Disputes

The purpose of the Oregon workers' compensation system is to provide fair and timely benefits to injured workers. An impartial forum for the resolution of disputes is an important part of this system.

The Oregon system provides several methods through which disputes may be resolved. In these processes, workers, employers, insurers, and, in some instances, medical service providers have legal rights. Workers may contest denials and benefits, and insurers and employers may defend against claims and benefits believed to be unwarranted. Medical providers may raise issues about medical services and fees.

The Oregon workers' compensation system has evolved into a two-part dispute resolution system:

- The Workers' Compensation Board is an independent agency that receives administrative support from the Department of Consumer and Business Services. It has original jurisdiction on insurer claim denials and certain claims-processing issues, such as time loss and time-loss rate when the claim is open. It also hears appeals of cases decided by DCBS Workers' Compensation Division (WCD) administrative review — primarily the reconsideration of claims closures, medical services and vocational assistance disputes, and nonsubjectivity and noncomplying employer determinations. Hearings decisions can be appealed to board review, and then to the Court of Appeals. Court of Appeals decisions can be appealed to the Oregon Supreme Court, whose review is discretionary.
- The Workers' Compensation Division provides administrative review for many types of disputes. Within the Benefit Services Section, the Appellate Review Unit resolves disputes involving claim closures and classifications, and the Employment Services Team resolves vocational disputes. The Medical Section resolves medical disputes.

Lessons from the Oregon Workers' Compensation System: Dispute Resolution

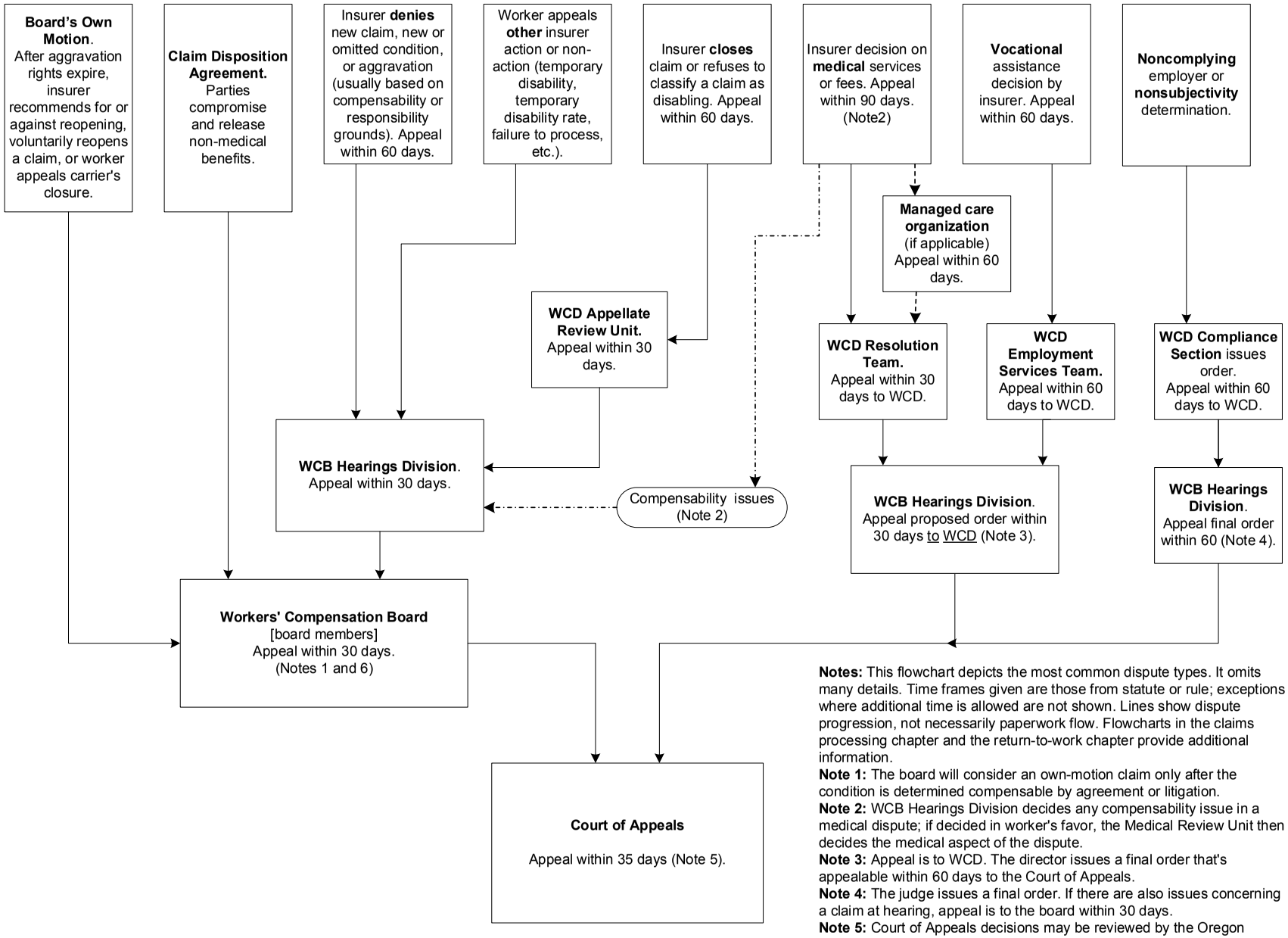
The Workers' Compensation Research Institute (WCRI) has recognized Oregon's workers' compensation system as a model that could provide lessons for other states. The study "Lessons from the Oregon Workers' Compensation System" provided four key lessons.

One of these lessons covers the system features that work together to increase certainty about the determination and payment of permanent partial disability (PPD) benefits and to reduce litigation over the benefit delivery. The goal is to resolve disputes swiftly, informally, and with a minimum of litigation. Following are the six key system features that increase certainty and reduce litigation:

- ***Reliance on the treating provider to offer the information needed to form the basis of an impairment rating*** when the worker reaches maximum medical improvement.
- ***Use of an Oregon-specific guide to rate permanent impairment***, thus allowing rating and compensation concepts to be consistent with Oregon statute and established case law.
- ***Use of objective criteria for assessing the factors affecting loss of earning capacity***, such as age, education, and occupation, in addition to permanent impairment, at all levels of decision-making.
- ***Active payer involvement in terminating TTD benefits and determining PPD benefits*** at initial claim closure.
- ***Use of a swift and mandatory mechanism for administrative dispute resolution (called reconsideration) to address objections to initial claim closure.*** The reconsideration process includes statutory time frames intended to avoid delays and is designed to minimize the need for attorney involvement on both sides.
- ***Use of a medical arbiter.*** Instead of parties spending resources on dueling experts, Oregon provides direct access to an impartial physician who is paid for by the insurer or self-insurer.

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**.

Figure 12. Disputes flowchart



The ------ and -·-·-·-·- lines indicate potential path of process.

Notes: This flowchart depicts the most common dispute types. It omits many details. Time frames given are those from statute or rule; exceptions where additional time is allowed are not shown. Lines show dispute progression, not necessarily paperwork flow. Flowcharts in the claims processing chapter and the return-to-work chapter provide additional information.

Note 1: The board will consider an own-motion claim only after the condition is determined compensable by agreement or litigation.

Note 2: WCB Hearings Division decides any compensability issue in a medical dispute; if decided in worker's favor, the Medical Review Unit then decides the medical aspect of the dispute.

Note 3: Appeal is to WCD. The director issues a final order that's appealable within 60 days to the Court of Appeals.

Note 4: The judge issues a final order. If there are also issues concerning a claim at hearing, appeal is to the board within 30 days.

Note 5: Court of Appeals decisions may be reviewed by the Oregon Supreme Court, but the high court's review is discretionary.

Note 6: Alternatively, the mediating administrative law judge may approve a CDA. Only CDA disapprovals are appealable to the courts.

The system, however, is more complex than the description above suggests. For instance, workers may have disputes in different venues at the same time; they may be disputing vocational assistance decisions while appealing PPD awards. In other cases, medical disputes may have two issues: whether the proposed treatment is related to the accepted conditions and whether it is reasonable and necessary. In such cases, after the WCB decides treatment is related to the accepted condition, the WCD Medical Review Unit decides on necessity or propriety. As another example, disputes with a managed care organization may begin with the MCO's review process and then go to WCD. Finally, the issue of insurer penalty for unreasonable conduct, and related attorney fees, may be heard by either WCD or WCB; WCD has original jurisdiction in proceedings involving *solely* these issues.

Reforming the dispute-resolution system

During the 1980s, there was a growing number of claims with disputes about the amount of permanent disability benefits payable to injured workers. Workers were requesting more hearings at the Workers' Compensation Board. Written standards or rules for determining permanent disability benefits had been available since 1980, but their use at hearings was optional. Parties presented their evidence at hearing and at further review by the Workers' Compensation Board and the courts. Dispute resolution was slow and inefficient.

In part to reduce litigation and speed up decisions, the Legislature enacted HB 2900 in 1987 and SB 1197 in 1990. HB 2900 reduced the time to request a hearing on a claim closure from one year to 180 days, required hearings to be scheduled for a date within 90 days of the request, required that orders be issued within 30 days of the hearing, and required that hearings be postponed only in extraordinary circumstances. It also required that the Hearings Division create an expedited claim service to informally resolve small claims for which compensability was not at issue. It required fact-finding about disability, emphasizing objective medical evidence, with the idea that uniform standards for permanent disability would reduce litigation. The bill also created the Office of the Ombudsman for Injured Workers, which reduces litigation by resolving complaints.

SB 1197 created new administrative review processes and provided for claim disposition agreements. Before 1990, there were voluntary administrative review processes to resolve disputes over claim closure and disability classification (disabling or nondisabling), but these processes were used infrequently. SB 1197 made the reconsideration processes mandatory. It also made the medical dispute process mandatory. Claim disposition agreements allowed workers to compromise and release claim benefits other than medical services, reducing litigation.

In 1995, SB 369 produced further changes. First, it restored to WCD jurisdiction over disputes involving proposed medical treatment. The Legislature also tightened the timelines in the reconsideration process, limited hearing issues to those that were raised at, or arose out of, the reconsideration, and limited evidence at hearings to that provided at reconsideration. For WCB, SB 369 allowed Hearings Division judges and the board to impose attorney sanctions for appeals that are frivolous, made in bad faith, or made for harassment purposes.

With SB 485, the 2001 Legislature addressed evidentiary concerns by providing for a worker deposition to be included as part of the reconsideration process. The insurer-paid deposition is limited to testimony and cross-examination about a worker's condition at closure. The bill also provided for a medical exam as part of a hearing on a compensability denial. In a denial case in which the worker's attending physician disagrees with the findings of an independent medical examiner, the worker can ask the WCD Benefit and Certifications Unit to select a physician to conduct a new independent exam. The insurer pays the costs of the exam and physician's report, which becomes part of the hearing record.

The appeal process has been changed frequently. With SB 369 in 1995, the Legislature transferred jurisdiction for appeals of vocational service dispute orders and most medical service dispute orders from the Workers' Compensation Board to the Workers' Compensation Division. Some reconsideration orders were also appealed to WCD. In 1998, however, a Court of Appeals decision, *James Jordan v. Brazier Forest Products*, determined that all Appellate Review Unit decisions were reconsideration orders and had to be appealed to the board. HB 2525 in 1999 created a centralized Hearing Officer Panel (later renamed the Office of

Administrative Hearings) and transferred WCD appeals to this panel. HB 2091 in 2005 transferred jurisdiction from the Hearing Officer Panel back to the Hearings Division of WCB. This dispute resolution process is unique: (1) The hearing request is made to WCD; (2) WCD refers the dispute to WCB; (3) the WCB judge sends to WCD a proposed and final order; (4) WCD issues a final order; and (5) appeal of the final order is made to WCD, but the Court of Appeals conducts the review (there is no board review).

Disputes resolved by the Workers' Compensation Division

Appellate review of claim closures and disability classifications

For injuries that have occurred since mid-1990, a party disputing a claim closure must seek departmental reconsideration before proceeding to hearing. If the extent of the worker's impairment is not disputed, the process must be completed in 18 working days. When impairment is disputed or medical information is insufficient to determine impairment, a medical arbiter is appointed to examine the worker, and an additional 60 days is allowed. No additional medical evidence may be used in subsequent litigation.

Since 1995, requests for appellate review have fallen — reconsideration requests have fallen much more than classification requests. The long-term trend of decreasing numbers of claim closures has contributed to this decline.

In 2001, insurers assumed total responsibility for claim closures, and the Legislature amended claims processing law. In 2003, SB 757 made changes in claim closure for workers injured in 2005, and HB 2408 in 2005 made changes in claim closure for workers injured in 2006. Despite the increased complexity of claim processing, disputes of closures and classifications have leveled off, as measured by the appellate review request rate. In 2009, 18 percent of closures were appealed.

There has been other legislation concerning the reconsideration process. In 2000, the Oregon Supreme Court (*Koskela v. Willamette Industries, Inc.*), in an exception to the evidence limitation, ruled that in permanent total disability cases, a worker must be allowed to testify about willingness to work and efforts to obtain employment. In response, SB 485 (2001) allowed for worker depositions to be included in the records of the reconsideration process. Through SB 285 in 2003, the Legislature permitted insurers to request reconsideration of their own notices of closure, in particular when they disagree with findings on impairment by attending physicians. In both 2008 and 2009, insurers requested reconsideration on about 150 of their notices of closure (143 and 166, respectively).

Nearly all appellate review orders are issued timely. The median time from request for review of claim closure to date of order issue was 66 days in 2009.

Appellate review orders may be appealed to the WCB Hearings Division. Overall, the trend for appealed orders is downward. In 2009, the rate was 22 percent, a near-record low. This trend is down considerably from the 50 percent appeal rates registered in the first years of administrative review of claim closures and disability classifications.

Medical disputes

The medical disputes process has been affected by court decisions, legislative changes, and process changes. Following the Court of Appeals' decision in *Jefferson v. Sam's Café* in 1993, the department lost jurisdiction over disputes involving proposed medical treatment. As a result, the number of requests fell sharply. SB 369 (1995) restored this jurisdiction, and the number of requests rose again. SB 369 also required that disputes concerning the actions of a managed care organization, regarding the provision of medical services, peer review, or utilization review, be handled through the medical dispute resolution process. In 2011, 9 percent of the requests concerned MCO issues.

With SB 728, the 1999 Legislature specified that the Hearings Division had jurisdiction over disputes concerning the compensability of the underlying medical condition or the causal relationship between the accepted condition and the medical service. Compensability issues are resolved before other medical issues, such as medical services or the appropriateness of treatment, are considered. Once compensability or causality is determined, a case is sent to the Medical Review Unit for resolution of the medical service dispute. Compensability cases represented just 4 percent of all 2011 medical dispute resolution requests.

In 2008, the number of requests nearly doubled to more than 3,300. This increase was due primarily to the initiation of the medical disputes alternative dispute resolution, which has proven very effective with medical fee disputes. Medical fee disputes jumped from 28 percent of all medical disputes issues in 2007 to 63 percent in 2008. Of the 2,214 dispute requests in 2011, 49 percent were medical fee disputes.

The medical dispute process differs from many of the other dispute processes; the injured worker may not be directly involved in the dispute. In 2011, 62 percent of the medical dispute requests were from medical providers; most requests concerned fee disputes and disagreements between the provider and insurer about services to which the injured worker may have been entitled.

With the implementation of HB 2091 in 2005, medical dispute orders could be appealed to the WCB Hearings Division; 6 percent were appealed in 2011.

Vocational assistance disputes

The Employment Services Team strives to resolve vocational disputes by mediating agreements between the parties. When agreement is not possible, EST issues an administrative review order.

The number of requests for vocational-dispute resolution has been stable during the past four years. There had been a decline before this period. Most of the long-term decline has resulted from the decline in the number of eligibility determinations for vocational assistance. About 20 percent of vocational eligibility determinations have had a vocational dispute. Most disputes follow an insurer's denial of eligibility for vocational assistance; other disputes concern vocational training programs, the quality of professional services, or worker purchases.

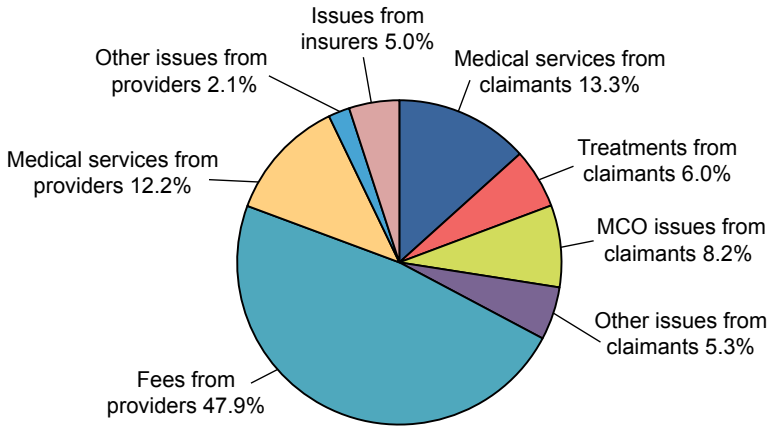
In 2009, 26 percent of the vocational disputes were resolved through agreement. Another 39 percent were dismissed, often due to a claim disposition agreement; remaining resolutions required a formal administrative order. The insurer prevailed in about 64 percent of those orders. With HB 2091, jurisdiction for appeals of these orders was returned to the WCB Hearings Division. During the past five years, about 14 percent of vocational dispute review orders, including orders of dismissal, were appealed.

About 93 percent of vocational disputes were resolved timely, as measured by a nonstatutory standard of 60 days. The median number of days from request for review of vocational assistance to date of resolution was 41 in 2009.

Disputes resolved at the Workers' Compensation Board

The Workers' Compensation Board's Hearings Division provides a forum for timely and impartial dispute resolution. In hearings conducted by administrative law judges (ALJs), parties have an opportunity to present their case. They have the right to be represented by counsel, to have a qualified interpreter, to present

Figure 13. Medical disputes, by issue and requester, CY 2011



evidence (lay and expert witnesses, personal testimony, medical and vocational reports, etc.), to compel testimony by subpoena and under oath, to receive pre-hearing disclosure of evidence, to present argument on issues of fact and of law, to provide cross-examination and impeachment evidence, to have the hearing postponed or continued, to have the hearing at a location not distant from the worker's home, and to request reconsideration of an order and appeal the order.

The Board Review Division hears appeals of ALJ orders, decides board own-motion cases (reopenings or additional benefits after aggravation rights have expired), approves claim disposition agreements, hears appeals of Department of Justice decisions in the crime victim assistance program, and resolves third-party disputes (distribution of proceeds from a liable third party, between insurer and worker). The board is composed of five governor-appointed members: the chair, two members selected because of their background and understanding of employer concerns, and two members with background and understanding of employee concerns. Appeals are heard by at least one "worker" member and one "employer" member.

Hearing requests

There were about 7,600 hearing requests in 2011. The number of requests dropped substantially in the early 1990s; in recent years, the number of requests has declined by about 3 percent per year. The primary reasons for the decline are fewer accepted disabling claims and legislative changes.

The creation of the reconsideration process by SB 1197 (1990) reduced hearing requests and resulted in a shift in the issues involved. Permanent disability dropped from being an issue in 32 percent of hearing orders in 1989 to 18 percent in 1991. This percentage has continued to drop, and was less than 3 percent in 2011.

SB 369 (1995) also reduced litigation by requiring that workers believing that a condition has been omitted from a notice of acceptance must notify the insurer and not allege a de facto denial in a hearing request.

In 2011, the most common issue at hearings was partial denial, which was at issue in more than 47 percent of hearing orders. Most post-acceptance compensability disputes that don't involve aggravation of the accepted condition are classified as "partial denial." The Legislature specifically provided for major-contributing-cause denials in SB 369.

The median request-to-order time lag for hearings was 127 days in 2011, while the median request-to-order lag for board review was 189 days. The median lag for 2011 Court of Appeals decisions was a record-high 586 days (1.6 years).

Mediation

Since 1996, the board has offered trained administrative law judge mediators and facilities, at no cost, to help settle disputes without formal litigation. Historically, the mediators completed about 250 mediations per year; this number was greater than 400 for 2011. This increase is in part due to a change in how mediations are counted. Most mediated cases deal with complex issues: mental stress claims, occupational disease claims, claims about permanent total disability, and claims with additional issues such as employment rights or other civil actions (tort, contract, etc.). Adding to that complexity, the average mediation deals with 1.2 hearing requests. About 90 percent of 2011 mediations resulted in settlement.

The board also has an agreement with the Court of Appeals to mediate cases pending before the court.

Appeal rates

The appeal rate of reconsideration orders has dropped from 53 percent in 1992 to 19 percent in 2011. The appeal rate of hearings orders has been declining slowly, from 12 percent in 1997 to less than 8 percent in 2011. The appeal rate of board-review orders dropped from 30 percent in 1987 to 13 percent the next year, mostly in response to HB 2900 (1987), which changed the court review standard from de novo to "substantial evidence." In the past seven years, board appeal rates have ranged between 12 percent and 15 percent.

Law changes may temporarily increase appeal rates, as new and sometimes precedent-setting reform issues arise and decisions are appealed.

Claim disposition agreements

In 1990, SB 1197 allowed workers to release their rights to claim benefits other than medical services in claim disposition agreements (CDAs). In 1995, SB 369

prohibited the release of preferred worker benefits. Since 1991, the board has approved an average of about 3,200 CDAs per year. There were 3,180 CDAs in 2011, and the average agreement was more than $20,800. CDAs significantly reduce subsequent litigation because workers relinquish rights for most benefits. Return-to-work studies show that workers who negotiate CDAs often have difficulty returning to work.

Claimant attorney fees

Fees are awarded to claimant attorneys for (1) getting a reversal of a claim or benefits denial, (2) getting an increase in indemnity benefits, (3) preventing a decrease in indemnity benefits, (4) getting a penalty against the insurer, and (5) negotiating a disputed claim settlement or claim disposition agreement. Fees for (1), (3), and (4) are assessed against insurers, while the others come out of award increases or settlement proceeds.

The 1990 law change limited penalty-related attorney fees to half of the penalty amount. Via SB 369, the 1995 Legislature made three changes that further reduced attorney fees. It limited fees in responsibility disputes, prohibited the Hearings Division from awarding penalties and fees for matters arising under the director's jurisdiction, and limited fees for the reversal of a denial to cases where the denial is based on the compensability of the underlying condition.

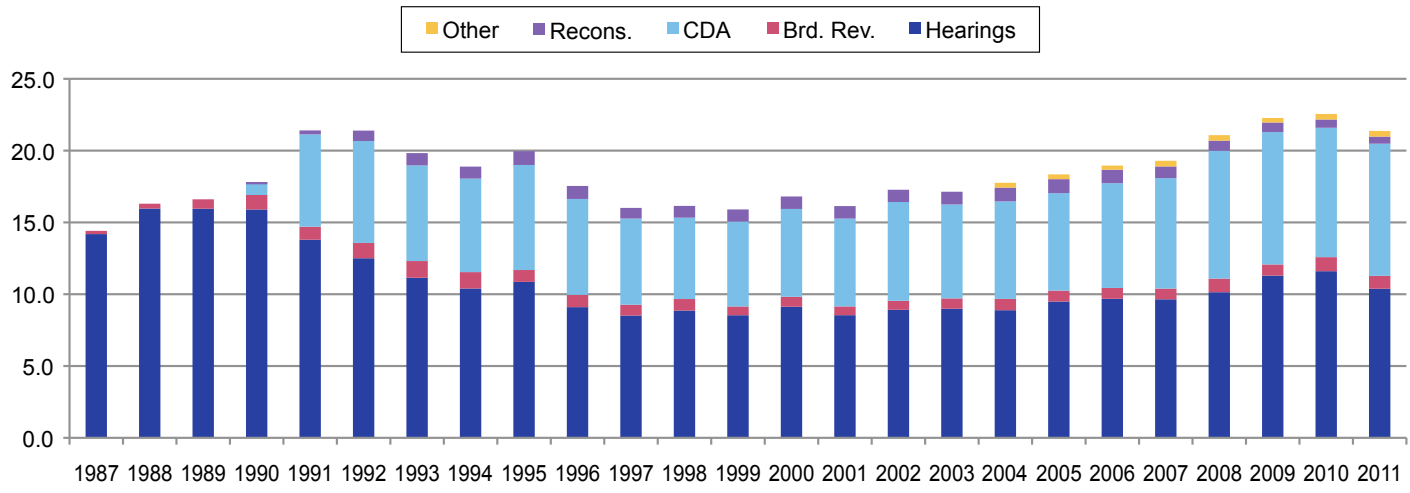
In 1999, for the first time in more than 11 years, the board changed its rules to increase fees allowed in disputed claim settlements, CDAs, and orders increasing disability awards.

With SB 620 in 2003, the Legislature reversed the 1990 law change by providing for penalty-related attorney fees proportional to the benefit, and limiting them, except in extraordinary circumstances, to $2,000. It also required a fee when a dispute is settled prior to a contested-case hearing.

Total claimant attorney fees reached a high of $22.6 million in 2010. Fees in 2011 totaled more than $21.4 million, included $494,000 at reconsideration, $10.382 million at hearing, $900,000 at board review, and $9.2 million for CDAs. Lump-sum settlements (CDAs and disputed claim settlements) have accounted for a growing share of total claimant attorney fees, rising to 70 percent of all claimant attorney fees in 2011.

In 2007, SB 404 made two additions to assist claimants and their attorneys in recovering costs and fees. First, it allows an administrative law judge to order payment for a claimant's reasonable expenses and costs for records, expert opinions, and witness fees. Second, if an injured worker signs an attorney fee agreement,

Figure 14. Claimant attorney fees, 1987-2011



and the attorney was instrumental in obtaining additional compensation or settling a worker's claim, the administrative law judge may grant the attorney a lien on additional compensation or proceeds from a settlement.

HB 3345, effective January 2010, increased maximum attorney fees allowed in disputes about insurer penalty, responsibility, and medical and vocational services. It also allowed attorney fees in areas for which they weren't provided for earlier (late-paid disputed claim settlement, affirming closure rescission, preventing a reduction of reconsideration awards, and appeal of classification orders), but these provisions were not expected to greatly increase total claimant attorney fees.

Board own motion

Legislation in 1987 limited worker benefits under own-motion authority to time-loss and medical services. In SB 485, the 2001 Legislature expanded benefits by providing for reopenings for treatment provided in lieu of hospitalization to enable return to work, permitting claims for new or omitted medical conditions after aggravation rights have expired, and allowing permanent disability awards in new or omitted medical condition cases.

Total own-motion orders peaked in 1991, and then decreased steadily to 243 orders in 2002. SB 485, passed in 2001, led to a doubling of the number of orders. The number of own-motion orders declined again after a 2005 law change (HB 2294).