

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of)	
436-009, Oregon Medical Fee and Payment Rules)	
436-010, Medical Services)	
436-015, Managed Care Organizations)	
436-030, Claim Closure and Reconsideration)	SUMMARY OF TESTIMONY AND AGENCY RESPONSES
436-035, Disability Rating Standards)	
436-040, Workers with Disabilities Program)	
436-045, Reopened Claims Program)	
436-050, Employer/Insurer Coverage Responsibility)	
436-060, Claims Administration)	
436-105, Employer-at-Injury Program)	
436-110, Preferred Worker Program)	
436-120, Vocational Assistance to Injured Workers)	
436-160, Electronic Data Interchange)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The public may obtain exact copies of the exhibits by contacting the Workers' Compensation Division, Fred Bruyns, E-mail: fred.h.bruyns@state.or.us, (503) 947-7717; fax (503) 947-7581, 350 Winter St. NE, Salem OR, 97301. The purpose of this summary is to provide the Director with a record of the agency's conclusions about the major issues raised.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated September 1, 2007. On September 24, 2007, a public rulemaking hearing was held as announced at 2:00 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through September 27, 2007.

No one testified at the public rulemaking hearing. The public submitted ten written documents as testimony.

Testimony list:

Exhibit	Rule divisions	Testifying
1	009	Kevin C. Tribout, Director Government Affairs, PMSI
2	110	Jerry Rutherford, Manager, Reemployment Assistance Unit, Workers' Compensation Division

Exhibit	Rule divisions	Testifying
3	110	Jerry Rutherford, Manager, Reemployment Assistance Unit, Workers' Compensation Division
4	030, 035, 050, 060	Ed Johnston
5	010, 060	Daniel Hanson
6	105	Brian R. Miller, Government Affairs - Oregon Farmers Insurance Group
7	050	Joey Blubaugh, TNT Management Resources, Inc.
8	110	Scott Stipe, Grace Smith, and Kathy Wallace Oregon Association of Rehabilitation Professionals
9	009, 010, 030, 035, 050, 060, 105	Chris Davie Vice President of Corporate Policy and External Affairs SAIF Corporation
10	010	Vern Saboe, DC Chiropractic Association of Oregon

Testimony: OAR 436-009-0010(2)

Exhibit 1

We support inclusion of a provider's NPI number on medical billings, where available. However, where a provider lacks an NPI, provision of **both** the license number and FEIN may prove to be daunting. A pharmacist may not have an FEIN [individual as opposed to the pharmacist's employer*], while a DME/Medical Supplier will have an FEIN but not a state license number.

We suggest changing the proposed rule to require that, in the absence of an NPI, the provider include on the billing either a license number or an FEIN. We strongly feel that changing the proposed language from "and" to "or" will accommodate all manner of providers who engage in servicing injured workers. It will not restrict billing entities and payers from receiving valid information, enabling them to correctly process and adjudicate bills, and it will ease restrictions on providers who do not have **both** a state license number and FEIN.

*Clarification based on a follow-up question to the testifier from the Workers' Compensation Division.

Response: We agree that there might be a potential problem for some provider types with the proposed language, but also see potential problems with the suggestion of changing "and" to "or". Therefore, we believe the solution is to add the following language to this rule; "For provider types not licensed by the state, "999999" must be used.

The IRS requires that all employers have a Federal Employer Identification number. If the pharmacist does not have a FEIN, then the pharmacy's FEIN should be used.

Testimony: OAR 436-009-0030 Appendix A, Modifier Codes

Exhibit 9

We do not have a way to identify refunds or additional payments with RF or DC codes. Our system does not support this. We suggest further discussion before you adopt this rule.

Response: This part of the rule is not new language. These are existing codes that were in the Bulletin 220 reporting requirement section. These codes will not be included in the ANSI 837 reporting requirements.

Testimony: OAR 436-010 (general issue)

Exhibit 10

You are likely not hearing from injured workers complaining that they cannot see a chiropractor and/or a chiropractor of their choice we believe for a few very basic reasons.

1. They have no idea where to complain. If you asked the average worker or even injured worker what does DCBS stand for they would have no idea. Nor the Investigations and Sanctions Unit of the Compliance Section, nor BOLI, etc.
2. Workers do not know Oregon's work comp law and as a consequence their treatment rights. This combined with the "steering" of these "clueless" injured workers namely by employers is another reason we believe.
3. Fear of termination from their jobs is another reason they don't complain, my colleagues and I hear this all the time.

Lastly recall our doctor survey findings I presented to MLAC in April of 2006.

When I asked my doctors:

"Has an injured worker(s) or patient(s) of yours ever indicated or complained to you that his or her employer told them they must go to a particular Occupational Medical Clinic?" 79% (289 respondents) said yes.

"Has an injured worker(s) or patient(s) of yours ever indicated or complained that they were told by their employer that they could not treat with you or "a chiropractor," that they were not "authorized" to see a chiropractor etc? 77% said yes

"Has an injured worker(s) or patient(s) of yours ever indicated that they were unaware that they could treat with you or any chiropractor?" 83% said yes.

Obviously it is our hope that the recent rewrite of the injured worker's rights booklet, and the various forms from DCBS, the audio recordings etc., will serve to chip away at this "steering" problem.

Response: WCD has posted to it's web page and sent a mailing to approximately 90,000 employers in the state informing them that an employer may not direct or control medical care of an injured worker. WCD has also rewritten and will soon publish a new form 1138 "What Happens if I'm Hurt on the Job" pamphlet for injured workers that explains the worker's rights to treat with the health care provider of their choice and any statutory time frames imposed on providers.

Testimony: OAR 436-010-0005(2)(c)(B)

Exhibit 9

A "Type B attending physician" is defined as the new category created by House Bill 2756, with limited treating authority. Section 7 of the bill requires these providers to certify that they have studied materials provided by the director before they are allowed to treat. There is already a similar requirement for nurse practitioners, which is recognized in 436-010-0005(3), where those

providers who have self-certified are referred to as “authorized nurse practitioners”. We recommend the same qualifying adjective for Type B attending physicians.

Response: The statute authorizing nurse practitioners and health care providers allowed to be attending physicians are distinct. At the external advisory committee meeting the group was asked how they would like to have this issue addressed. The conversation and consensus was to clarify the differences between the two types of attending physicians as opposed to three types of health care providers.

Testimony: OAR 436-010-0240 & 0265

Exhibit 5

Because the insurer pays for the IME, the patient by current law does not have access to the cover to cover medical file submitted to the IME doctor. This is not acceptable, a medical file is being generated and used against patients that we have no access to.

IME doctors should at least be qualified to render decisions in the respective field. As an example of an IME rendered by an unqualified person, my surgeon, a back specialist, viewed my MRI film and concluded that a surgical plan was required to address the physical damages caused by my work-related injury. The IME to counter my surgeon was done by a radiologist. Who has the most expertise? Why can a radiologist's opinion be as strong compared to a spine specialist?

I have been through many IME exams. What I cannot accept is that they have had an opinion of me formed before they even saw me. I have e-mails from the insurer and their MCO in which they have told the doctor ahead of my visit what the outcome is going to be. Because current law states that the insurer can submit what they feel is relevant the IME, doctors are receiving edited medical files and communications through phone calls and e-mails from the insurer laying out the direction of the exam before a patient even arrives. This is not acceptable; the full medical file needs to be submitted.

The IME reports written by the doctors need to be back under the jurisdiction of the Oregon Medical Board.

Response: The matters subject to the testimony were not considered by the External Advisory Committee. The division will take the issues under advisement for possible future action.

Testimony: OAR 436-010-0280(4)

Exhibit 9

This proposed rule requires a PCE in every case in which the worker has not been released or has not returned to regular work, regardless of the date of injury or possibility that the worker will be entitled to factoring or work disability. It also provides a vague standard for requiring a WCE without specifying who will determine the need for the WCE and without giving a clear statement of when it is required.

Subsection (a) attempts to cover all claims, but the possibility of work disability or factoring under the circumstances listed in the rule varies, depending on the date of injury. For an injury before 2006, even if a worker has not returned to regular work, he or she might not be entitled to work disability or factoring if the reason for the non-return was a termination or resignation.

Subsection (b) uses passive tense and indefinite syntax, which might lead to varying interpretations of the rule during reconsideration, regarding the need for a full WCE, which could lead to rescissions of closures and additional expense.

We also note that the Statement of Need and Fiscal Impact fails to mention the cost impact of this rule change, which may be significant. The allowed amount for a PCE2 is \$321.60; the allowed amount for a WCE is \$678.60.

We recommend that the rule be redrafted as follows:

(a) A physical capacity exam must be completed when, based on the attending physician's closing report, the worker will be entitled to an award for work disability or for the "social/vocational" factors, under the version of ORS 656.726(4) in effect at the time of injury

(b) A work capacity exam must be completed when the attending physician's closing report indicates that the worker will be unable to return to suitable and gainful employment. The attending physician may also require such an exam to specify the worker's ability to perform specific job tasks.

Response: We agree with the testimony and will therefore not make the proposed changes to section (4), formerly section (8), of this rule. Except for spelling out "PCE" and "WCE," section (4) will exactly match the wording in section (8) of the current rule.

Testimony: OAR 436-030 (general issue)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

The Workers' Compensation Division is beginning to look at ways to improve its administrative rules. The goal is to clarify regulatory requirements for the parties. Part of that effort will be reducing the volume of the rules to help people find and focus on what they need to know. To accomplish that, we will move descriptions of division processes to other documents, and use plain language in the rules. There may also be changes in the way the rules are organized. These changes will not be done all at once, and may take several rule revisions to accomplish. The Division 030 rules contain more than the usual amount of language in which the division is describing its own processes. This increases the length of the rules, and sometimes obscures the responsibilities of system players. The issues in this section are aimed at removing much of the director's "self regulation" (though not all of it) from the rules.

This sounds good, but should not be used to obscure the rules of administrative procedure relating to consequence of public safety issues that guide and bind WCD. If you separate out the text describing rules from the OARs, how will the injured worker ever, if he is diligent, find them? Even lawyers may not know. Where will your explanation of the rules/process go to? Instead of removing these descriptions of WCD process, you should pull them out of their various existing OAR locations, and bring them together in a new section of OARs entitled "Rules and Procedures that Bind WCD procedure."

Is the real purpose here to avoid or remove actionable rules that if not followed by the agency now can bring a lawsuit against the agency? Mailed letters do not always get to their recipient,

people do not always read the websites (some don't have computers or the financial means to buy them), and brochures are merely a general statement that a state court may not enforce. With all due respect to the state, having these procedures listed in letters, brochures and websites, does not make them binding. Having them in the OARs makes them plausible, binding and legally enforceable. Please do as I recommend, or leave the obscure writing alone. Better some difficult text that is available and binding than difficult text that is unavailable and not binding! The worst outcome is the one you propose. The best option would be to put the information in educational material and make sure workers get that material – and also reorganize the OARs as suggested in this comment.

Response: The Workers' Compensation Division is not trying to avoid or remove actionable rules that if not followed by the agency could bring a lawsuit against the agency. In fact, the division's legal counsel confirms that when the division communicates it will do something in letters, brochures, its website, or through other media, it is accountable to do what it promises. The division will still be accountable.

The division's objective is to look at ways to improve its administrative rules. The goal is to clarify regulatory requirements for the parties. Part of that effort will be reducing the volume of the rules to help people find information quickly and focus on what they need to know. To accomplish that, we will move descriptions of division processes to other documents, and use plain language in the rules. There may also be changes in the way the rules are organized. These changes will not be done all at once, and may take several rule revisions to accomplish.

The Division 030 rules contain more than the usual amount of language in which the division is describing its own processes. This increases the length of the rules, and sometimes obscures the responsibilities of system players. During this rule revision it's our goal to remove much of the director's "self-regulation" (though not all of it) from the rules.

Concurrent with this rule revision, the division will update brochures and make relevant information available on its website. This should make information about WCD processes more accessible to everyone, any time it is needed.

Testimony: OAR 436-030-0007(1)(b) & 0135(10)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

Current rules do not accurately describe the time frame in which the Appellate Review Unit can abate and withdraw its own Order on Reconsideration. One could interpret the rules to mean that the Unit could abate and withdraw an Order on Reconsideration more than 30 days after the Order issues because there is a hearing request preventing the Order from becoming final by operation of law. In reality and practice, the ARU can only abate and withdraw an Order within the 30 days immediately following issuance, whether there is a hearing request or not. Changing this rule will not change current practice but will clarify the process for the parties.

The whole idea that there is only 30 days for an injured worker to seek a Reconsideration is inappropriate and biased against the worker. I don't care which language change you make, just change "30 days" to "90 days."

Response: This rule specifically addresses the director's time frame in which she can abate and withdraw her order on reconsideration, not how much time the worker has to request reconsideration. Per statute, the worker has 60 days to appeal a claim closure.

Testimony: OAR 436-030-0007(4)(c)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

OAR 436-030-0007(4)(c), regarding director's administrative reviews, states: A director's order will be issued and will specify if the order is final or if it may be appealed. With rare exceptions (stipulations of the parties, abatements of orders on reconsideration, and abatement's of reclassification orders), the division includes and will continue to include appeal rights in its orders. This is an important point to emphasize in educational brochures and web content. But there is no need for a rule to state the policy.

I think this should be in a rule. The current WCD administration does this, but there will be other administrations, other administrators, in the future that might not abide by it.

Response: When an Order on Reconsideration issues it can always be appealed under ORS 656.268(6)(g). There is no need to specify in the rules if the order is final or if it may be appealed. The important part of the appeal language is the amount of time that the worker or insurer has to appeal. This language, in addition to the fact that the Order can be appealed, will continue to be included in the order.

Testimony: OAR 436-030-0035(5)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

This rule section prescribes how impairment findings may be made by the attending physician through concurrence with another physician's closing report. With the passage of House Bill 2756, some medical providers are called attending physicians but cannot make findings of impairment, so the term "attending physician" is too general for the purpose of this rule. The rule needs to be clarified by referring to the definition of attending physician in ORS 656.005(12)(b)(A) when referring to an attending physician who is authorized to make impairment findings. Also, this rule refers to "an insurer medical examination." To be consistent with other division rules, the word "insurer" should be changed to "independent."

I prefer the attending physician to be the final word on this, not the medical arbiter; I have too much experience with medical arbiters who have made bad judgment calls. It is the attending physician who knows the claimant and his condition(s) best, and he should have the last medical word.

Response: This proposed rule change is to incorporate changes made by HB2756 – including

new providers in the definition of “attending physician” for treatment purposes and the limits of their authority regarding findings of impairment. The testimony provided refers to limiting the impact of the objective findings of a medical arbiter for rating permanent impairment. ORS 656.268(7)(a) states, “If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker’s disability, the director shall refer the claim to a medical arbiter appointed by the director”. The director has no authority to change statute.

Testimony: OAR 436-030-0115(5)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

Should ARU review all aspects of the claim closure, regardless of the issues brought to ARU by the parties? Historically, WCD/ARU has reviewed all aspects of the claim closure when a reconsideration has been requested. WCD has received feedback from both employers' and workers' representatives that they prefer the division review only the issue(s) raised by the parties. Both parties to the reconsideration have a chance to raise their issue(s), so every issue important to the parties would get reviewed.

There is a solid argument that there should be a full and complete record for an appellate court to review. So if you are determined to restrict ARU review, as suggested by the comment that both insurers and workers representatives (whoever they are) favor restricting ARU review, then there must be provision to ensure a complete record goes through that review and on to the appellate court if and when there is an appeal to court. Less than that is insane, immoral and probably unconstitutional.

A second thought: you could let the ARU review issues not raised in the event that a preliminary review indicates that not taking up the otherwise unraised issue(s) would result in "substantial injustice" or "significantly and unfairly prejudice the case of a party."

Response: The parties will continue to have the opportunity to raise any issue(s) regarding the claim closure and are able to submit those documents pertaining to the claim which include, but are not limited to the complete medical record and all official action and notices on the claim, under OAR 436-030-0135. These documents become the reconsideration record and are available if the case is appealed to a higher level.

Both the claimant’s and employer’s representatives presented the suggested change of only addressing those issues raised. Reviewing aspects of the claim closure that neither party raised as issues is considered paternalistic. The division’s policy and practice is not to treat and govern people in a parental manner.

Testimony: OAR 436-030-0135(1)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

OAR 436-030-0135(1) regarding the reconsideration procedure states: If the director assists the worker in completing the request for reconsideration, the director will notify the worker that the proceeding may result in an increase, decrease, or no change in entitlement to benefits. This is current practice and the practice will continue. It is not an appropriate subject for administrative rules and WCD suggests deleting this language.

Keeping the requirement for the disclosure that assistance from the director (or any member of the agency) may or may not increase or decrease the injured worker's recovery protects the agency. And this is appropriate.

Response: Rule will be revised as proposed.

Testimony: OAR 436-030-0135(2)(a) through (d) **Exhibit 4**

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

OAR 436-030-0135(2)(a) through (d) regarding the reconsideration procedure explains the WCD process rather than regulatory requirements of the parties. WCD suggests deleting this language.

I disagree with this. First of all, the timeline should not begin until the claimant has in writing by certified mail to WCD acknowledged receipt of the letter from the agency. See my comments under the section "streamlining the rules," above, as it applies to this, too.

Response: The time line is required by statute and rule cannot change statute. When reconsideration is requested by a worker, WCD sends out a letter to all the parties informing them of the fact that the proceeding has started. When the reconsideration is requested by an insurer, WCD sends out a letter stating the insurer has requested the reconsideration, but the proceeding will not start until the worker responds or the 60 days after claim closure has expired. If the 60 days have past without word from the worker, the proceeding begins and WCD sends out another letter informing the parties that it has begun. This process will continue.

Testimony: OAR 436-030-0135(3) **Exhibit 4**

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

Claim records received by ARU are not in chronological order, have numerous duplicates, and contain documents that do not pertain to the reconsideration. Requiring the insurer to provide the reconsideration record in exhibit list format would decrease the amount of paper submitted, eliminate most duplication, and reduce the amount of unnecessary documentation that ARU currently receives. This would lower file storage and copying, and reduce the amount of time it takes for file review, resulting in faster dispute resolution, and everyone involved in the dispute and in later appeals would know what was used to reach the final decision. ARU would be able to send a clean, organized copy of the medical record to the medical arbiter. Costs for the medical arbiter process would potentially decline because a smaller record would be sent.

Alternatives: 1. Require submission of record in exhibit list format. 2. Require record to be submitted in chronological order 3. No change.

By the way the issue is put, it seems either alternative 1 or 2 is clearly the better. But is there a downside here? There should be a fiscal impact statement so we can identify the potential benefits to the agency, the insurers and most of all, the ratepayers.

Response: The external advisory committee for these rules discussed this in great detail and determined that if the insurer was required to provide the record in exhibit list format that there would be additional cost to the system. But providing the record in chronological order would not be costly. The benefit to having the record in chronological order is quicker review and resolution of claim closure disputes at reconsideration, which results in workers getting their benefits sooner.

Testimony: OAR 436-030-0135(4)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

This rule section requires the parties submit copies of reconsideration requests to other interested parties. It states failure to do this may result in exclusion of that information from the reconsideration record. The last sentence of this rule states the director may assist a worker in meeting this requirement. WCD does assist unrepresented workers in meeting this requirement, but that last sentence is more appropriately explained in other documents more accessible to the worker.

First, if the worker cannot afford to do this, because the record or his file is too extensive, there should be a budget line in the WCD – probably Ombudsman's office – for covering these costs and the workers should be made aware of it. Beyond that, this proposal would effectively deprive the injured worker of the knowledge that the director may assist the uninjured worker. Of all the one sided, biased garbage I have seen, this one is certainly near the top. Who proposed it? Was it the insurance company? When the game is already so stacked against the worker, why do this?

Response: The last sentence of this rule states that the director may assist a worker in meeting the requirement of providing copies of reconsideration requests and any pertinent related documents This change does not eliminate the director’s intent to continue assisting workers in meeting the requirement. It is a removal of a self-regulating provision from the rule, with a plan to insert it in a pamphlet or other (more appropriate) means of educating parties to the reconsideration process.

Testimony: OAR 436-030-0135(8) & (9)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

WCD proposes to eliminate parts of these rules that merely inform people what an order on reconsideration will include. That information can be explained in other media designed to inform and educate people about the reconsideration process. If the parties feel it is important to specify how an order can affect disability awards, we could simply state that. WCD suggests the

above rules be replaced with the following: OAR 436 030 135(8) The reconsideration order may affirm, reduce and replace, or increase and replace the compensation awarded by the Notice of Closure.

Excellent! Please do this. What a concept: telling the worker how his compensation was calculated? That should occur each and every time, not "if appropriate." When could it not be appropriate to tell the worker this? Finally, this kind of notification must be by certified return receipt – otherwise how could WCD be sure the worker has had the notice to reply to, if necessary? Also, once the agency has made this decision and notified the worker thereof, the agency should be prohibited from changing its mind and not making payments. Bizarre as it seems, this actually has happened to me. It's on the record. This section of OAR should be amended or enlarged to prevent this ever happening to another Oregonian ever again.

Response: This rule as written and the proposed deletions do not involve any of the concerns expressed in the testimony. Current rule addresses what the director will put in the Order on Reconsideration, not how compensation is calculated. The changes that have been made address self-regulation and plain language –please see the response for 436-030 (general issue).

Testimony: OAR 436-030-0145(6)(a) through (c) **Exhibit 4**

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

OAR 436-030-0145(6)(a) through (c) explains that the director will notify the parties that the reconsideration is stayed and gives conditions for doing so. Due to the passage of House Bill 2218, temporary rules will no longer be used to determine extent of disability. Further, the rules should address not what the director will do, but the conditions under which the stay on reconsideration will occur. Therefore, WCD recommends the rule language be replaced with the following: {See Proposed amendments to OAR 436-030-0145.}

Seems reasonable, but I cannot say for sure without a more clear inclusion of the language to be removed and the cases that would be affected.

Response: Two issues were addressed in this rule (1) eliminating reference to temporary rules required by HB 2218 and (2) to clarify and streamline. With the passage of House Bill 2218, temporary rules will no longer be used when the Rating Standards don't address a condition. The extent of permanent disability resulting from the worker's impairment in those cases will be addressed in the order on reconsideration and will be considered a temporary standard rather than a temporary rule. For the second issue, the rules were reorganized to address not what the director will do, but the conditions under which the stay on reconsideration will occur.

Testimony: OAR 436-030-0155(2)(a) & (b) **Exhibit 4**

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

OAR 436 030 0155(2)(a) and (b) addresses the medical record that is submitted to the medical arbiter. The division only sends some types of medical and non-medical information to the medical arbiter at the request of the parties. WCD suggests renumbering the rule and using the

*following language to eliminate wording that appears to regulate the director: “(3) The director will send non medical information, nursing notes, or physical therapy treatment notes to the arbiter if: * * *.”*

Non medical information, i.e., school records, law enforcement, FBI files and whatever else is non medical should not go anywhere; it is all not relevant to the WCD process. It should be destroyed.

Response: The intent of this rule has not been changed, just reworded. Appellate Review Unit’s past practice of sending only those medical records relevant to the accepted medical condition will continue. The only time Appellate Review Unit sends any other information is when they ask a medical arbiter to assess the worker’s adaptability relative to job demands.

Testimony: OAR 436-030-0155(4) **Exhibit 4**

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

OAR 436 030 0155(4) states in part: “Any information the director adds to the record, such as the medical arbiter report, will be copied to all parties.” This language need not be stated in the rules, so WCD proposes eliminating it.

Fine, just so long as it must be available to the worker.

Response: This will not change WCD practice of copying the parties, which includes the worker.

Testimony: OAR 436-030-0155(5) **Exhibit 9**

The proposed rule removes the sentence stating that any information the director adds to the record, such as the medical arbiter reports, will be copied to all parties. Although OAR 436-030-0165(9)(c) requires the arbiter to send copies to the insurer within five days after completion of the review, the arbiters do not always do this. In addition, the appellate reviewers generate post-exam faxes to and from the arbiter, but the arbiter’s responses are often not sent to the insurer.

We cannot think of any reason why the director has elected to end the obligation to make sure that all the parties have a complete record. The system clearly benefits when all parties are fully informed. If new material is generated through the reconsideration process, the director has a duty to make sure that everyone’s record is complete. We ask that the sentence be retained in the rule.

Response: The idea of taking this out of the rule is not to eliminate the practice but to streamline the rules by removing the unnecessary rules that regulate the director. See 436-030 (general issue) response. It is common practice to copy all the parties with any correspondence and the director will continue to honor that practice whether it is in rule or not.

Testimony: OAR 436-030-0155(5) **Exhibit 4**

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

This rule section states that certified copies of the reconsideration record will be made at a charge to the requesting party. This rule is outdated and doesn't reflect current practice. The division neither certifies nor charges for the copies made and sent to the requesting party.

Fine. But lets make sure the rule now reflects the practice, which respects the financial burdens already upon the injured worker, who often cannot afford to pay for the files.

Response: The concern voiced in this testimony focuses on the worker's ability to assume financial responsibility for copies of the reconsideration record. WCD will continue to assist the worker as it has in the past. The removal of the reference to a service "for cost" is consistent with both practice and other services that WCD provides at no cost without such a reference being in the rules.

Testimony: OAR 436-030-0155(6)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

This rule section states the original claim file or a certified copy of the claim file is delivered to the Hearings Division two days prior to the hearing, and that the original claim file must be returned to the director within two days after the hearing. This rule is outdated and doesn't reflect current practice. The Hearings Division receives copies of the documents from the parties. They don't request a copy of the record from the division, and the division doesn't send it.

It should be seven days, not two days, to provide adequate time for evaluation of the case, and adequate notice to all parties involved.

Response: This rule change will reflect current practice and Workers' Compensation Board rules. The WCB rules establish the requirements for (1) what documents comprise the record, (2) how much time is allowed to provide the record, (3) who will provide the record, and (4) in what format the record is to be provided. The timeframe for providing the record to WCB is not something over which WCD has authority.

Testimony: OAR 436-030-0165(1)(a) and (b)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

The basis for this rule is in statute and need not be repeated in this rule. This rule tells about WCD process, which can be explained in other documents for the benefit of all the parties.

The time clock on this should only start to run after the worker or employee has received and sent back a certified return receipt letter from the WCD. See my comments under the section "streamlining the rules," above, as it applies to this, too.

Response: These are statutory requirements and statute does not give the director the authority to extend these time frames. If the reconsideration proceeding has to be postponed for an additional 60 days it allows the worker time to attend a medical arbiter examination. See ORS 656.268(6)(d).

Testimony: OAR 436-030-0165(4)(a) through (c) & 436-030-0165(5) & 0165(6)(a)&(b)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

These rules do not clearly instruct the worker about what is required if they miss a medical arbiter examination, or what happens if they do not cooperate with the examination. Confusion may have resulted in benefits being suspended when in reality the worker had "good cause" for missing the examination. This creates additional paperwork and extends the reconsideration process up to an additional 60 days.

You should include a "good cause" exception. If the worker is too sick (with a doctor's note to show it,) or incarcerated, or in an accident, could not obtain transportation or had a death or severe medical problems in the family, etc that would be good cause. Otherwise, you risk penalizing the worker double first by the stacked game, as I have personally experienced it, of biased IMEs, then by not giving the worker a chance to make a new appointment without penalty. If you want to cut the paperwork, create a fast track process for rescheduling the worker, then use a "hold in place" approach that keeps everything as was before the missed appointment, and requires nothing but one paper, indicating a good cause delay.

Response: OAR 436-030-0165(5) does provide a "good cause" exception – this is not being eliminated. The change in this rule is to clearly explain what the worker needs to do to prevent having their benefits suspended. Part of this process is to provide "good cause" to the director for missing the examination. Even if the worker does not provide "good cause" they still are allowed an additional 60 days to reschedule and attend the examination or withdraw their request for reconsideration. See ORS 656.268(7)(e)(B).

Testimony: OAR 436-030-0165(7)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

OAR 436-030-0165(7) talks about when a suspension of a worker's benefits will be lifted. The rule starts with "As addressed in the Order on Reconsideration." which indirectly regulates the division by telling it what will be in an order. The division suggests we delete that phrase from the rule and include lifting of benefits suspension in educational materials.

See my comments under the section "streamlining the rules," above, as it applies to this, too.

Response: See 436-030 (general issue) response at the beginning.

Testimony: OAR 436-030-0165(8)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

The division suggests reducing the length of this rule to give essential information, as follows: If none of the events which end the suspension under section (7) of this rule occurred prior to the expiration of the 60 day additional postponement, the suspension of benefits will remain in effect.

Again, I would prefer the suspension start in 90 days not 60. This is too important a life matter to be done so quickly. We don't want a worker to lose his benefits because his house is a mess or due to a family crisis requiring the worker to be out of town for a month or more.

Response: ORS 656.268(7)(e)(B), (C), & (D) establish the timeframes for imposing and lifting benefit suspensions. It is not something over which WCD has authority.

Testimony: OAR 436-030-0165(9)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

OAR 436 030 0165(9) requires medical arbiters to do a record review or examine the worker as requested, and says the director will provide notice of the examination of the worker to all parties. While this is part of the director's role and process, it is not a regulatory item and doesn't need to be in this rule.

This does need to be in this rule. What harm is there in keeping it? The insurers know that a failure of notice can be used in the legal process with great effect. How many unrepresented workers - or even new, less costly attorneys that people can afford - also know it? This benefits only the financial interest of the insurer and its stockholders, not the worker or his family or the ratepayers. The medical arbiter should be required to do a medical review on all the worker's medical conditions relevant or possibly relevant to his claim, and the worker must get a copy thereof.

Response: This rule specifically addresses the elimination of the language in the rule regarding the appointment notice that WCD sends to the parties when the worker has been scheduled for a medical arbiter examination. This notice will continue to be sent to the parties because it is the best method of notifying the worker of the appointment. This is another example of the director taking out language in the rules that is unnecessarily self-regulating. The rule still requires the medical arbiter to review the medical record as requested by the director.

Testimony: OAR 436-030-0165(9)(a)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

OAR 436-030-0165(9)(a) instructs the parties in submitting issues they wish to be addressed by a medical arbiter. It also says the director will only submit issues appropriate to the reconsideration proceeding to the medical arbiter or panel of medical arbiters. This is an explanatory item about the division's role and can be included in other documents.

All issues raised by the worker should be submitted to the medical arbiter or panel of arbiters; let them winnow through them, not the director.

See my comments under the section "streamlining the rules," above, as it applies to this, too.

Response: The rule was changed to clarify the intent and did not change the content. The director has been, and will continue to be responsible for the information that the medical arbiter reviews.

Testimony: OAR 436-030-0175(2)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

This rule section explains penalties to the insurer if reconsideration results in an increase in a PPD award above certain levels, and outlines conditions under which the penalties will not be assessed. One of those cases is (a) "The promulgation of a temporary emergency rule." With the passage of House Bill 2218, temporary rules will no longer be used when OAR 436-035 doesn't address a condition. The extent of permanent disability resulting from the worker's impairment in those cases will be addressed in the order on reconsideration, and the rules will reflect that change.

That is how WCD cut the \$30,000 from me; the insurance company filed and stated it did not want to pay it. This is wrong; it takes away the chance for financial security of the worker. I received a PPD award, and yet never received a dollar on it; the insurer should indeed be penalized if it does not meet its obligation to make such payment, in a timely manner – in 60 days. Why hasn't my insurer been penalized under this rule when I already originally won the case? It should have ended there.

Response: Testimony voices concern over failure to assess a penalty on the insurer for failing to pay a PPD award. The issue in this rule is when and if to assess penalties on an insurer when an increase in PPD results from promulgation of a temporary rule. With the passage of HB 2218, the previous temporary rule process has been eliminated and replaced with identification of a temporary standard and rating of a condition(s) unique to a particular claim. For this reason, WCD needs to eliminate reference(s) to temporary “rule” promulgation and replace with the new temporary “standard” process. The circumstance(s) under which an insurer may have such penalties assessed has not changed.

Testimony: OAR 436-030-0175(4)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

The rule establishes a cap for attorney fees by referencing the Workers' Compensation Board (WCB) rules, which is in conflict with statute. The WCB case Timothy H. Krushwitz, 7 Van Natta 2207 (1995) determined that statute - ORS 656.268(6)(c) - does not allow the Director discretion to impose a maximum fee award pursuant to Board rules.

I would allow the attorney, if he has worked hard and long on an extremely complex case, to get paid for all, not some, of his labor. Otherwise, the injured worker will never have a chance to get legal representation. Why would an attorney take the case? Otherwise, there is an incentive for insurers to string along the process until the case is so long and complex no attorney will waste

time without major compensation up front – which the injured worker can't afford. Get rid of the rule that establishes the cap on attorney fees.

In addition, when a worker represents himself, the worker should be paid for expenses – phone bills, travel, copying, etc, and really, in fairness, for his time lost, too. It would best if he got paid a fee as an in lieu attorney, or as power of attorney for himself, too. But at least expenses and time should be compensated when attorney fees would have been awarded except that there was no attorney on the worker's side.

Response: The attorney fees at reconsideration are set by statute, under ORS 656.268(6)(c), and it does not give the director the authority to modify them, nor does the statute allow the director to write in rule expense reimbursements for the worker, whether represented or not.

Testimony: OAR 436-035-0005(6)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

The use of "compensable injury" in the definition of "direct medical sequela" has generated questions on whether a direct medical sequela can be part of the injury but not directly related to the accepted condition. The determination and rating of a direct medical sequela should always be based on an accepted condition. The fact that the definition uses the term "compensable injury" may lead someone reviewing a claim to rate a direct medical sequela that is not directly related to the accepted condition, but was reviewed as part of the injury and later denied. Changing the language to "accepted condition" would be consistent with ORS 656.268(14).

Alternatives: 1. Change "compensable injury" to "accepted condition" 2. No change.

I think this whole definitional issue is an embarrassment and a black mark on the good name, such as it is, of Oregon workers’ compensation. It seems that each item in any definition is used as yet another sieve by which to catch and exclude from compensation somebody who simply was hurt on the job. Alternative one would simply add another sieve, and further bias the game against the injured worker and the ratepayer. I propose [new] alternative 3: Change "compensable injury" to "compensable injury, including the whole injury and not solely the accepted condition." I doubt you will accept this, but hope that by standing up for the workers where it appears few people, if anybody, else does that I can shift the entire debate a bit away from the obvious anti injured worker bias of the "issues" here and provided "alternatives" here.

Response: ORS 656.005(7)(a) provides specific criteria for determining what is a “compensable injury”. Previous rules referenced “compensable injury” rather than the “accepted condition” when discussing “direct medical sequela”. This was not consistent with the statutory provisions and is the reason for the proposed change. Testimony suggests changing the rule/definition to one inconsistent with what presently exists in statute. An administrative agency may not, by its rules, amend, alter, enlarge or limit the terms of a statute. See U. of O. Co-oper. V. Dept. of Rev., 273 Or. 539 (1975).

Testimony: OAR 436-035-0250

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

Is the current way the standards calculate hearing loss equitable? A new way of calculating hearing loss was promulgated two years ago and now that the industry has had time to work with it, the division would like your feedback. Hearing loss became an issue back in 2004 when it was brought to the director's attention that the presbycusis tables may need to be expanded. Upon extensive research, the physicians determined there was a mathematically inaccurate "double deduction" for presbycusis. WCD worked with the physicians to determine the proper method to calculate hearing loss impairment and incorporated the methodology into rule.

I doubt anybody on the board is competent to comment on this. We should hold this door open to obtain testimony from workers who have personally lived through hearing loss due to their employment or conduct an independent survey of affected workers and an analysis of the results. This is a matter of basic human decency and respect for the disabled injured worker, not statutory interpretation.

Response: When this rule was originally promulgated, insurers expressed concern regarding the methodology used to calculate hearing loss. Because of the insurer's concern, the division committed to revisit hearing loss so they could provide the division with feedback on the adequacy of the new methodology. This is the only testimony the division received on hearing loss and it is from a claimant.

Hearing loss compensation was discussed extensively in 2004 and most of the research was conducted in 2003. The research included numerous medical professionals that are highly qualified in this field. Below is an excerpt from the Testimony and Response document from the 2004 public hearing, which provides evidence of the extensive research performed prior to changing this rule.

“At the time of the last revision of the disability rating standards there was testimony recommending revising the presbycusis to extend it past the age of 60. Testimony was submitted by Richard A. Hodgson, M.D. which included a table he had created based on formulas found in the (International Organization for Standardization) ISO-1999 and (American National Standards Institute) ANSI S3.44-1996 based on the Annex (database) A formulas for a highly screened population that has no otologic disease and has not been exposed to occupational or non-occupational noise. Dr. Hodgson stated this table represents as close as we can come to purely age-related hearing loss (presbycusis). A graph was also submitted which clearly shows age related presbycusis values being subtracted from the total decibels of hearing measured over all six frequencies levels starting at zero decibels. Dr. Hodgson further noted the original presbycusis tables included in the Oregon Disability Rating Standards came out early in his practice and he never clearly understood how the original tables were established. This proposed recommendation to extend the presbycusis tables past the age of 60, was postponed for further study and consideration at the time of the next revision of the standards.

Since the last revision of the Disability Standards research was conducted into how the original presbycusis tables were established, current medical literature, and how other state and federal jurisdictions were currently determining presbycusis. It was discovered the original presbycusis table which combined the presbycusis values for the six standard frequencies were based on NIOSH (National Institute of Occupational Safety and Health) presbycusis values for these frequencies, which NIOSH has since abandoned. Iowa, one of the few states that provide a mathematical formula for calculating hearing loss, is still using the old NIOSH tables which stop at the age of 60.

Richard A. Hodgson, M.D. again testified on the proposed rules this revision stating he had written to Aram Glorig, M.D. at the House Ear Clinic in Los Angeles a number of years ago asking him about the Oregon method of hearing impairment evaluation as he is considered to be the “father” of noise-induced hearing loss evaluation. Dr. Glorig responded by writing: “The 25dB low fence has already deducted the amount of average loss (0.5, 1, 2 and 3 KHz) that occurs from presbycusis by age 65-70. If you must correct for presbycusis you start at zero audiometric level, otherwise you are making a correction (for age) twice.” Dr. Hodgson concurred that the Oregon formula was deducting twice for age. Additionally, he recommended an elimination of the deduction for presbycusis or if the presbycusis deduction continued to be used that it extend past the age of 60. The presbycusis table in the rules is the table Dr. Hodgson had provided based on formulas found in the (International Organization for Standardization) ISO-1999 and (American National Standards Institute) ANSI S3.44-1996 based on the Annex (database) A formulas. This deduction for presbycusis will only impact the permanent impairment value after the presbycusis value exceeds the low fence in order to eliminate the double deduction which was identified in the current method of calculating hearing loss. As a result presbycusis will only decrease a rating of permanent partial disability in a compensable hearing loss claim where the worker is older than 68 if male and older than 77 if female.

The presbycusis tables are based on a preponderance of the current medical thinking on how aging alone effects hearing loss for each year of life in the average man or average woman with no history of otologic disease or exposure to occupational or non-occupational noise. The articles submitted by George Gates, M.D. from the University of Washington and Karen Cruickshank, Ph.D., suggest the noise-damaged ear ages at an accelerated rate following noise exposure. Since the presbycusis table in the rules is based on a population without significant noise exposure, the values in the table would only decrease permanent disability by the amount which would have been expected to occur during the normal aging process. An individual who continues to work past the age of 68, will receive an impairment value based on the portion of hearing loss which exceeds the value anticipated from the aging process based on established norms. There is no differentiation in determining permanent disability between individuals who have continued to work and those who have retired. The differentiation by age and gender is consistent with other disability rating in the rules which are based in part by this type of delineation.

The human ear has the capacity to hear in frequencies from 20 Hz to 20,000 Hz with maximum sensitivity in the range of 2000 to 4000 Hz which includes most of the speech frequencies. The loss of hearing usually occurs at a frequency that is considered in the normal speaking / hearing range of 500 Hertz (Hz), 1000, 2000, 3000, 4000 and 6000 Hz. The AMA Guides to the

Evaluation of Permanent Impairment only include the four lower frequencies of 500, 1000, 2000 and 3000 Hz, which include the primary frequencies associated with speech. The formula used to determine bilateral hearing impairment is 5 times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by 6. Additionally, research has documented the lower frequencies are not as significantly effected by aging as are the higher frequencies, so it is not necessary to consider the effects of aging when looking only at these lower frequencies. This is why most other states which only utilize the lower frequencies do not need to take presbycusis into consideration when calculating hearing loss.

The higher frequencies include the high-frequency consonant sounds such as "th" and "s", birds singing, crickets chirping, some warning/alarm bells, leaking pressurized gas or steam, and the higher pitched frequencies in the voices of women and children. Loss of the ability to discriminate the "s" sound is particularly difficult. This sound is not only one of the most common sounds in our language, but it also conveys more grammatical information than most other sounds, for example; pluralization, possession, contractions, and second person singular. As a result it may be the single most important sound in the English language. At the same time, it is the most difficult one for many people with high frequency hearing losses to perceive. Its energy usually begins around 3000 Hz and may extend up to 8000 or 10,000 Hz, precisely the areas where the hearing thresholds are generally the poorest for people with hearing loss.

Additionally, NIOSH has stated that audiometry shall, at a minimum; consist of pure-tone air-conduction threshold testing of each ear at 500, 1000, 2000, 3000, 4000, and 6000 Hz. as all of these frequencies are important in deciding the probable etiology of a hearing loss. They also recommended testing at 8000 Hz to enhance the decision about probable etiology. This is due to the fact that noise induced hearing loss typically shows up as a notch in the audiograms at the 6000 Hz level. Consequently, Oregon has incorporated this level into the calculation of hearing loss impairment, in order to include the frequency which demonstrates the initial loss of hearing due to noise exposure.

The Oregon statute contains the formula of seven times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by eight. Codifying this into law provided a method to calculate the full range of hearing loss, and allow the inclusion of the six frequencies which cover the initial noise induced hearing loss and the full range of normal speaking / hearing, not just the primary speech frequencies. However, as the higher frequencies are more prone to changes due to aging it was determined an objective standard to assess presbycusis was needed to limit litigation and any variation in rating based on physician's personal philosophies regarding the impact of presbycusis. Establishing an objective standard for assessing presbycusis when determining permanent disability, eliminated the potential for discrimination based on inherent presumptions.

Additional testimony was received during this rule revision from Richard A. Hodgson, M.D., stating when the rules were created audiometers did not go past 100 decibels (dB). Since that time, the technology has improved and the more recent models of audiometers may test up as high as 120 dB. However, a person who cannot hear at 100 dB is just as impaired as one whose threshold is 120dB. Robert A. Dobie, M.D., Department of Otolaryngology, UC-Davis Medical

Center, concurred with Dr. Hodgson's opinion that any threshold of 100 dB or more should be entered at 100 dB. Additional research clearly demonstrated that putting an upper limit of 100 dB on the value to the maximum frequency would result in a more accurate and consistent assessment of the worker's overall loss of hearing."

Testimony: OAR 436-035-0350(2)

Exhibit 9

The proposed terminology governing post-surgical awards is confusing. "One disc or one vertebra or two vertebrae, or any combination" could have many interpretations. It seems to imply that the worker must have two of something, and one disc or one vertebra isn't enough. And what exactly is the threshold for awarding the additional 1%? This rule cries out for a table that clearly shows the intended award, rather than trying to convey the intent in a narrative form.

Response: The statement was modified to match the Webster dictionary's meaning of <this, that, or the other>.

It provides the different alternatives based on the Webster dictionary of <this, that, or the other>, which gives you all the options necessary to rate the surgical value of 1%.

Testimony: OAR 436-035-0350(2)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

The rating of these spinal surgical procedures was inadvertently changed during the last revision of the rules when "and/" was removed. The intent of this rule is to give a maximum rating for spinal surgical procedures that involve any combination of a disc and two vertebrae. The current language of "or" allows for a surgical rating of a disc and one or two vertebrae.

Alternatives: 1. Rewrite rule to say, "Involving up to one disc and two vertebrae." 2. No change

Recommendation: I do not see any actual difference between "and two vertebrae" versus "one or two vertebrae" since, as a practical matter, no physician will operate on two vertebrae if only one requires it. That is how you have presented the issue.

The issue is broader than what you have placed before the advisory committee with this linguistic correction. The true issue is not of linguistics, it is of fairness, equity and the early prevention of further deterioration in injured workers.

Response: This rule was modified only to clarify the intent, not review the adequacy of compensation. The idea is that there are many surgical procedures that may include one or a combination of spinal parts and any one of those scenarios would receive 1% for the first surgical procedure. The percentage given this surgical value is established using the AMA Guide to the Evaluation of Permanent Impairment, which is the common method in establishing percentage of impairment. The adequacy of compensation, which was not being addressed in this rule revision, is mandated by statute and cannot be changed by rule.

Testimony: OAR 436-035-0390(12)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

The Court of Appeals case Ainsworth v. SAIF invalidated the director's rule, which leaves the industry without guidance on how to address these cases. OAR 436 035 0390(12) states: If a value of impairment is determined under section (10) of this rule, no additional value for speech or psychiatric impairment is allowed. The Courts stated in this case that, "The statute cannot be read to permit partial compensation or to segment the disability caused by a single compensable injury into distinct organic and psychiatric parts and then compensate only one of them." The Court went on to say, "The employer argues the director has discretion to presume that brain injury disabilities overlap with psychiatric disabilities to such an extent that rating only the brain injury can always be said fairly to accomplish the objective of full compensation. We disagree. The director's assumption is true only to the extent that the psychiatric disability is wholly contained within the brain injury disability."

Recommendations: I agree with the quote from a Court cited in the above. (i.e., the text statement: "We disagree. The director's assumption is true only to the extent that the psychiatric disability is wholly contained within the brain injury disability.") But there is more. The reverse is also true. In point of fact there may be psychiatric injuries that have little to do with organic brain injury, and there may be organic brain injuries that have little to do with psychiatric injuries. Each should be separately compensable. Eliminate the misguided OAR and go with the Court's ruling.

Response: The rule has been deleted in response to the decision by the Court of Appeals.

Testimony: OAR 436-035-0420(11)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

Vaginal prolapse is not in the rating standards so an order on reconsideration would have to be written to cover this condition. Putting this condition in rule would allow the insurer/self insured employer to rate the condition and not have to come through ARU to have it rated in an order. This may result in the worker receiving benefits sooner and may reduce the number of reconsideration requests sent to ARU.

This one is so obvious it needs no explanation. Do it.

Response: Agree – it will be included in the Standards under this rule.

Testimony: OAR 436-035-0500

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

House Bill 2218 (effective 1/1/08) amends ORS 656.268 & 656.726, which eliminates and replaces the temporary rule process for the Appellate Review Unit. The temporary rule process has been used to rate conditions not in the rating standards (Division 035) and is claim specific.

The department currently researches and writes the temporary rule, submits it to the Secretary of State, and then refers to the rule in the Order on Reconsideration. HB 2218 will allow ARU to rate the condition that is not in the rating standards by just inserting the results of its research into the language of the Order on Reconsideration.

There may be a benefit in having an extra pair of eyes on a situation that is, by definition, rare and outside the norm that WCD is used to dealing with. On balance, while streamlining is good it is more important, when there is a question that is outside the usual stream of cases at WCD, to have a separate review process established, as a check on mistakes by WCD. I would keep the Secretary of State's office in this loop. Further, since both public employees and private employees are among those who might be injured, retaining the Secretary would provide an additional check that might reduce lawsuits by public employee and private employee unions and enable those unions to do a better job for their members with less litigation.

Response: The purpose of this rule change is to bring the method for processing temporary “standards” into line with methods for processing other reconsideration orders now that there is no provision for developing and publishing temporary “rules” (eliminated by HB 2218). This rule change does not affect the outcome or end product—a reconsideration order containing specialized information and rating disability unique to a given situation or condition. The only change is in timeliness, providing the worker a quicker response to their request for reconsideration. The testimony indicates a concern that leaving the Secretary of State “out of the loop” in such cases may increase the potential for error. However, the Secretary of State does not review documents for substance or content. They format rules as necessary to meet publication requirements.

Testimony: OAR 436-050-0005(18)

Exhibit 9

We propose a revised definition of premium:

“Premium” means the consideration paid for a contract of insurance including monetary consideration, unreturned or uncompleted payroll reports.

Unlike other property and casualty lines of insurance, workers’ compensation premium arises from an employer’s payroll. The actual monetary consideration for an insurance policy is not pre-determined at policy issuance, but determined after an employer’s payroll for the policy period is completed. This total monetary consideration can only be ascertained by payroll reports submitted to insurers by employers and by a premium audit.

When an employer fails to return a payroll report, a workers’ compensation insurer is unable to assess the proper monetary consideration for the insurance policy. Even when monetary consideration is paid, an employer’s failure to submit a payroll report leaves an insurer without the ability to assess whether or not the monetary consideration due and owing has been paid. We submit that premium includes the vehicle used to actually determine the monetary consideration for the insurance policy.

Response: HB2783 allows for and requires at least a ten day notice to the employer for termination of a guaranty contract when the termination is based on nonpayment of premium. Expanding the term “premium” to include and satisfy reporting obligations is beyond the specific language focused on monetary considerations in the statute. An insured’s failure to report payroll can be grounds for termination of the guaranty contract but requires the more substantial 45-day

notice to the employer.

Testimony: OAR 436-050-0440(1)

Exhibit 7

New section 436-050-0440 (1) places a burden on both new applicants and renewing licensees to obtain "A letter of verification or and good standing from the controlling regulatory agency of those states in which a worker leasing license or certification was previously, or is currently held;". As we have previously discussed, it is not possible for a renewing licensee to "temporary" suspend its worker leasing activities because another state regulatory agency has chosen or failed to respond to a request for the above required information. Any disruption in operation would result in substantial harm to clients, employees, and the reputation of the worker leasing company. It would be an irony that an otherwise compliant worker leasing company was at odds with the department due to the failure of another state's ability or willingness to respond timely. This seems like bad public policy.

One suggestion I offer is the department develop a form that the applicant would be required to complete and provide to the department during the application or renewal process. The department would then direct that form to the appropriate state(s) and seek response and follow up. State agencies are generally more responsive to each other than to an inquiry from an individual. This process would also avoid inconsistent language in how states respond. Lastly, failure of the department to receive this form back (assuming no other discrepancies in the application and investigation process) would not be considered grounds to withhold issuing a license.

Response: It is important for both the integrity of worker leasing licensing activities and the protection of Oregon businesses and workers that the licensing authority have complete information about an applicant's business standing. However, we agree the burden on renewing licensees from having to rely on a timely response from an otherwise non-engaged jurisdiction could put Oregon businesses and workers in jeopardy as an unintended consequence of the rule as proposed. We will amend the rule to apply to persons applying for an initial license. As to the renewing licensees, the Director will solicit the information from other jurisdictions based on the information the renewing licensee must provide under OAR 436-050-0440(2)(n). The standing of renewing licensees is already better known to Oregon and that knowledge can be supplemented at our own solicitation.

[Revised wording] "(1) For a person applying for an initial license, a letter of verification and good standing from the controlling regulatory agency of those states in which a license or certification to provide workers by contract and for a fee was previously, or is currently held;"

Testimony: OAR 436-060-0008(4)(c)

Exhibit 4

This testimony was inserted into text from "issues" documents prepared by the Workers' Compensation Division for advisory committees. The division's (summarized) wording is italicized.

Subsection (4)(c) says the division will specify whether the order issued is final or whether the aggrieved party may request a hearing under section (3). The rule says that if an order is final it cannot be appealed; however, the type of order determines whether it can be appealed (only director's opinions regarding reemployment assistance issues cannot be appealed) Under ORS

656.704(2)(a) a party is entitled to request a hearing on any matter not concerning a claim; the rule conflicts with statute.

Presumably the statute must prevail over the rule. The description is sufficiently ambiguous as to make it unclear which – the rule or statute – is more protective of workers' rights to appeal. I support maximizing that right, and whatever change – recommended or not – that would ensure that maximum.

Response: Agreed. This rule was modified to be consistent with statute.

Testimony: OAR 436-060-0010(4)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

First-aid log entries may be sufficient notice of an injury under ORS 656.265. The Division 060 requirement to keep the first-aid log for only one year may be inadequate. Currently, OSHA requires an employer to maintain their first-aid logs for 5 years and recommends they maintain them for 10 years.

Change to be consistent with OSHA. This is a no-brainer.

Response: Agreed. This change was made to provide consistency in record keeping for employers.

Testimony: OAR 436-060-0010

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

Should the rules require that claim reports (to the insurer or division) specifically identify claims that fall under “wrap up” policies? This may cause a claim to be assigned to an employer’s primary workers’ compensation policy rather than the “wrap up” policy where the liability rests.

It seems that common sense goes with the wider use/requirement for use of the wrap up policy. It does not seem likely to hurt injured workers, but should streamline the process.

Response: Further review of OAR 436-060-0010(9) confirms the existing requirements for reporting claims to the division includes the “wrap-up policy” information. The problem is caused by the employer using a form with the incorrect information; not their lack of providing the “wrap-up policy” information. No changes are being made to this rule.

Testimony: OAR 436-060-0015(3)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

Replace “Understanding workers’ compensation claims” with “A Guide for Workers Recently Hurt on the Job.”

I like it.

Response: This change was made to provide the referenced form with a title that better describes the purpose of the form.

Testimony: OAR 436-060-0017; 436-050-0120 **Exhibit 4**

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

WCD receives complaints from workers because the insurer has not responded to the worker’s request for copies of their medical records. When an insurer receives a request for copies of a worker’s medical record, should an incomplete response be considered the same as no response?

If the omission or ambiguity that constitutes the “incomplete response” is not material or its absence cannot in any way prejudice the worker, there is no need to treat it as the same as no response. However, it would seem that this circumstance should be deemed an exception – in the context of a general presumption that an incomplete response is indeed non responsive. With such a presumption should go a specific rule. Only WCD should be allowed to recognize the possibility the exception applies, or else, the fact of the articulation or claim of exception should be viewed as conclusive evidence that the incompleteness did harm the worker. Since this is not a matter of criminal law, there is no application of the constitutional right to not incriminate oneself.

Response: Our rulemaking committee deferred action on this issue because the Management-Labor Advisory Committee, which is a standing committee with Governor-appointed representatives for both labor and business, agreed to form a subcommittee to look into this matter.

Testimony: OAR 436-060-0018(6) **Exhibit 4**

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

The rule states certain documents “must” accompany the appeal of a “ Notice of Refusal to Reclassify.” ORS 656.277 only requires the worker submit a request for review to the Director within 60 days, it does not require the additional information noted in the rule. When the Workers’ Compensation Division receives an appeal, the documents are requested from the insurer.

As it stands, the current rule is clearly an invitation to insurers to not provide the documents it possesses, to the harm of the worker's case. This is asking the fox to guard the hen house. Please eliminate the requirement to submit the additional information with the appeal of a “Notice of Refusal to Reclassify.”

Response: This rule has been modified to be consistent with statute.

Testimony: OAR 436-060-0025(5)(m) Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

When a worker is employed on a cyclical basis (e.g., seven days on/seven days off) the insurer may average his or her earnings for the entire cycle, and sometimes the worker does not receive 66 2/3% of the wage when time is lost for a portion of the work cycle. In this example the work cycle is a two-week period and the worker would have no scheduled days off for the basis of payment of time loss benefits. If the worker was off work for the entire two-week cycle, the worker would receive 66 2/3% of the average weekly wage (subject to the maximum time loss rate). However, if the worker was off work for only one work day during the cycle, the worker would only receive 50% of 66 2/3% of the daily wage. Conversely, a worker may be paid for days the worker was not scheduled to work.

It would seem basic fairness requires changing the rule to address time loss payments for partial weeks worked.

Response: The external advisory committee acknowledged there are circumstances when application of this rule may not be equitable; however, any changes should be considered as part of a global review of OAR 436-060-0025. No changes are being made at this time.

Testimony: OAR 436-060-0055

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

With the passage of Senate Bill 762 the maximum amount an employer may pay for medical services in nondisabling workers' compensation claims is modified. SB 762 requires the director to adjust the maximum amount annually to reflect changes in the United States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of each year. Because the amount is adjusted to the nearest \$100 there may be years with no annual adjustments.

The real problem here is that the official CPI inflation rate excludes, I believe, two critical components: energy costs and food costs. That is the case, I know, with the federal “Core Inflation Rate” calculated by the federal Dept. of Commerce. In the real world, working, poor and middle class individuals and families spend disproportionately large portions of their income on food and energy, so the omission harms them far more than it harms more affluent families and individuals. It would be appropriate, than, at the least, to not only require the director to adjust the maximum amount annually, but to set a minimum required upwards adjustment, of, perhaps two or three percent.

Response: Senate Bill 762 requires the director to use United States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of each year when considering annual adjustment to the maximum amount an employer may pay for medical services in nondisabling workers' compensation claims. This rule has been modified to be consistent with statutory changes made by SB 762.

Testimony: OAR 436-060-0060

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

With the passage of HB2218 insurers are required to make lump sum payment of permanent partial disability (PPD) if requested by the worker unless specified conditions exist. Currently, if the insurer denies the request for the lump sum payment, statute automatically refers the issue to the director to review the denied lump sum payment, whether or not the parties want to appeal the matter. If the insurer denied the lump sum payment for any of four allowed reasons, the director upholds the denial. This bill removes the director from the process of automatically reviewing all denied lump sum payments. If a worker disagrees with the insurer’s decision, the worker may request that the Workers’ Compensation Division investigate for a possible penalty for unreasonable delay in payment under ORS 656.262(11).

There is a case to be made that non lump sum payments may actually be better for the injured worker (i.e., enforcing fiscal discipline and ensuring funds are available over at least some time period). There is another argument on the other side (i.e., that the worker has accumulated bills to pay and needs the money promptly to avoid losing the home, eviction, or other crisis). I would prefer to let the worker make that determination, and that WCD have in place a very strong presumption that he (or she) knows which is best for him, and that the director's review is premised upon such presumption, and the director will only conclude against the worker's preference if he is shown good reason why doing so (a) will benefit the worker (not the insurer) and (b) that the evidence submitted in support of (a) meets a standard of at least clear and convincing, and perhaps better, beyond a reasonable doubt.

Response: HB 2218 requires insurers to issue a lump sum payment when requested unless four specific conditions exist. This rule has been modified to be consistent with the statutory changes made by HB 2218.

Testimony: OAR 436-060-0140(11)

Exhibit 4

This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

This rule requires insurers to notify each affected service provider of the results of compensability determination, but does not specify a time frame. Some insurers may not notify service providers in a timely manner; therefore, when a service provider submits bills for payment the insurer reduces them for late submission.

Do modify the rule as proposed [to specify a time frame].

Response: Agreed. This rule was modified to provide a specific time frame for informing medical providers of the date compensability was determined.

Testimony: OAR 436-060-0140(11)(c)

Exhibit 9

The rule may inadvertently introduce “compensability date” as a new, undefined term. We recommend deletion of the word “compensability” from the new (bold) language on the first line of the rule [subsection (c)].

Response: Agreed. We will remove “compensability” from the first line of subsection (c).

Testimony: OAR 436-060-0147(4) *Exhibit 4*
This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

The reference to section (4) should be corrected to section (3).

Do it.

Response: This change does not substantively change this rule; it was for housekeeping purposes only.

Testimony: OAR 436-060 0150(5)(k), (7)(e), (10) *Exhibit 4*
This testimony was inserted into text from “issues” documents prepared by the Workers’ Compensation Division for advisory committees. The division’s (summarized) wording is italicized.

Senate Bill 253 amends ORS 656.236 to allow an Administrative Law Judge who mediates an agreement between parties to enter into a Claims Disposition Agreement (CDA) to approve the CDA; current law only allows the board to approve CDAs. The rules refer in one way or another to board approval of CDAs. Should WCD add “and Administrative Law Judge” to the rule?

Extra eyes on a final determination (or quasi final, short of appeal) are probably a good idea. Please so modify.

Response: The rules have been modified to be consistent with the changes made by SB 253.

Testimony: OAR 436-105 *Exhibit 6*
Why doesn't WCD approve insurer reimbursement requests (such as the wage subsidy program) "upfront" or at the time of submission? Current rules create somewhat of a disincentive for adjusters and companies to utilize retroactive reimbursement programs for fear that a simple mistake (of the proverbial "t crossed and i dotted" variety) discovered on a state audit (that often occurs a year or two later) and the ensuing return of that wage subsidy, could erase all of the administrative cost benefits received while participating in the program. Insurers would feel more confident and utilize these programs to a greater extent if they could have each transaction approved or certified by the WCD that it met regulations.

Response: Many years ago WCD tried to approve EAIP reimbursements individually, and therefore not require a later audit. There were at least two large down sides to processing reimbursements this way. We needed to have copies of all the EAIP documentation as well as claim file information from the insurer if we were going to properly evaluate the requests. It was also a workload issue and WCD developed an unacceptable backlog in processing

reimbursements. Thus the current system of checking for basic information, but leaving the review of back-up information to auditors, was born.

Testimony: OAR 436-105-0005(10) & 0520(1) *Exhibit 9*

The proposed addition of the word “taxable” will eliminate from reimbursement portions of the worker’s wages that the worker elects to direct to pre-tax accounts such as child care. As the full wage is still being paid by the employer, regardless of how the worker directs the money, we recommend deletion of the word “taxable”.

Response: We agree that the proposed language could be problematic, and we will modify these rules to clarify our intent.

Testimony: OAR 436-105-0500(5)(d) *Exhibit 9*

To provide greater clarity we recommend the following alternative language:

A medical release, and any restrictions it contains, remains in effect until another medical release is issued by the worker’s medical service provider.

The work release should remain in effect until replaced by a new release, even if any expiration date of the original work release has passed. A worker should not have to schedule a medical appointment to obtain a new release if the worker can continue to perform the job satisfactorily.

Response: We agree, and will change the rule language to clarify our intent. This rule is renumbered to OAR436-105-0500(6).

Testimony: OAR 436-105-0540(2) *Exhibit 9*

We applaud the department’s proposal to increase the EAIP administrative fee to \$120. This will appropriately recognize the increase in the cost to provide this service since the existing fee was set.

Response: Thank you.

Testimony: OAR 436-110-0240(3) & (4) *Exhibit 2*

The addresses in these notices should be changed to the division’s standard mailing address: P.O. Box 14480 97309-0405.

Response: We are changing the addresses to our standard address.

Testimony: OAR 436-110-0330(6) *Exhibit 3*

The reference to the Preferred Worker Eligibility Card should have been changed to Preferred Worker Identification Card. Under these proposed rules the eligibility card is eliminated.

Response: We have changed Eligibility to Identification.

Testimony: OAR 436-110-0345 *Exhibit 8*

A frequently voiced concern relates to the lack of direct placement services available through the Preferred Worker Program for those workers who are not eligible for vocational assistance. Rehabilitation professionals are frequently informed that injured workers have difficulty finding employment on their own and overcoming other barriers to employment without assistance.

The changes recommended in 436-110-0345 are significant in that (1) indicates that such purchase is available for the worker to “find” employment. Item (i) [of section (2)] refers to miscellaneous purchases that may be used to help a worker to find, accept or retain employment. Private rehabilitation counselors should be able to provide direct services in this section in order to assist injured workers in developing leads for employment, assisting with job search skills, scheduling leads for employment, assisting with PWP contracts, and providing monitoring services, such that the individual has a better likelihood of being retained by the employer. The maximum fee of \$2,500 per claim opening is sufficient to provide an injured worker with quality services that could be expected to significantly increase utilization of PWP funds while also improving the likelihood of workers return to work.

Services under the Preferred Worker Program could be limited so as not to duplicate vocational services. Provision of such limited, targeted, and direct services under the Preferred Worker Program can be seen as a practical, logical means of increasing utilization of PWP while increasing the likelihood of workers no longer eligible for vocational assistance, in obtaining and retaining employment consistent with their needs.

Response: Paying for direct services for a worker to find employment was not explored or discussed in the advisory committees. They approved of things like a haircut, gas money, bus pass, child care, etc., for a worker to land a job. This recommendation would be a significant departure from the issue that gave rise to this additional category of Employment Purchase, and we will retain the limitation of “finding employment” to necessary purchases to go to an interview in Oregon.

Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 2nd day of November, 2007.

WORKERS' COMPENSATION DIVISION

/s/ Fred Bruyns

Fred Bruyns, Hearing Officer

/s/ Holly Mercer

Holly Mercer, Assistant Manager
Medical Section

/s/ Jim Van Ness

Jim Van Ness, Manager
Appellate Review Unit

/s/ Reg Gregory

Reg Gregory, Manager
Employer Compliance Unit

/s/ Dan Schmelling

Dan Schmelling, Manager
Benefits & Certifications Unit

/s/ Rae Howe

Rae Howe, Assistant Manager
Benefit Services Section