LC 696: Quality Care for Injured Workers

Four Emerging Crises

Injured workers are on the front line when it comes to changes in the workers' comp system, the proverbial canaries in the mineshaft. Because of recent court interpretations of the law, they are experiencing new barriers to the quality care needed to get back on the job.

A. If the original diagnosis is incomplete, the insurer should pay for additional tests to determine the extent of the injury. (p. 3)

If a worker bruises their knee on the job, and the insurer accepts the bruise, current law allows the insurer to deny testing to determine whether a ligament has been torn because the torn ligament is not an accepted condition.

B. The severity of the injury event should always be considered in evaluating the insurer's responsibility for the resulting conditions. (p. 3)

If an insurer denies a claim because a pre-existing condition is the major cause of the worker's need for treatment, the severity of the injury event is compared to that of the pre-existing condition. If the insurer accepts and later denies a combination between a compensable condition and a pre-existing condition, the severity of the injury is not weighed. The analysis should be the same in both situations.

C. A worker's immutable characteristics (age, sex, disability, race, etc) are not pre-existing conditions (PEC). (p. 7, 44-45, 49, 79)

Women are pre-disposed to having narrower wrists. Narrow wrists may pre-dispose a woman to carpal tunnel syndrome. A woman should not be denied workers' comp benefits if the only other cause of her carpel tunnel syndrome is her repetitive work activity. This is discrimination pure and simple. LC 696 addresses this by clarifying that immutable characteristics are not pre-existing conditions. This change also helps older workers. Current law allows the insurer to treat normal age-related arthritic changes as a pre-existing condition, even when they have never been limited by those changes. Older workers should not be required to prove their claim to a higher standard just because of normal age related changes to their physiology. Another option is to eliminate the heightened burden of proof for pre-existing conditions altogether and restore the burden of proof to what it is in civil court that workers' compensation was designed to substitute for. It is notable that health insurers are no longer allowed to deny coverage for pre-existing conditions. Workers' compensation should be moving in the same direction.

D. If a worker requests that a condition be added to their claim, and the insurer denies the request, the worker should only be required to prove the existence of the condition with reasonable specificity. (p.49-50)

If 10 doctors examine an injured worker's back and 6 call the ailment a disc herniation and 4 call it a disc protrusion, benefits should not be denied because of a distinction in terminology that reasonably refers to the same condition.

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Six Smaller Yet Important Changes

Workers and insurers should be subject to the same deadlines for correcting issues with time loss payments. (not in current draft) Workers should be able to rely on the insurer's calculations of their lost wage payments, and should not be surprised by reductions in their compensation for large overpayments that are discovered by the insurer long after the payments were issued. Our concept would provide a deadline for insurers to discover and correct overpayments so they do not continue to accrue into a large amount and so the worker can promptly correct any deficiencies in the restrictions.

Workers should be allowed to collect lost wages while the insurer is in the process of evaluating their permanent impairment. (p. 52-53, 64-65) Current law allows insurers to deduct any lost wages paid past the date of maximum improvement from future compensation. If the doctor says in hindsight the worker actually reached maximum improvement months before making that declaration, the worker suffers a large overpayment which is recovered from their permanent impairment compensation. Under our concept this would not be permitted.

Workers should be notified before payments of lost wages are cut off. (p.40-42) Current law does not require insurers to notify the worker that their next wage loss check will not be issued or provide a reason in advance. The worker may first learn there is an issue when the check for lost wages does not appear. This simple requirement would allow workers correct any deficiencies before payments are withheld, or plan for the loss of needed income before it suddenly occurs.

Insurers should have incentives to make settlement payments on time. (p. 21) Current law allows an unsuspecting worker to waive penalties for late payment of their settlement. These penalties should not be waivable.

Insurers should be required to respond to pre-authorization requests for medical treatment. (p. 24, 35) Current law provides no deadline for general medical services, leaving clinicians and workers in limbo. LC 696 proposes a 14-day deadline.

Workers should be re-evaluated for Permanent Disability Compensation after vocational rehabilitation. (p. 61) If a motivated worker seeks job re-training, but ultimately fails to regain job skills, they should be given the option to seek Permanent Total Disability compensation when the training ends.

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Larger Consideration

The meaning of "compensable injury" should be clear. (p. 3) Recent court rulings underscore a big problem with the workers' comp statutes. The word "injury" is used throughout the statute, but it is not clear whether this refers to an event or a medical condition. This ambiguity is generating major changes from the courts that harm injured workers. It should be clarified that "compensable injury" refers to a compensable event.

Workers should have a level playing field with independent medical exams. (p. 82-83) Current law allows the insurer to request three independent medical exams in virtually any dispute over benefits. All exams conducted within a 72-hour period count as one exam! The insurance companies have access to a bevy of specialists they contract with repeatedly. Under current law, the worker may be eligible for one exam (not 3) to respond to the reports prepared for the insurer, but the worker does not get to choose the clinician for the additional exam. LC 696 levels the playing field by allowing the worker to choose the clinician and to get the same number of exams as the insurer.

Workers should be able to negotiate settlements of Own Motion Benefits. (p. 21) Current law does not require the insurer to pay certain benefits on older claims, the benefits are paid by the Workers Benefit Fund (WBF). This includes cost of living increases on Permanent Total Disability and Death benefits. The WBF is not allowed to negotiate a settlement of their prospective obligations. They should be required to participate in such negotiations.

Workers should have due process in evaluating their permanent impairment. (51, 59-61, 71-74, 78) Current law does not provide adequate process for the worker to challenge the conclusions of a medical arbiter that provides an opinion regarding the amount of impairment. Our concept would provide that process and limit the number of arbiters that can be assigned to a given case.

Workers should receive compensation for impairment caused in material part by the injury event. (p. 17, 21, 51, 63) Current law allows insurers to reduce a worker's impairment compensation if a doctor attributes part of the impairment to a pre-existing condition, even if that is the first reference to such a condition. Our concept would provide compensation when the injury is a material factor in causing the impairment. This is in line with the standard for other benefits. The insurers cannot apportion doctor bills or wage loss in this manner.

In a dispute over time loss calculations, employers should be expected to produce the wage records. (p. 81) If a worker and an employer are in dispute over wages that the employer did not document, the worker's testimony should receive more weight.

HB 3022: Quality Care for Injured Workers

Worker Stories

Junction City woman denied testing for conditions excluded from original claim

A Junction City forklift driver injured her low back at work, which also caused pain in her leg. She was diagnosed with a herniated disc, disc protrusion and tears in the fibers around her disc. The workers compensation insurer, however, accepted the claim for a lumbosacral (or back) strain and refuses to pay for diagnostic injections because they would determine the extent of the claimant's disc problems, which are the ailment, rather than the strain, which is what the insurer accepted.

Lane County police officer denied her benefits because of asymptomatic pre-existing condition

A female police officer in Lane County was injured while taking an under-the-influence arrestee to jail. The person being arrested instigated a fight, and her knee was injured when an audible "pop" was heard. Prior to the fight, she had pre-existing arthritis in her knee, but was able to engage in activities like long distance running. Her request for surgery recommended by her doctor to treat the ailment was denied on the basis that surgery was for pre-existing arthritis.

Older workers face discrimination because the normal health of an older worker is considered a pre-existing condition

A 60-year old medical records director from Springfield injured her knee and shoulder at work. A needed shoulder surgery was delayed because the insurer claimed the need for surgery was arthritis, which had no previous symptoms, rather than the workplace accident.

A 76-year old Eugene man who worked on-call at a cemetery in Lane County was called in to work to move a container with a body. While lifting the container, he injured his shoulder – his coworkers heard an audible pop. He underwent shoulder surgery, but his workers' compensation claim was denied on the basis of pre-existing age-related degenerative change in his shoulder along, with pre-existing age-related arthritis.

An Astoria man was doing maintenance in a restaurant in Clatsop County when he fell at work, injuring his back, and required low back surgery. His workers' compensation insurer denied his claim, saying that the major cause for surgery was a degenerative condition that had no previous symptoms, rather than the fall. He was unable to get medical care and is now living with this disability.

Worksite event triggers asymptomatic back disease. Worker cut off from care.

A laborer at a farm supply company based in Yamhill County hurt his back on the job. The event on the job was serious enough to severely strain his back and to trigger previously existing but asymptomatic spondylolithesis - slippage of the vertebrae. As a result, this low-wage worker had nerve damage in his back that he had never experienced before. The insurer paid until the strain went away but now the worker is suffering from the nerve damage and has no way to pay for treatment.

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