, and then on the processing aspect. Whether they have returned to work and are receiving wages – that goes into the offsetting and prorating – it is a situation they already encounter, where they don't receive releases within a certain period of time to prevent benefits from lapsing with no notice being provided to the worker.

Dave Boyd described a scenario where a worker is released to full duty on the first of a month, but they are not notified until the fifth of the month, then employers would still be on the hook for time-loss for those days?

Elaine Schooler responded that if we think of a worker who has a modified work release, and they go back to work, they still have an entitlement, but it is not payable. If they return to work with a regular work release, not only has the entitlement ended, which is what the notice would explain, but also time-loss is not due and payable because they are earning their wages. Just as the insurer would offset with a modified work release, the insurer would offset with a full duty work release.

Dave Boyd said that a challenge that has come up a lot lately is light duty that misses the full average weekly wage by a few cents per hour, so there is no credit for providing modified work, because they didn't quite get paid their average weekly wage due to a clerical error, such as not factoring in overtime. Scenario: If the worker has a full release on the first at their normal work rate, but without overtime, but is not notified until some subsequent time, there would still be a difference between the pay and what would have been the average weekly wage, so therefore the liability for time-loss would keep accruing.

Elaine Schooler replied that, in the example given, if the worker had worked a lot of overtime, so they had an inflated rate, and they return to work with eight-hour shifts, there could be that situation. There are two different types of time-loss, substantive and procedural. One is time-loss the worker is entitled to keep and the other is recoverable at the closure from a disability award. In their discussions with Keith Semple and Jovanna Patrick, they noted that some of this is unclear and might need to be litigated down the road, because this is something new. In the past, regular work release meant time-loss ended. Even if you paid past that, it would be recoverable at closure. Does this change that process? They don't know for sure.

Summer Tucker relayed chat from Tricia Jones: "Will days paid over the full duty release based on when an ending time loss letter is issued qualify as an overpayment once notice of closure is issued? The NOC would list dates authorized vs date ending time loss letter is sent. |
"Time loss can be paid up to a week in arrears. Would time loss need to be paid beyond the return to work date if the worker returns to work modified or full duty before the person paying time loss is aware of a release (employer received release but delayed forwarding to person paying time loss)."

Summer Tucker asked if we have addressed Tricia's comment. Tricia replied in chat: "yes."

Changes to temporary disability, special circumstances exception – ORS 656.262 (4)(g)(A) and (B)

There will be certain circumstances where provisions of ORS 656.262 (4)(g)(A) will not apply. ORS 656.262 (4)(g)(A) contains two provisions:

- That temporary disability is not due and payable after the worker's attending physician or nurse practitioner ceases to authorize temporary disability, or for any period of time not authorized by the attending physician.
- Temporary disability can be authorized for no more than 45 days prior.

ORS 656.262 (4)(g)(A) will not apply in these circumstances:

i. During periods in which there is a denial under the jurisdiction of the Workers' Compensation Board that affects the worker's ability to obtain authorization of temporary disability;

ii. During periods in which there is a dispute over the identity of, or treatment by, an attending physician or nurse practitioner that affects the worker's ability to obtain authorization of temporary disability; or

iii. When the new written notice (required before ending temporary disability) has not been given.

7. What specific dates should define the beginning and end of the periods in circumstances (i) or (ii)? For example, should the period for (ii) begin the date a request for hearing is submitted?

Minutes:

Summer Tucker provided an overview of the issue – see shaded box above.

Jovanna Patrick said that, as written, we are looking at a disruptive event, a denial or dispute that causes the worker perhaps not to be able to be seen by the doctor – the doctor not wanting to see them while this disruptive event is happening. It would be on that date that the exception would apply, because that is the date that availability to the doctor is likely to be disrupted. We have various appeal deadlines, and for workers who are unrepresented, a denial or dispute might be the trigger to get them to look for an attorney.

Ashley Willard asked, regarding circumstance i, if there is a denial, does the notice requirement apply? If the denial is overturned, if the worker had previously been released to full duty – it doesn't apply, but how is that looked at? Do they just apply the old rules that nothing would be owed after that date of release to full duty? Or, would they have to go back and pay that entire time period because we didn't send a notice? Some clarification about this is needed.

Jovanna Patrick replied that the intention was to provide exceptions to time-loss authorizations, not to provide exceptions to the notice rules.

Ashley Willard asked if a notice would still be required on a denial, when they are released back to full duty and they are in litigation.

Jovanna Patrick replied that, as part of the ongoing processing requirements of the carrier, the insurer would need to continue to send the notices that are required by different areas, regardless of whether an exception applies to the requirement for the worker to get time-loss authorizations.

Thais Lomax asked if it would be better if there was additional language in the denial notice about a worker's rights and responsibilities while that denial is not final.

Jovanna Patrick replied that the division is looking at possibly modifying the denial wording, which is already quite lengthy – a lot for workers to digest, and that they are not digesting well at this time. The division could consider this as well.

Julie Riddle said that after a denial, the need to send an ending notice would seem not to be applicable. When the denial is overturned, there should be a physician who is able to address the disability aspect and the retroactivity – how far back they can go in that scenario. Whether it's an attending physician or IME, someone needs to address it. Just because someone is off work doesn't mean they are disabled for that period.

8. Are there any situations where clarification would be needed regarding the exceptions in (i) through (iii)?

Minutes:

No additional input.

Changes regarding medically stationary status and closure process – ORS 656.268 (1)(a)

Currently, one of the triggers for closing the claim is when the worker has become medically stationary and there is sufficient information to determine permanent disability. The new law will specify that the 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. Additionally, within seven days following receipt of information that the worker is medically stationary, the insurer will be required to mail or deliver written notice to the worker and the worker's attorney.

9. If the attending physician declares a medically stationary date more than 60 days prior, is a specific process needed in the administrative rules to address this issue?

Minutes:

Summer provided an overview of the issue – see shaded box above.

Ashley Willard asked if the seven days are calendar or business days (excluding legal holidays and weekends). Clarification will be helpful.

Summer Tucker said the bill doesn't specify calendar or business days, so clarification might be needed.

Summer relayed a chat message from Keith Semple: “We didn't see a need for a specific process on this issue.”

Thais Lomax said, going back to the problem they have had with doctor communication, as the rule stands right now, a person can only be declared stationary on the date of an actual visit. What can we do when we cannot get doctors to respond to our written requests for clarification or updates – whether medically stationary, etc.? Under the rules that are going into effect, we would have to set a whole new exam to get the closing information.

Keith Semple was not aware of a rule that required the medically stationary date to be the date of a particular visit. They see concurrences with IMEs and other declarations of medically stationary that isn’t on the date they saw the attending physician.

Thais replied that the stationary date doesn’t have to be the date they saw the attending physician, but has to be the date of an exam.

Ashley Willard said it is just saying “a physician,” not the “attending physician,” so in the cases where we do get an independent medical exam, and we send it (IME report) to the attending physician, and the attending physician in not getting back to us on a concurrence, and the 60 days goes out – now they are in the position of having to get another IME or to see if the attending physician is now willing to see the patient to declare them medically stationary, because the IME is now past 60 days. That does come up – some doctors don’t respond for months. Additional IMEs will increase insurers’ costs.

10. What are the intended impacts to the claim closure process if:

- The written notice is not issued at all?
- The written notice is issued more than seven days after receiving the medically stationary information?
- The notice of closure and written notice are issued at the same time?
- The notice of closure is issued *before* the written notice?

Minutes:

Keith Semple said that these are hard questions and good questions, but they think the main effect will be on not so much the closure of the claim, but on the declaration of any overpayments that would exist based on the medically stationary date and the transition between substantive and procedural temporary disability. When the notice is not issued, they would think there would be a simple civil penalty. The effects (of failure to give notice) on the worker in terms of protection are somewhat open questions.

Ashley Willard responded that here it just says physician or nurse practitioner. If an IME doctor says the worker is medically stationary, and they issue that letter within seven days, and then the attending physician comes back and says the worker is not medically stationary – then we send a letter saying “just kidding, you are not medically stationary.” Ashley added that the statute needs something to clarify it. This might be confusing to workers and prompt calls to their attorneys.

Keith Semple said the point is well taken.

Ashley Willard added that the way it is written, any physician can do it (declare worker medically stationary).

Elaine Schooler said the goal was that workers not be surprised. In Ashley's example, if the worker is declared medically stationary, notice would go out. If the circumstances changes, and the doctor disagrees, that would prompt follow-up, but the intent was that workers are informed when the status of their claim is changing. Their thought is that this is not tied to the closure, nor does it affect the closure. It is a notice requirement much like any other. The closure is a separate step when there is sufficient information. If the insurer fails to provide the notice, then the remedy would be a civil penalty. It wouldn't otherwise delay or impact that closure process.

Scott Alto noted that, related to recent discussions about unrepresented workers receiving so many forms all at once, we would like input on whether information should be spaced out.

Dave Barenberg said it seems every time we try to simplify the system we add more forms.

Elaine Schooler said, regarding the notices of both medically stationary and time-loss, the intent there was to fill a gap where notices are not going out to workers, and there is potentially a disruption to their benefits; a change is happening and they are unaware of it. While we are generating more notices and this may lead to more questions, the goal was that workers are informed about their claims through the various stages. SAIF Corporation already notifies workers when their claims are determined medically stationary and inform them about the next steps in their claims.

Summer Tucker relayed Keith Semple's chat input: "On the issue of whether the attending says med stat or an IME says med stat, it would be helpful if the notice said which."

Other

11. What other issues should the division consider regarding HB 4138 related claim processing changes?

Minutes:

David Barenberg expressed thanks that the division jumped on this so quickly with a detailed agenda.

Summer Tucker thanked the committee members for their input and for their time.

Fred Bruyns said we will send out meeting minutes. Also, if anyone has additional thoughts about the agenda items, send written input to Fred [wcd.policy@dcbs.oregon.gov] or just pick up the phone [971-286-0316] – within a couple of weeks, if possible.

Summer thanked the committee again and closed the meeting.