SATHER BYERLY & HOLLOWAY LLP
ATTORNEYS

KEVIN J. ANDERSON
Licensed in Oregon
Direct Dial: 503.595.2130
kanderson@sbhlegal.com

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Theresa Van Winkle
MLAC Administrator
theresa.a.vanwinkle@oregon.gov

Re: Response to OTLA Time Loss Issues

Dear MLAC Members:

In response to the Oregon Trial Attorney Associations August 5, 2019 letter regarding timeloss issues I have drafted a response on behalf of our firm. We represent employers, self-insured employers, insurers, and third-party administrators.

1. Workers and insurers should be subject to the same deadlines for correcting issues with time loss payments.

RESPONSE: We do not agree a deadline is needed as there is no equitable basis to prevent the insurer or administrator from correcting claim mistakes or recovering benefits that do not rightfully belong to the worker. The insurer is already limited in recovering these benefits from potential future benefits as opposed to directly collecting them from the worker. There is currently no requirement that an insurer or administrator run its own audit of temporary disability benefits and often such a review cannot be completed until the claim has been closed and all litigation has resolved. These reviews are useful though in identifying both over and underpayments to injured workers. Insurers are also already incentivized to conduct these reviews as the auditing process from the WCD can penalize the insurers for both under- and over-payments of benefits to the worker. ORS 656.319(6) currently provides a two year limitation for a worker to file a hearing request regarding a failure to process a claim or allege that a claim was improperly processed. If a deadline is considered, we would suggest two years consistent with the insurers' exposure for correcting mistakes for claim processing issues.

2. Workers should be allowed to collect lost wages while the insurer is in the process of evaluating their permanent impairment.

RESPONSE: There has been significant litigation regarding post-medically stationary timeloss payments. Our current system requires the insurer to continue paying benefits until the claim is closed and permanent disability payments take the place of temporary disability benefits. This allows the worker to continue to receive temporary benefits until the closure documents can actually issue. Insurers must close a claim within 14 days of confirming medically stationary status and obtaining sufficient information to close a claim. OAR 436-0030-0020. Insurers have 10 days to close (or refuse to close) if the worker requests claim closure. OAR 436-030-0017. There is no incentive for an insurer to continue paying temporary disability benefits and leaving the claim open just to generate an overpayment, which may or may not be recoverable.

There are instances of an attending physician saying in hindsight the worker was stationary. Many attending physicians will release the worker back to regular duty on a trial basis and instruct the worker to return for a closing examination. If the worker fails to see the doctor, the doctor can make the determination claimant was stationary when they last examined claimant. The ARU would likely find insufficient information for medically stationary status if the doctor declared claimant stationary without that stationary date being tied to an examination. Similarly, if the ARU rescinded a closure for insufficient impairment findings, the attending physician can provide that missing information without it affecting their opinion on the medically stationary date. The worker could receive temporary disability benefits while the insurer re-closes the claim, but would presumably be precluded from recovering these post-stationary payments.

Attending physicians will also monitor claimant's recovery and conclude that due to a lack of improvement, claimant was in fact stationary a while ago. In both of these circumstances, it is a medical determination of when the worker became stationary not a legal determination. Precluding the insurer from recovering post-medically stationary temporary disability payments allows the worker a double-recovery with permanent disability benefits.

3. Workers should be notified before payments of lost wages are cut off.

RESPONSE: Many insurers and third-party administrators already do this. Imposing a requirement that a notice be issued only encourages litigation over the procedural issues of sending the notice without any substantive benefit to the worker. Additionally, all notices the insurer is required to send to the worker are currently sent by mail. Adding a notice requirement would likely delay claims processing and benefit payments without encouraging the claims adjuster and the worker to work together to address any lapses in benefits.

4. Insurers should have incentives to make settlement payments on time.

RESPONSE: OAR 436-060-0150(10) states CDA payments must be made within 14 days of the board approving the settlement. There is no administrative rule specifically stating when the DCS proceeds are due, but OAR 436-060-0400(1) allows for penalties and fees to be paid if the insurer does not pay the DCS proceeds within five days of being notified by the worker the benefits are late. The majority of benefits in our system are due within 14 days of a WCB order becoming final. We would support clarity on the subject of when settlement payments are due before considering imposing penalties for not following unclear processing rules. If the worker is already represented, their attorney should know to look for this issue.

5. In a dispute over time loss calculations, employers should be expected to produce the wage records.

RESPONSE: As the party initiating a dispute of average weekly wage calculations, the worker has the burden of proof to show an error in the calculation. The worker is allowed to request wage records under OAR 438-007-0015 and pursue penalties for the insurer's failure to provide the requested records. Employers routinely provide this information even before a discovery request is made. Employers are already required to keep this information under various employment statutes and employees are allowed to request those records (FLSA, ORS 653.045, ORS 652.720). Additionally, a judge is already permitted to find claimant's testimony at hearing more persuasive than records not contained in evidence. It is not clear from OTLA's issue statement what new remedy is required in light of the current requirements.

RECOMMENDATIONS

Generally, if the issue is regarding timely correcting temporary disability issues, we would support a mechanism of review similar to a reclassification dispute. If a worker believes their benefits are incorrectly calculated and provides the insurer new information to correct that mistake, the insurer could be allowed a 14 day period to review the request and make the necessary corrections without risk of penalties and fees. If the insurer refuses to make the correction, the worker would still be able to file a hearing request to litigate the issue. This would encourage the parties to identify issues early so they can be corrected sooner without fees/penalties driving unnecessary litigation.

Also, while addressing temporary disability issues, we would like to see a discussion about having a worker's ability return to work (temporarily or permanently) be based on a preponderance of the evidence with deference given to the attending physician. Currently, an attending can provide restrictions without any medical basis for their opinion. An insurer can request an arbiter to review permanent impairment, but they are precluded from challenging the worker's

ability to actually return to work. Our current rules allow for a medically stationary status determination to be made based on a preponderance of the evidence.

Thank you for your consideration. I plan on attending the meeting on October 11th and look forward to a discussion on these issues.

Sincerely,

Kevin J. Anderson

KJA: