



Workers' Compensation Claim Compensability and Denial, Oregon, Fiscal Years 1989-1997

Research & Analysis Section

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In 1986, Oregon ranked sixth highest in the nation in the average workers' compensation premium rates paid by employers, and it had one of the nation's highest occupational injury and illness claims frequencies. Medical and permanent disability costs for injured workers in Oregon were among the highest in the nation, while benefits were considered among the lowest. During the 1987 legislative session, major reform legislation was enacted in HB 2900 and HB 2271 to improve what seemed to be an ineffective workers' compensation system. Three years later, Oregon's premium rate ranking had improved a little but left much room for improvement. Workers' compensation costs were still considered an urgent problem and many small employer policies were being canceled.

These conditions provided the impetus for further reform efforts culminating in the passage of SB 1197 and SB 1198 during a special session of the Oregon Legislature in May 1990. Several refinements to the reforms were enacted during the 1991 and 1993 legislative sessions.

**Figure 1. Workers' compensation claim counts,
Oregon, FY 1989-97**

Fiscal year	Accepted disabling	Denied disabling	Denied nondisabling
1989	40,515	6,640	8,022
1990	35,918	9,534	10,551
1991	31,156	8,024	12,426
1992	28,577	7,522	12,930
1993	29,125	6,013	13,414
1994	29,733	6,232	13,254
1995	29,725	6,494	13,417
1996	27,240	5,764	14,276
1997	26,785	5,337	14,884

Notes: Disabling claims are those that result in more than three days of time loss, inpatient hospitalization, permanent disability, or death. Accepted nondisabling claims are not reported to the department. The acceptance status is the original claim status.

In 1994 and 1995 several court decisions lessened the impact of some reform provisions. The 1995 Legislature passed SB 369, which brought further significant changes in the workers' compensation system and adopted increases in benefits. It also restated the legislative intent of those provisions questioned by the earlier court decisions.

Compensability

One purpose of a no-fault workers' compensation system is to fairly compensate injured workers only for work-related claims. Restricting claims to those that are work-related reduces the costs to the workers' compensation system. Oregon's reforms tightened the requirements for establishing that an injury, disease, or aggravation claim is work-related. The reforms covering compensability are summarized in Figure 2.

HB 2271 had two major sections that involved compensability. One section stated explicitly that the worker has the burden of proof of showing that an injury is compensable and of showing the extent of the disability. The other section restricted mental stress claims to those arising out of employment conditions not generally inherent in every working situation and for which there was "clear and convincing evidence" that the mental disorder arose out of and in the course of employment. In part because of this change, the acceptance rate of disabling stress claims fell sharply, from 32 percent of disabling stress claims in CY 1986 to 14 percent in CY 1989. The acceptance rate of mental stress claims has remained about 13 percent throughout the 1990s.

With SB 1197, the legislature spelled out more explicitly that only work-related injuries and conditions were compensable. Injuries from recreational and social activities were excluded. Also, injuries which arose from the use of alcohol or drugs were excluded when proven by clear and convincing evidence that the drug or alcohol was the major contributing cause.

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**Figure 2. Oregon workers' compensation reform legislation
involving compensability**

1987 legislative session - HB 2271

656.266 Placed on the worker the burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability. The worker cannot prove compensability simply by disproving other explanations.

656.802 (3) Restricted mental stress claims only to those arising out of real and objective employment conditions not generally inherent in every working situation and required "clear and convincing evidence" that the mental disorder arose out of and in the course of employment.

1990 special session - SB 1197

656.005 (7) Redefined compensable injury to require that it be established by medical evidence supported by objective findings. In addition, the compensable injury must be the major contributing cause of a consequential condition. If the compensable injury combines with a preexisting condition, the resultant condition is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment. Excluded injuries from recreational and social activities; excluded injuries which arose from the use of alcohol or drugs if it is proven by clear and convincing evidence that the drug or alcohol use was the major contributing cause.

656.262 (6) Allowed insurers to deny a previously accepted claim at any time up to two years from the date of claim acceptance if the claim is accepted in good faith but is later determined not to be compensable or that the insurer is not responsible for the claim.

656.273 Required that claims for aggravation be established by medical evidence supported by objective medical findings that the worsened condition resulted from the original injury.

656.308 Specified that when a worker sustains a compensable injury the responsible employer shall remain responsible for future aggravations unless the worker sustains a new compensable injury involving the same condition.

656.802 (1) and (2) Changed the definition of occupational disease, provided that compensable diseases must be caused by substances or activities to which an employee is not ordinarily subjected or exposed, and stated that the employment be the major contributing cause. The existence of the disease must be established by medical evidence supported by objective findings.

Figure 2, continued. Oregon workers' compensation reform legislation involving compensability

1995 legislative session - SB 369

656.005 (7)(a)(B) Decreed that a combined condition was compensable only as long as and to the extent the otherwise compensable injury was the major contributing cause of the combined condition or the need for treatment.

656.005 (7)(b)(C) Reduced the standard of proof required to show that the major contributing cause was consumption of alcoholic beverages or a controlled substance to "preponderance of evidence" from the previous "clear and convincing evidence."

656.005 (7)(c) Reduced the previous definition of "disabling injury" to specifically exclude those injuries where no temporary benefits were due and payable, unless there was a reasonable expectation that permanent disability would result from the injury.

656.005 (19) Expanded the definition of "objective findings" to be verifiable indications of injury or disease, and excluded physical findings or subjective responses to physical examinations that were not reproducible, measurable, or observable.

656.018 (1) Stated that the liability provisions of workers' compensation law applied to all injuries, diseases, and conditions arising out of employment, regardless of whether or not they were compensable.

656.262 (6)(a) Authorized the denial of an accepted claim to be issued at any time when the denial was for fraud, misrepresentation, or other illegal activity, to be proved by a preponderance of evidence. Changed the standard of proof for a back-up denial based on evidence uncovered after acceptance that the claim was not compensable or the insurer was not responsible, to "preponderance of evidence" from "clear and convincing evidence."

656.262 (14) and (15) Required injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Required the director of DCBS to suspend for non-cooperation all or part of compensation due a worker, and authorized the insurer or self-insured employer to deny the claim if the non-cooperation continued for another 30 days.

656.265 (1) Tripled the time for filing of a claim to 90 days.

656.268 (1) Authorized claim closure before the worker's condition became medically stationary if the accepted injury ceased to be the major contributing cause of the worker's combined or consequential condition, or, if without the approval of the attending physician, the worker failed to seek medical treatment for a period of 30 days or failed to attend a closing examination.

The definitions of compensability for both injuries and diseases also were changed. A compensable injury must be established by medical evidence supported by objective findings. A compensable injury must be the major contributing cause of a consequential condition for that condition to be compensable. Also, when the compensable injury combines with a preexisting condition, the resulting condition is compensable only as long as the compensable injury remains the major contributing cause of the disability. This restriction affects both the original compensability and the duration of compensability. In addition to the above changes, the definition of a compensable occupational disease was changed so that the disease must be caused by substances or activities to which an employee is not ordinarily subjected and the employment must be the major contributing cause of the disease.

After several court decisions lessened the impact of some reform provisions, the 1995 Legislature passed SB 369. It restated the legislative intent in SB 1197 by rewriting some of the language concerning preexisting conditions. It also expanded the definition of “objective findings” and reduced the burden of proof for denial of claims because of alcohol or drug use. It also stated that workers’ compensation law was the exclusive remedy for injuries and conditions arising from employment, regardless of whether or not the injuries were compensable.

Claim denial rates

The recent denial rates for disabling claims are approximately three percentage points higher than they were in FY 1989 (see Figure 3). The legislative changes have had some effect on the denial rates of claims. However, SAIF Corporation’s claims management practices have had a larger impact. SAIF’s denial rate of disabling claims jumped from 16 percent in FY 1989 to over 30 percent in fiscal years 1990-92; it has been approximately 22 percent over the past five years (see Figure 4).

The change in disabling claims denial rates explains only a small portion of the decline in accepted disabling claims. The increased denial rate of 16.6 percent in FY 1997 over the denial rate of 14.1 percent in FY 1989 accounts for only nine percent of the drop in accepted disabling claims from 40,515 to 26,785.

The denial rates of claims vary greatly by the type of injury or disease (see Figures 5 and 6). The denial rates of occupational disease claims have been around 37 percent; SAIF’s denial rates of occupational disease claims have been over 45 percent.

Figure 3. Percent of disabling claims denied, Oregon, FY 1989-97

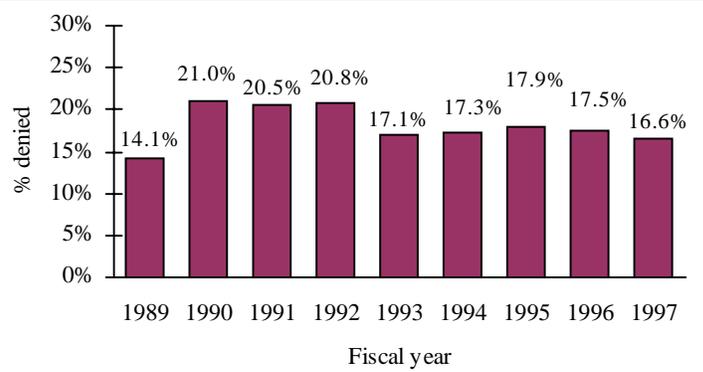
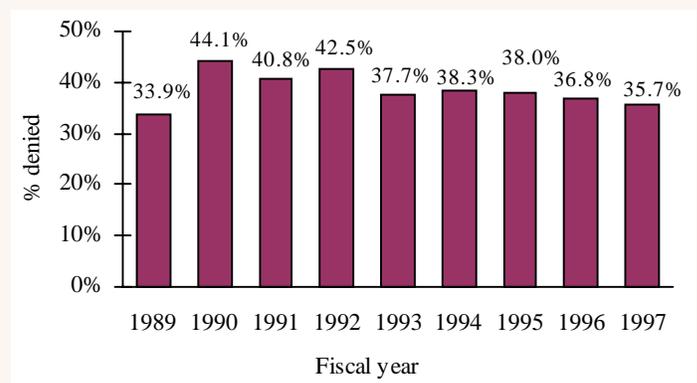


Figure 4. Percent of disabling claims denied, by insurer type, FY 1989-97

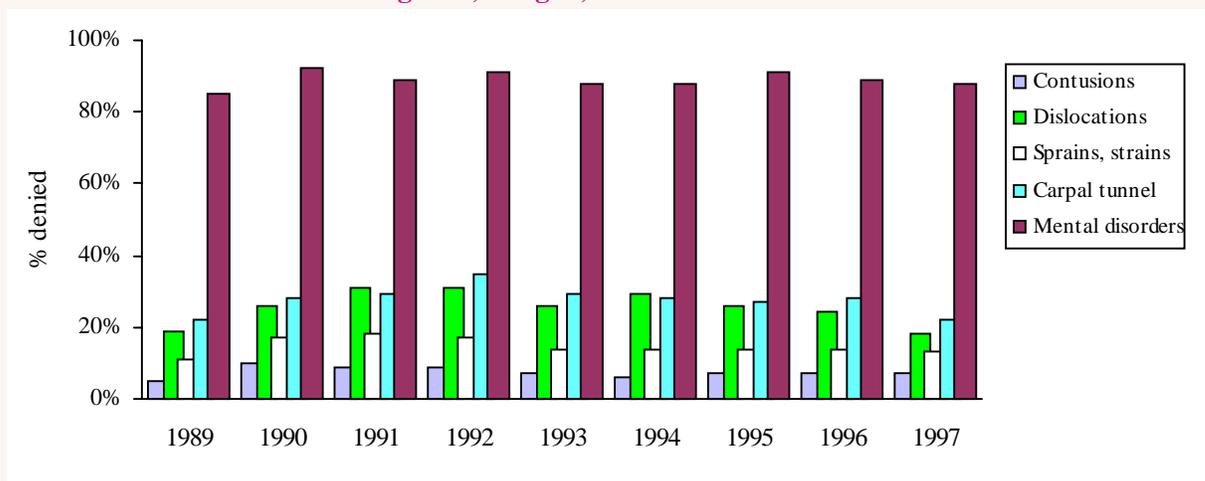
Fiscal year	SAIF Corp.	Private insurers	Self-insured employers	All insurers
1989	15.9%	12.6%	14.6%	14.1%
1990	34.7%	14.6%	15.7%	21.0%
1991	34.3%	15.3%	14.6%	20.5%
1992	31.9%	16.8%	15.0%	20.8%
1993	21.6%	15.1%	15.7%	17.1%
1994	21.4%	15.6%	15.1%	17.3%
1995	23.2%	15.6%	15.2%	17.9%
1996	22.4%	15.7%	15.0%	17.5%
1997	21.1%	14.2%	14.9%	16.6%

Figure 5. Percent of disabling occupational disease claims denied, Oregon, FY 1989-97



Injuries from clear, sudden events, such as amputations or contusions, have the lowest denial rates. Injuries that are not so visible, such as back sprains, have higher denial rates. Cumulative trauma injuries, such as carpal tunnel syndrome, have still higher denial rates. Mental stress claims have the highest denial rates.

Figure 6. Percent of disabling claims denied, selected injury categories, Oregon, FY 1989-97



Reasons cited for the original denial of disabling claims

A study of the reasons that insurers were citing in 1997 in their denial letters showed that most disabling claims were denied because the insurer felt the injury did not arise out of the employment, the employment conditions were not the major contributing cause of the injury or disease, the insurer was not responsible for the claim, or there was insufficient evidence that the claim was compensable (see Figure 7). The data were from a sample of 250 denied disabling claims set up on the department’s workers’ compensation claims system between June and September 1997. The reasons for the denials were taken from copies of the denial letters sent by insurers to the workers. The denials were classified by the statute language that most closely applied. Multiple reasons were cited in a number of the denial letters.

The data should not be over-analyzed. Most denial letters contain general language that different people could classify differently; very few letters include detailed explanations of the denials. The language and the degree of specificity vary by insurer, and different insurers use different language to cover similar events. Also, most denial letters include a statement that the insurer does not waive other defenses should the denial be challenged. Therefore, the letters are not complete, specific explanations of the reasons these claims were denied. The letters are, however, the explanations that workers receive when their claims are denied.

The letters used by private insurers did not differ much from those used by SAIF, except that SAIF more often denied responsibility for the claim, citing this reason in 28 percent of the letters, compared to 14 percent for private insurers. There were several letters in which SAIF identified an employer and an insurer and told the claimant to file another claim with the identified insurer.

The denials of disease claims differed from the denials of injury claims chiefly in the use of the “major contributing cause” language. Insurers often stated that their employers were not responsible for the development of the occupational disease and told claimants that they should file claims against the other employers for whom they had worked. The denial reasons did not vary much among the types of disease, except for mental stress; mental stress denials often stated that the claim did not meet the statutory definition or used general denial language.

Reasons cited for the partial denial of disabling claims

A sample of 100 disabling claims with partial denials received between January and September 1997 was also examined. Insurers issue partial denials when claimants file claims or seek treatment for conditions that the insurers don’t feel are related to the original, compensable injury. They also issue partial denials when the original injury is no longer the major contributing cause of the need for treatment. Most denial letters are very general. The example below is one of the few letters that was specific. It also describes one of the most common instances in which partial denials are issued.

[The insurer] accepted your claim as a lumbar strain combined with degenerative disc disease. Based on our review of your medical records, your combined condition is no longer the major contributing cause of your current condition or treatment needs. Your physician indicates that your degenerative disc disease has become the major contributing cause as of June 4, 1997. Accordingly, [we agree] to pay all medical expenses related to your accepted combined condition up to that date. We must issue this current condition denial for your condition and treatment needs past June 4, 1997, and expressly deny compensability of your preexisting degenerative condition.

Figure 7. Reasons cited in original denial letters

	<u>% of claims</u>	<u>% of injury claims</u>	<u>% of disease claims</u>
Compensability (656.005(7), 656.802(2))			
1. arising out of and in the course of employment	31.6%	36.0%	23.3%
2. requiring medical services or resulting in disability or death	1.2%	1.8%	0.0%
3. established by medical evidence supported by objective findings	4.0%	3.0%	5.8%
4. (a) compensable injury is the major contributing cause	16.0%	6.7%	33.7%
5. (a)(A) compensable injury is the major contributing cause of a consequential condition	0.0%	0.0%	0.0%
6. (a)(B) compensable injury is the major contributing cause when combined with a preexisting condition	9.6%	11.0%	7.0%
7. (b)(A) assaults or combat	0.4%	0.6%	0.0%
8. (b)(B) recreational or social activities	0.4%	0.6%	0.0%
9. (b)(C) alcohol or drugs	0.8%	1.2%	0.0%
10. Responsibility (656.023, 656.027)	19.2%	18.3%	20.9%
11. Noncooperation (656.262(14),(15))	2.8%	3.7%	1.2%
12. Timeliness (656.265, 656.273, 656.807)	2.4%	1.2%	4.7%
13. Burden of proof (insufficient evidence)(656.266)	15.2%	18.9%	8.1%
14. Aggravation claims (656.273)	0.8%	0.6%	1.2%
15. Mental disorder (656.802(3))	2.8%	0.0%	8.1%
16. General denial statements	5.6%	3.7%	9.3%
17. Claim withdrawn by worker	1.2%	1.8%	0.0%
Total number of claims	250	164	86
Number of reasons cited	285	179	106

Notes on some of the categories in the table:

Category 1: This was the most common reason used.

Category 3: This clause was added in SB 1197. The definition of objective findings was modified in SB 369.

Categories 4-6: These sections were added in SB 1197. Prior to SB 1197, the standard was material cause. The sections, especially the occupational disease conditions, were reworded in SB 369. The claims in category 4 are those in which the language was similar to either, “your employment was not the major contributing cause of your condition” or “your injury/disease was not the major contributing cause of your condition.” The cases may have included preexisting or consequential conditions, but this was not stated in the letters. This language was the most common language used in the denial of disease claims.

Category 8: The wording was changed from “activities solely for the worker’s personal pleasure” to “activities primarily for the worker’s personal pleasure” in SB 1197.

Category 9: The clause was added in SB 1197. Wording was changed from “clear and convincing evidence” to “preponderance of the evidence” in SB 369.

Category 10: This category includes those instances in which the claimant was not a subject worker or was not employed by the company against whom the claim was filed. It also includes cases in which the insurer was not the employer’s workers’ compensation insurer. It also includes the disease claims for which the insurer stated that the disease may have been the responsibility of a different employer and insurer.

Category 11: These sections were added in SB 369.

Category 13: This section was added in 1987 in HB 2271. This category includes the instances in which the language was similar to, “there is insufficient evidence that the claim was compensable.” It was used in many situations, including cases which seem straight forward. For example, the claim from a man who fell off a loading dock was denied for insufficient evidence.

Category 14: Objective medical findings language was added in SB 1197.

Category 15: This section was changed in 1987 in HB 2271.

Category 16: This category includes the instances in which very general language was used, such as “your injury is not compensably related to your employment.”

Hearings on claim denials

Over the 5-year period, FY 1992-96, the denial of nearly half of disabling claims and 15 percent of nondisabling claims was appealed to the Hearings Division (see Figures 8 and 9). In 29 percent of these cases, the insurers' denials were reversed.

In 52 percent of the cases, the claims were settled with Disputed Claim Settlements (DCS). In this type of settlement, the worker receives some compensation, often to cover medical expenses, in exchange for acceding to the insurer's denial.

Figure 8. Claim denials, fiscal year averages for FY 1992-96

	Total claims	Accepted	Denied	% denied	% of denials appealed
Disabling	35,285	28,880	6,405	18.2%	49.8%
Nondisabling	89,658	76,200	13,458	15.0%	15.0%
Total	124,943	105,080	19,863	15.9%	26.2%

Note: Insurers do not submit accepted nondisabling claims to WCD. Therefore, estimates based on historical data are used.

Figure 9. Hearing orders on claim denials, calendar year averages for CY 1992-96

O&Os and stipulations	Accepted	% accepted	DCSs	%DCSs
4,995	1,465	29.3%	2,595	52.0%

Notes: The Hearings Division figures are the cases in which the claim denial was an issue; cases may involve more than one issue. The data exclude dismissals and withdrawn hearing requests.

Acceptances are reversals of insurers' denials.

Disputed Claim Settlements (DCSs) are denied stipulations in which workers may receive some compensation.



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