Claims Processing

Insurer performance is an important part of the workers' compensation system. Legislation since 1987 has addressed certification of claims examiners, timelines for acceptance or denial of claim compensability, and resolution of a claim through claim closure or a claim disposition agreement.

The department provides a workers' compensation information line for the benefit of workers, insurers, medical providers, attorneys, employers, legislators, and others. The department also monitors insurer performance issues, such as by audits of the first payment of temporary disability benefits, claim compensability decisions, and claim closures. It also issues civil penalties to insurers and self-insured employers that do not meet acceptable performance standards.

Claim compensability decisions

To enable insurers to make better decisions, the statutory time limit for the acceptance or denial of claim compensability was changed from 60 days to 90 days by SB 1197 in 1990. It was hoped that this would lessen the number of appealed denials. The median number of days to accept a disabling claim increased after 1990, peaking at 52 days in 1998, but this resulted in longer periods of uncertainty for workers and medical providers.

In 2001, as part of SB 485, the Legislature reduced the statutory time limit back to 60 days. This affected the processing time for compensability decisions. Since 2002, the median time to accept a disabling claim has ranged from 39 days to 42 days. In 2009, 94 percent of the compensability decisions were made within the 60-day period – the highest rate since 1996.

Modified acceptance decisions

The 1997 Legislature passed HB 2971, which required insurers and self-insured employers to modify notices of acceptance when medical or other information changes a previously issued notice of acceptance. At the time of claim closure, insurers are also required to issue an updated notice of acceptance that specifies the compensable conditions. If a medical condition, whether omitted from the notice of acceptance or new, is later found to be compensable, then the insurer must reopen the claim for that condition.

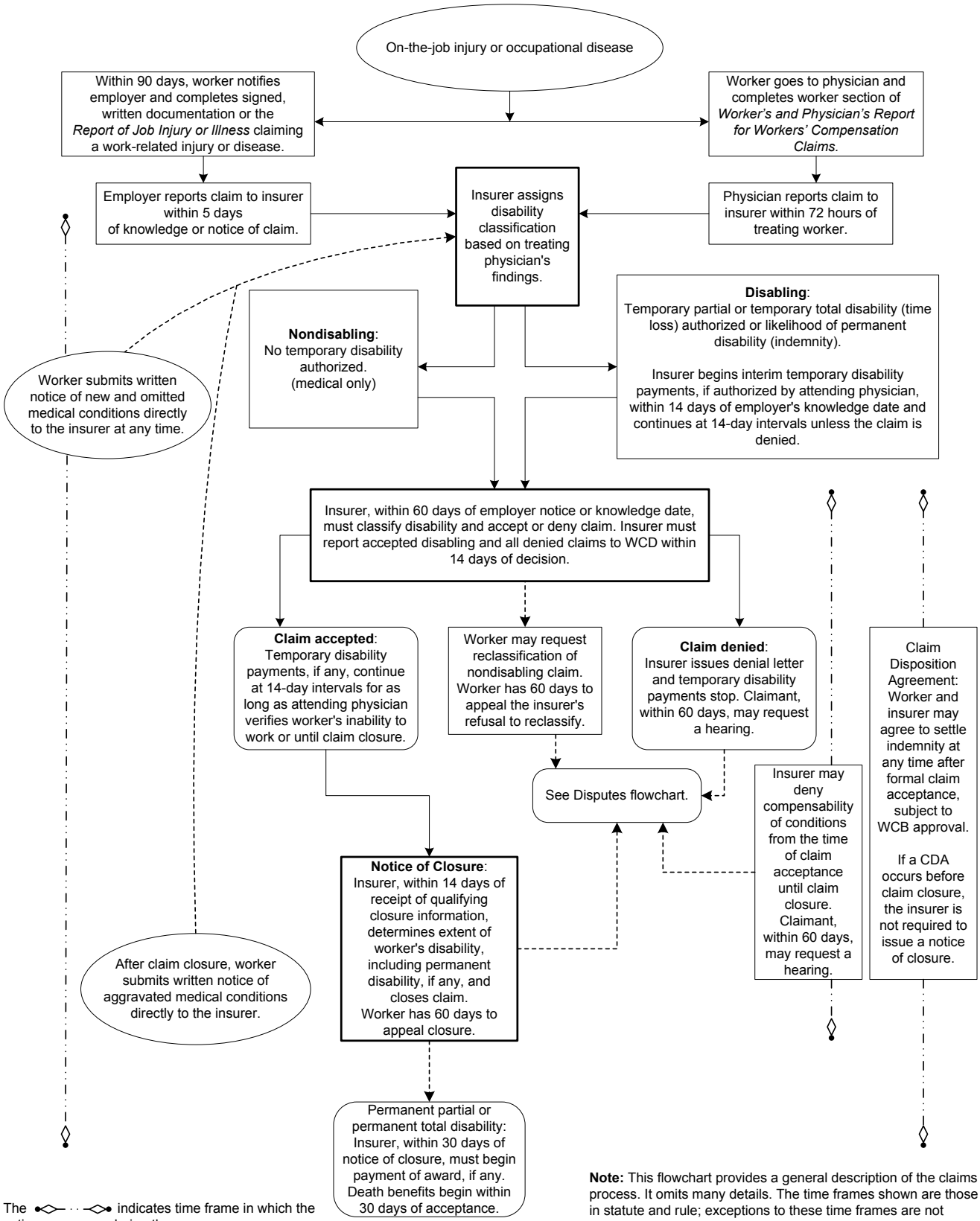
The Court of Appeals, in the 1999 Johansen v. SAIF Corporation decision, ruled that there are no time limits for liability on an omitted or new condition. In SB 485, the 2001 Legislature refined the process. A worker must request formal written acceptance of a new or omitted medical condition, which the insurer has 60 days to accept or deny. The period for disabling claims aggravation rights extends five years after the first closure. If a new compensable condition arises during this period, the insurer pays the claim costs. If the new condition arises after the aggravation period and the insurer doesn't voluntarily accept the claim, the worker must pursue the claim through the Workers' Compensation Board's Own Motion process. If the insurer or the board finds the condition compensable, then benefits are paid from the Workers' Benefit Fund, Reopened Claims Program.

Claim resolution

Before 1987, only the department could close claims and rate permanent disability. That year, the Legislature passed HB 2900, allowing insurers to close permanent disability claims if the worker had returned to work. Passage of SB 1197 in 1990 allowed insurers to close claims upon the attending physician's release of the worker to return to work and thereby terminate temporary disability payments earlier in the life of a claim. The 1999 passage of SB 220 shifted responsibility for all claim closures from the department to insurers. The transition was completed January 2001. The department continues to promulgate disability standards that insurers must use. Following passage of SB 757 in 2003, the standards for claims with dates of injury since Jan. 1, 2005, were changed to do away with the distinction between scheduled and unscheduled body parts. Permanent impairment is now expressed as a percent of the whole person.

Since July 1990, a worker with an accepted claim can resolve a claim by agreeing to release rights to workers' compensation benefits, except for medical services and the Preferred Worker Program, by

Figure 5. Claims process flowchart



The ◇—·····—◇ indicates time frame in which the action may occur during the process.
The ------- indicates potential path of process.

Note: This flowchart provides a general description of the claims process. It omits many details. The time frames shown are those in statute and rule; exceptions to these time frames are not shown. Flowcharts in the return-to-work chapter and the disputes chapter provide additional information.

means of a Claim Disposition Agreement (CDA). Since 1990, the percentage of initial claims resolved by CDA rather than claim closure has risen each year. This mode of claim resolution, while still used in a small minority of claims, has been growing more rapidly in recent years and was at 6.7 percent of resolved claims in 2009.

Workers' compensation information line

Workers' Compensation Division employees answer workers' questions about their claims, describe workers' rights and responsibilities, and help people understand the workers' compensation system. In 2009, there were 9,660 calls to the information line. Of the callers, 5,446 were workers and 4,214 were insurers, medical providers, attorneys, employers, legislators, and others. A change to the inquiry-handling program made over the past few years is referral of cases requiring translation or advocacy to the Office of the Ombudsman for Injured Workers.

Civil penalties

The department issues civil penalties to insurers and self-insured employers who do not meet acceptable performance standards. Each year between 2006 and 2008, the department issued more than 900 citations with penalty amounts of more than $575,000. There were 739 citations issued in 2009, just under the 20-year average of 741 citations; these citations totaled $404,525. Stipulated agreements, which may encompass various violations of rules and statutes under ORS Chapters 656 and 731 and set up various performance expectations, are not included in these statistics.

Training

You may find information about the Workers' Compensation Division training and events at the following site:

http://wcd.oregon.gov/communications/training/training.html.

Lessons from the Oregon Workers' Compensation System: Audits

In its 2008 study, "Lessons from the Oregon Workers' Compensation System," the Workers' Compensation Research Institute (WCRI) recognized Oregon's workers' compensation system as a model in achieving certain desirable outcomes. One of the four key lessons was Oregon's standards that result in accurate and timely benefits for injured workers.

The study cited the Workers' Compensation Division's long-term redesign project as an example of its reputation for constant program evaluation and improvement. As part of this redesign, the WCD is shifting its claims processing performance audit activities and emphasis to two basic audit types:

- Annual Audit - timeliness of benefit payments and processing actions; and
- Focused Audit - accuracy in specific performance areas identified via performance data, system indicators, trends, problems, or policy decisions.

These will replace the quarterly claims processing performance (QCPP) audit, the compliance audit, and the Workers' Benefit Fund reimbursement audits. WCD's revised audit program will do the following:

- use more flexible programs and responsive cycle times
- reward companies that perform well and require greater accountability and improvement from companies that perform poorly
- build on consultation and education to identify company and industry problems and to provide clear expectations and direction to improve compliance

Find relevant industry notices, under "regulatory redesign" here: **http://www.cbs.state.or.us/wcd/compliance/fau/ptd/audinfo.html**.

For more information about this report, see the "Lessons" press release at: **http://www.oregon.gov/DCBS/docs/news_releases/2008/nr_5_06_08.pdf?ga=t**.