Claims Processing

Insurer performance is an important part of the workers' compensation system. The department monitors insurer performance issues, such as the first payment of temporary disability benefits, claim compensability decisions, and claim closures.

The department issues civil penalties to insurers and self-insured employers who do not meet acceptable performance standards. In both 2006 and 2007, the department issued more than 900 citations, with penalty amounts of more than $575,000. Not included in these statistics are stipulated agreements. These may encompass various violations of rules and statutes under ORS Chapters 656 and 731 and set up various performance expectations. One recent stipulation, issued under an Insurance Division order, set a penalty at $5 million, with $4 million suspended pending the insurer group meeting certain conditions.

Claim acceptance or denial

Several legislative changes have affected time frames for insurers' action to accept or deny a claim. To enable insurers to make better decisions, the statutory time limit for the acceptance or denial of a claim was changed from 60 days to 90 days by SB 1197 in 1990. It was hoped that this would lessen the number of appealed denials. The median number of days to accept a disabling claim increased after 1990, peaking at 52 days in 1998, but this resulted in longer periods of uncertainty for workers and

Figure 7. Median calendar days from employer knowledge to claim acceptance or denial, 1988-2007

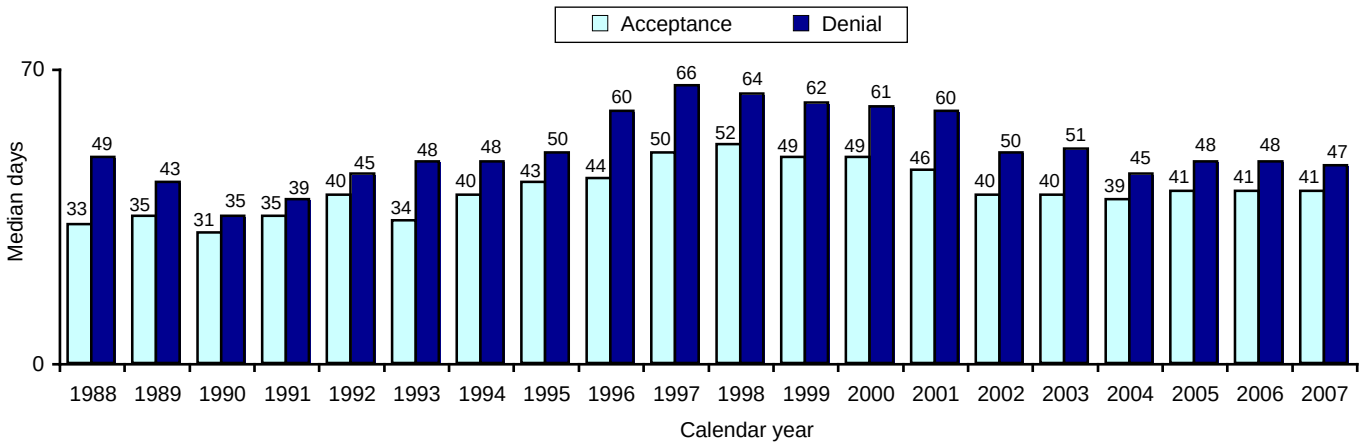


Figure 8. Insurer timeliness of acceptance or denial and of first payments, 1990-2007

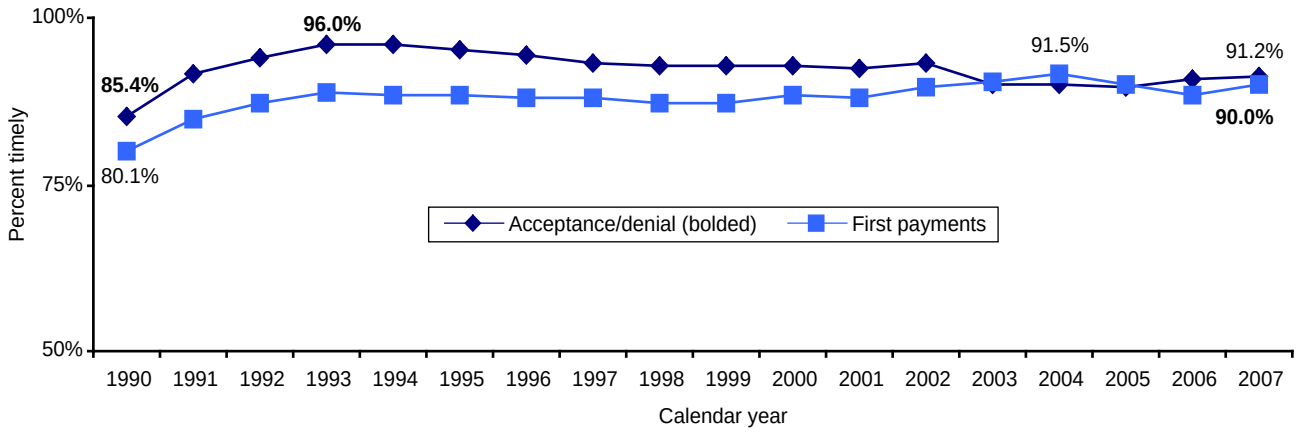
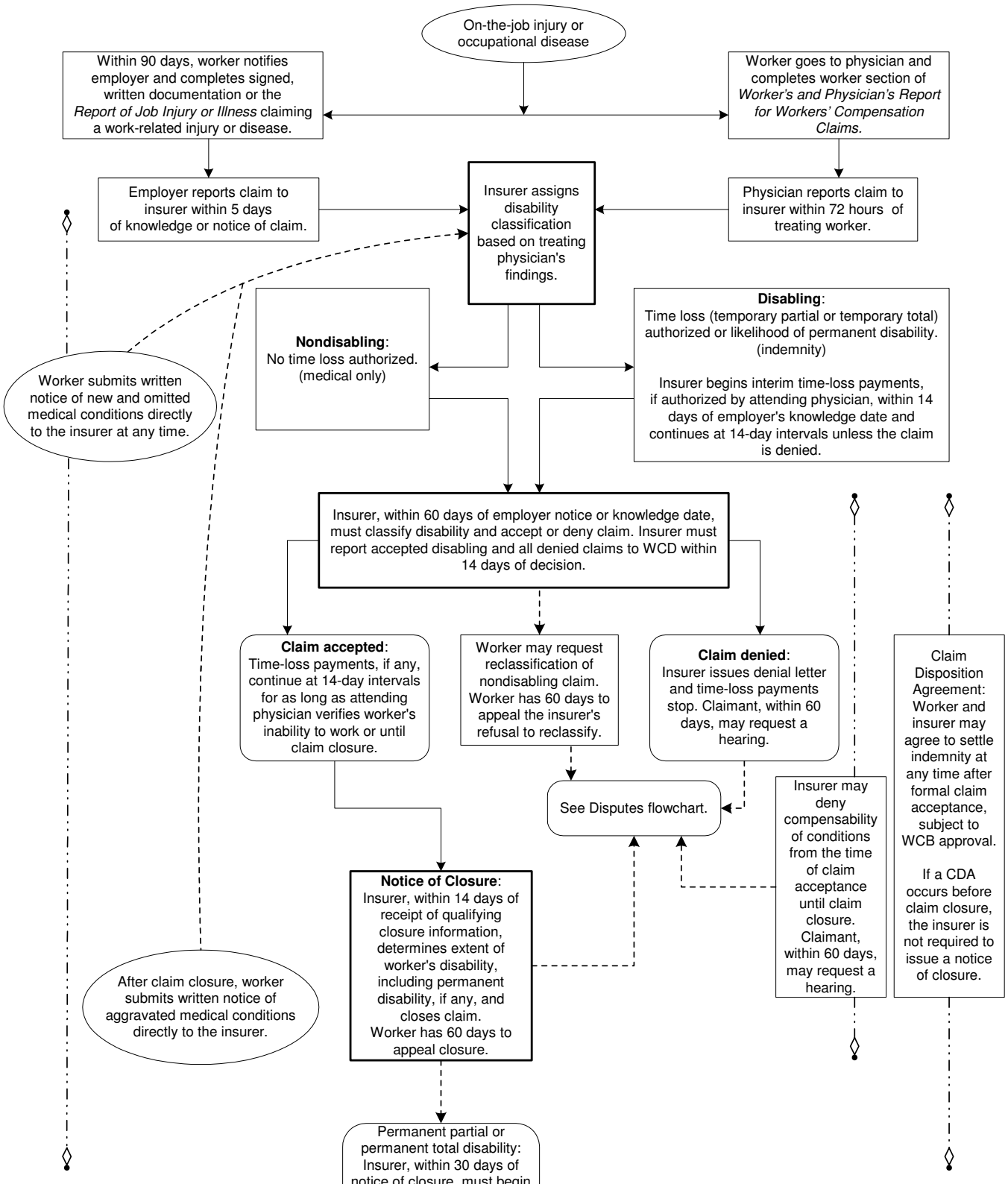


Figure 9. Claims process flowchart



The ●◇— · · —◇● indicates time frame in which the action may occur during the process.
The – – – – – indicates potential path of process.

Note: This flowchart provides a general description of the claims process. It omits many details. The time frames shown are those in statute and rule; exceptions to these time frames are not shown. Flowcharts in the return-to-work chapter and the disputes chapter provide additional information.

medical providers. In 2001, as part of SB 485, the Legislature reduced the statutory time limit back to 60 days. This affected the processing time for compensability decisions. Since 2005, the median time to accept a disabling claim has been 41 days. Just over 90 percent of the compensability decisions in 2007 were made within the 60-day period.

In an effort to streamline reporting, the requirement for insurers to notify the department within 21 days of receiving a claim was changed. Since 2003 with the passing of SB 914, the insurer must notify the department within 14 days of the decision to accept or deny the claim. It was hoped this would speed up compensability decisions, but this has not occurred.

Modified acceptances

The 1997 Legislature passed HB 2971, which required insurers and self-insured employers to modify notices of acceptance when medical or other information changes a previously issued notice of acceptance. At the time of claim closure, insurers are also required to issue an updated notice of acceptance that specifies the compensable conditions. In addition, if a condition is later found to be compensable, the insurer must reopen the claim for that condition.

The Court of Appeals, in the 1999 Johansen v. SAIF Corporation decision, ruled that there are no time limits for liability on a new condition. In SB 485, the 2001 Legislature refined the process for new conditions. A worker must request formal written acceptance of a new or omitted medical condition, which the insurer has 60 days to accept or deny. The period for disabling claims aggravation rights extends five years after the first closure. If new compensable conditions arise during this period, the insurer pays the claim costs. If the new condition arises after the aggravation period and the insurer doesn't voluntarily accept the claim, the worker must pursue the claim through the Workers' Compensation Board's Own Motion process. If the condition is found compensable, benefits are paid from the Workers' Benefit Fund.

Claim closures

Prior to 1987, only the department could close a claim and rate permanent disability. HB 2900 (1987) allowed insurers to close permanent disability claims if the worker had returned to work. At the same time, the department was permitted to promulgate disability standards that the insurers had to use. In 1987, insurers completed 36 percent of the claim closures. Insurers' authority was expanded in 1990; with SB 1197, the Legislature allowed insurers to close a claim when the worker's attending physician released the employee to return to work. This let insurers terminate time-loss payments earlier in the life of a claim. In 1992, insurers completed 58 percent of the claim closures.

In SB 220, the 1999 Legislature shifted responsibility for all claim closures from the department to insurers and self-insured employers. The transition was completed Jan. 1, 2001.

The median number of days from injury to first closure was 150 calendar days for claims first closed in 2007. The median has been between 154 and 157 days in eight of the past 10 years.

System abuse

The department works to eliminate abuse of the workers' compensation system. The WCD investigates allegations of inappropriate actions by employers, medical providers, insurers, workers, and other parties. (Insurers also conduct investigations; the department does not have a count of the number of these investigations.) In fiscal year 2008, eight investigations of fraud or abuse complaints were opened. Historically, the most frequent complaints received have been employers pressuring employees not to file claims; improper claims processing by insurers or medical providers; employers improperly directing the medical treatment of workers; and failure to report or improper reporting of claims-related documents by employers, insurers, and medical providers.

Workers' compensation information line

The Workers' Compensation Division has a workers' compensation information line to answer workers' questions about their claims, describe workers' rights and responsibilities, and help them understand the workers' compensation system. In 2007, there were more than 12,300 calls to the line. Of the callers, about 7,300 were workers and about 5,000 were insurers, medical providers, attorneys, employers, legislators, and others.