Compensability and Claims Processing

The Oregon workers' compensation system is a no-fault system. In other words, the compensability of a claim is not dependent upon demonstrating that either side in a dispute is negligent. One purpose of a no-fault system is to compensate injured workers for work-related claims promptly and fairly.

Definition of compensability

When an injury or illness occurs and a claim is filed, the compensability decision controls whether the claim is covered within the system. This is the initial decision point in processing a claim, and is made by the insurer. The workers' compensation law governs the standards of compensability. The definition of a compensable claim was revised several times between 1987 and 1995. These revisions were partly responsible for the decrease in the number of accepted claims in the early 1990s. Details of the law changes can be found in the Compensability section of Appendix 1, Workers' Compensation Reform Legislation.

Definition of Accepted Disabling and Accepted Nondisabling Claim

An accepted disabling claim entitles the worker to medical services and disability or death benefits. An accepted nondisabling claim only entitles the worker to medical services.

Claim compensability decisions

The prompt determination of compensability is also an aspect of insurers' claim processing performance, which is an important part of the workers' compensation system. Legislation since 1987 has addressed timelines for acceptance or denial of claim compensability, certification of claims examiners, and resolution of a claim through claim closure or a claim disposition agreement.

To enable insurers to make better decisions, SB 1197 in 1990 changed the statutory time limit for the acceptance or denial of claim compensability from 60 days to 90 days. 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 2011, just over 94 percent of the compensability decisions were made within the 60-day period – the highest rate since 1996.

Modified acceptance decisions

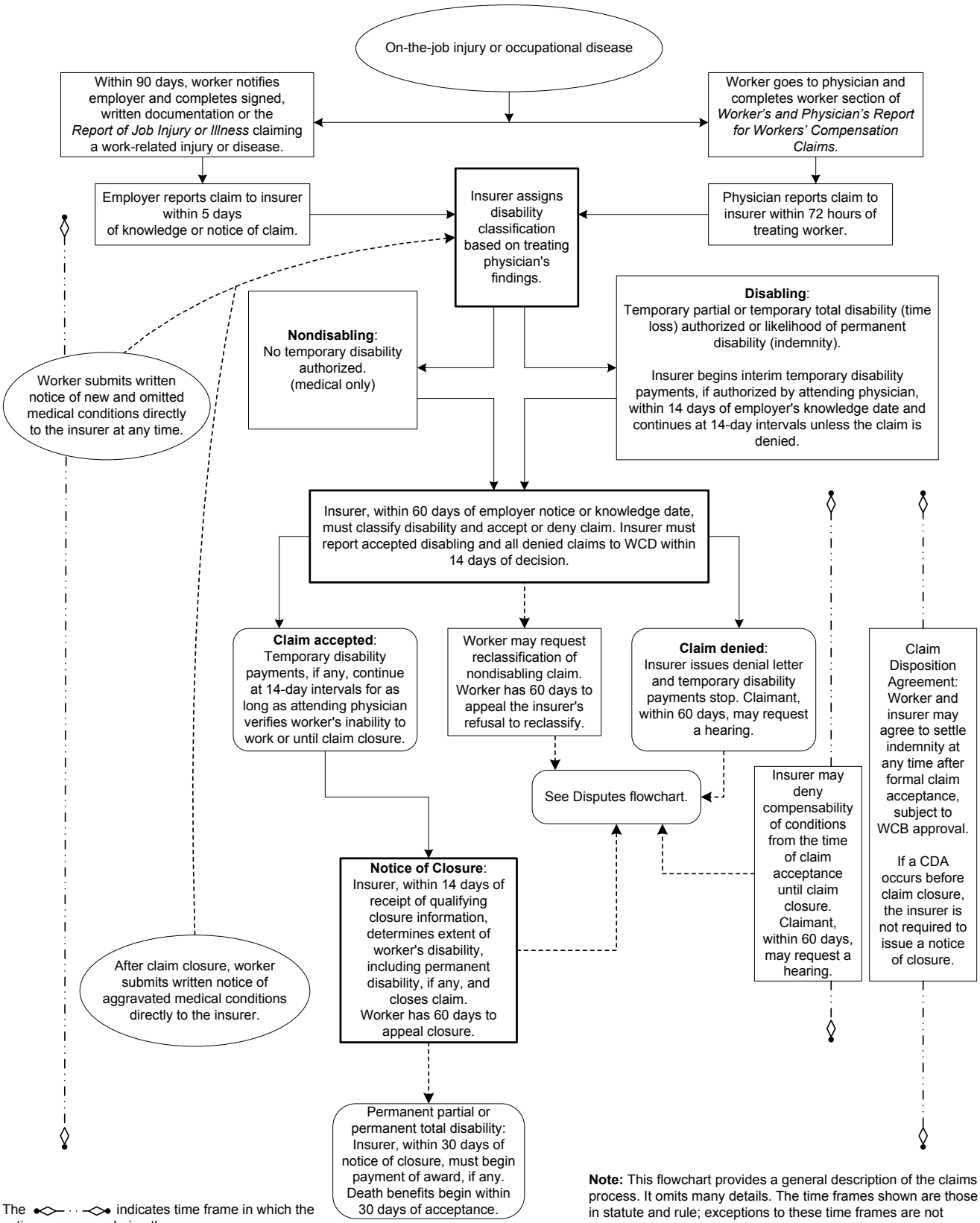
The 1997 Legislature passed HB 2971, which required insurers and self-insured employers to modify notices of acceptance when medical or other information changes a previously issued notice of acceptance. At the time of claim closure, insurers are also required to issue an updated notice of acceptance 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

Figure 5. Claims process flowchart



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.

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 2001, the standards for claims with dates of injury since Jan. 1, 2005, were changed to implement the new law. 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 means of a Claim Disposition Agreement (CDA). Since 1990, the percentage of initial claims resolved by CDA rather than claim closure has been trending upwards.

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 2011, there were 4,632 calls to the line. Of the callers, 2,714 were workers and 1,918 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 660 citations issued in 2011, below the 22-year average of 727 citations; assessed penalties totaled $369,500. Stipulated agreements, which may encompass various violations of rules and statutes under ORS Chapters 656 and 731 (workers' compensation and insurance law, respectively), and set up various performance expectations, are not included in these statistics.

The 1999 Legislature allocated funds to study the effects of the compensability language changes in SB 1197 and SB 369 on workers' compensation costs and worker benefits. The department contracted for a major study by leading academic researchers, which was completed in 2000. More detail on this study can be found in previous editions of this report (http://www4.cbs.state.or.us/ex/imd/external/reports/index.cfm?fuseaction=dir&ItemID=2000) or the study report itself (http://dcbs-reports.cbs.state.or.us/rpt/index.cfm?fuseaction=version_view&version_tk=175934&ProgID=CCRA024).

Smothers v. Gresham Transfer, Inc.

In May 2001, during the legislative session, the Oregon Supreme Court issued its decision in the *Smothers v. Gresham Transfer, Inc.* case. The court ruled that when a workers' compensation claim is denied for failure to prove that the work-related incident was the major contributing cause of the injury or condition, then the exclusive-remedy provisions implemented by SB 369 are unconstitutional. The court ruled that the statute violated Article 1, Section 10 of the Oregon Constitution, which guarantees every Oregonian "remedy by due course of law for injury done him in his person, property, or reputation."

The 2001 Legislature addressed this court decision by passing SB 485, which created a process for worker civil suits against employers. It also revised the definitions of pre-existing conditions and established that, while a worker continues to have the burden of proving that the claim is compensable, the employer has the burden of proof in showing that the compensable condition is not the major contributing cause of the need for treatment.

Although it was estimated that the *Smothers* decision could affect as many as 1,300 cases per year and cost up to $50 million per year, there have been no known cases in which workers have prevailed at trial; in a few cases workers have received settlements.