February 25, 2021

To: Keith Semple, Oregon Trial Lawyers Association
Management-Labor Advisory Committee

From: Sally Coen, Administrator

Subject: Workers' compensation claim document retention requirements

At the February 19 MLAC meeting, we were asked to provide more information about the claim document retention requirements for insurers and self-insured employers.

The division does not receive or keep a full copy of the worker's claim record. The documents we do get are reports of accepted disabling claims, fatality claims, and all denied claims, as well as information related to disputes under the division's jurisdiction (e.g., medical, vocational, reconsideration, return to work). In 2001, we adopted rules to require insurers and self-insured employers to keep claim records until "all potential for benefits to the injured worker is gone." Bulletin 329 effective March 24, 2003 explains the requirements.

For the documents that are reported to the division, we follow the Oregon State Archives record retention schedule (Number 2015-0013(193) effective April 2017):

- Retain fatal claims and permanent total disability claims 99 years after the record closure date, destroy
- Retain Workers with Disabilities Program claims 75 years after the record closure date, destroy
- Retain denied claims without litigation 6 months, destroy
- Except as otherwise specified in the special schedule, retain all other Workers' Compensation Claims Files 10 years after the record closure date, destroy

**Insurer and self-insured employer claim document retention requirements**

There are a number of statutes and rules that govern the retention of claim documents by insurers and self-insured employers. The current law is listed below. Note that both of the statutes cited are also in HB 2039, our proposal to address insurer claim processing practices such as telework and offsite record storage.

**ORS 731.475** requires insurers to keep complete claim records and that the records must be available to the department for examination and audit at all reasonable times upon notice.

**ORS 656.455** requires self-insured employers to keep complete claim records and that the records must be available to the department for examination and audit at all reasonable times upon notice.

**OAR 436-050-0120(1)** specifies the claims records insurers must keep in Oregon and that the insurer is required to make those records available to the director upon request, including:

- Written records used and relied upon in processing claims;
- Written record of all payments made as a result of any claim including documentation of payment amounts, date issued, and date mailed.
- Written records of the approval or denial of claims
- Written records, or copies of records, of claims processed by prior service companies

**OAR 436-050-0120(2)** states that an insurer may remove the following records from Oregon, under the following conditions:

- For denied claim records, after all the appellate procedures have been exhausted and the denial is final by operation of law; and
- For accepted claims, including a denied claim that is found to be compensable, after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

**OAR 436-050-0120(3)** states that the insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker's beneficiaries is gone.

**OAR 436-050-0220(1)** describes the types of records the self-insured employer must keep, including:

- Payroll records
- Complete records of all assessments, employer and employee contributions, and all such money due the director;
- Written records relating to its safety and health program
- Written records used and relied upon in processing claims;
- Written record of all payments made as a result of any claim including documentation of payment amounts, date issued, and date mailed.
- Written records of the approval or denial of claims
- Written records, or copies of records, of claims processed by prior service companies
- Written records of all reimbursements and recoveries received on each claim

**OAR 436-050-0220(2)** states that a self-insured employer may remove the following records from Oregon, under the following conditions:

- For denied claims, after all the appellate procedures have been exhausted and the denial is final by operation of law.
- For accepted claims, including a denied claim that is found to be compensable, after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.
- If administrative or judicial review is requested, the claim records may not be removed from this state or disposed of until the review is concluded and the time for an appeal from such review has expired, or at least one year after final payment of compensation has been made, whichever is the last to occur.

**OAR 436-050-0220(3)** states that the self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker's beneficiaries is gone.

**Requesting claim documents from the insurer or self-insured employer**

There are rules relating to the request by workers or their representatives to request claim records from insurers or self-insured employers. Failure to follow these rules may result in civil penalties.

**OAR 436-060-0017(3)** requires the insurer or service company must provide, without charge, legible copies of documents in its possession relating to a claim, upon request of the worker, worker's attorney, worker's beneficiary, or beneficiary's attorney at times other than those provided for under ORS 656.268 and OAR chapter 438.

**OAR 436-060-0017(1)** "Documents" means the written records making up, or relating to, the worker's claim, including but not limited to:

- Medical records;
- Vocational records;
- Payment ledgers for both temporary disability and medical services;
- Payroll records;
- Recorded statements;
- Insurer generated records, excluding a claims examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications;
- All forms on the claim filed with the director;
- Notices of closure; and
- Electronic transmissions and correspondence between the insurer, service providers, worker, director, or board.

**OAR 436-060-0017(4)** requires that the insurer must provide copies of documents requested within the following time frames:

- For unarchived files, documents must be mailed within 14 days of receipt of a request;
- For archived files, documents must be mailed within 30 days of receipt of a request;
- If a claim is lost or has been destroyed, the insurer must so notify the requester in writing within 14 days of receiving the request for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice; and if the insurer does not possess any documents at the time the request is received:
    - The insurer must mail any documents relating to the claim it receives to the requestor within 14 days of receipt of the documents; and
    - The request will be considered ongoing for 90 days.

**OAR 436-060-0017(5)** states that complaints about a violation of the rules regarding release of requested claims documents must be made in writing and mailed or delivered to the division within 180 days of the request for documents.

- When notified by the director that a complaint has been filed, the insurer must mail or deliver a written response to the director within 14 days of the mailing date of the director's inquiry letter. A copy of the response, including any attachments, must be simultaneously mailed to the requester of claim documents.
- If the director does not receive a timely response or the insurer provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty against the insurer. Assessment of a penalty does not relieve the insurer of its obligation to provide a response.