Compensability and Claims Processing

The Oregon workers' compensation system is a no-fault system. In other words, the compensability of a claim is not dependent upon demonstrating that the employer or worker was negligent. One purpose of a no-fault system is to promptly and fairly compensate injured workers for work-related claims.

Definition of compensability

When an injury or illness occurs and a claim is filed, the insurer's compensability decision controls whether the claim is covered within the system. An accepted disabling claim entitles the worker to medical services and disability or death benefits. An accepted nondisabling claim entitles the worker only to medical services.

The workers' compensation law governs the standards of compensability. The definition of a compensable claim was revised several times between 1987 and 1995. These revisions were partly responsible for the decrease in the number of accepted claims in the early 1990s. Details of the law changes can be found in the Compensability section of Appendix 1, Workers' Compensation Reform Legislation.

The 1999 Legislature allocated funds to study the effects of the compensability language changes on workers' compensation costs and worker benefits. The department contracted for a major study by leading academic researchers, which was completed in 2000. More detail on this study can be found in previous editions of this report (http://www4.cbs.state.or.us/ex/imd/external/reports/index.cfm?fuseaction=dir&ItemID=2000) or the study report itself (http://dcbs-reports.cbs.state.or.us/rpt/index.cfm?fuseaction=version_view&version_tk=175934&ProgID=CCRA024).

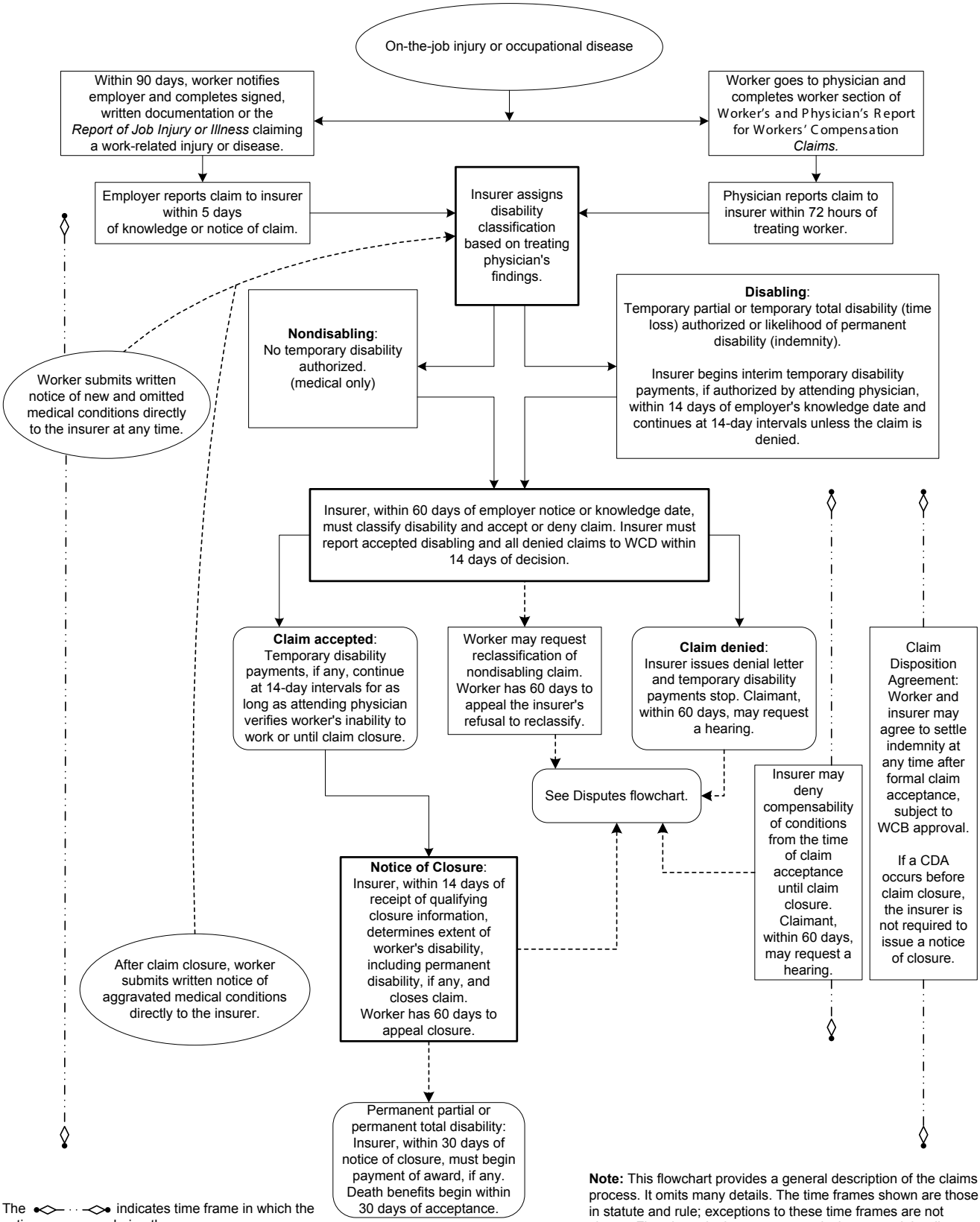
In May 2001, during the legislative session, the Oregon Supreme Court issued its opinion for the *Smothers v. Gresham Transfer, Inc.* case. The court ruled that when a workers' compensation claim is denied for failure to prove that the work-related incident was the major contributing cause of the injury or condition, then the exclusive-remedy provisions implemented by Senate Bill 369 of 1995 are unconstitutional. The 2001 Legislature addressed this decision by passing SB 485, which created a process for worker civil suits against employers. It also revised the definitions of pre-existing conditions and established that, while a worker continues to have the burden of proving that the claim is compensable, the employer has the burden of proof in showing that the compensable condition is not the major contributing cause of the need for treatment. Although it was estimated that the *Smothers* decision

Recent significant court decisions

In December 2013, the Oregon Supreme Court issued its opinion for *Schleiss v. SAIF Corporation*. The issue was whether an injured worker's permanent impairment can be apportioned to exclude that portion of the impairment that is due to conditions that have not previously been formally acknowledged or identified, either as part of the claim processing or resulting litigation. The court concluded that no portion of permanent impairment can be attributed to any condition the worker may suffer from that is not formally part of a combined condition or has not been established as a pre-existing condition.

In May 2014, the Oregon Court of Appeals issued its opinion for *Brown v. SAIF Corporation*. The issue was whether an insurer, to deny a combined condition, must prove it is the accepted condition or the accidental work-related injurious incident that is no longer the major contributing cause. The court ruled that the compensable injury is the work injury resulting from the work action, not the condition the insurer accepts. The burden, therefore, on an employer or insurer seeking to deny a previously accepted combined condition is to prove the work-related injury is no longer the major contributing cause of the disability or need for treatment.

Figure 6. Claims process flowchart



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.

could affect as many as 1,300 cases per year and cost up to $50 million per year, there have been no known cases in which workers have prevailed at trial; in a few cases workers have received settlements.

Modified acceptance decisions

The 1997 Legislature passed House Bill 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 also must issue an updated notice of acceptance that specifies the compensable conditions. If a medical condition, whether omitted from the notice of acceptance or new, is later found to be compensable, then 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 an omitted or new condition. In SB 485, the 2001 Legislature refined the process. 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 a new compensable condition arises during this period, the insurer pays the claim costs. If the new condition arises after the aggravation period and the insurer does not voluntarily accept the claim, the worker must pursue the claim through the Workers' Compensation Board's own-motion process. If the insurer or the board finds the condition compensable, then benefits are paid from the Workers' Benefit Fund, Reopened Claims Program.

Claim resolution

Before 1987, only the department could close claims and rate permanent disability. That year, the Legislature passed HB 2900, allowing insurers to close permanent disability claims if the worker had returned to work. Passage of SB 1197 in 1990 allowed insurers to close claims upon the attending physician's release of the worker to return to work, and thereby terminate temporary disability payments earlier in the life of a claim. The 1999 passage of SB 220 shifted responsibility for all claim closures from the department to insurers. The transition was completed in January 2001. The department continues to promulgate disability standards that insurers must use. Following passage of SB 757 in 2001, the standards for claims with dates of injury since Jan. 1, 2005, were changed to implement the new law. Permanent impairment is now expressed as a percent of the whole person.

Since July 1990, a worker with an accepted claim can resolve a claim by agreeing to release rights to workers' compensation benefits, except for medical services and the Preferred Worker Program, by means of a Claim Disposition Agreement (CDA). Since 1990, the percentage of initial claims resolved by CDA rather than claim closure has been trending upwards. See the chapter on indemnity for statistics about claim resolutions.

Claim compensability decisions

The prompt determination of compensability is also an aspect of insurers' claim processing performance, which is an important part of the workers' compensation system. To enable insurers to make better decisions and reduce the number of appealed denials, SB 1197 in 1990 changed the statutory time limit for the acceptance or denial of claim compensability from 60 days to 90 days. 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 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 2002, the median time to accept a disabling claim has ranged from 39 days to 44 days. In 2013, about 94 percent of the compensability decisions were made within the 60-day period.

Workers' compensation information line

Workers' Compensation Division benefit consultants answer workers' questions about their claims, describe workers' rights and responsibilities, and help people understand the workers' compensation system. In 2013, there were 6,614 calls to the line, 3,617 from workers and 2,997 from insurers, medical providers, attorneys, employers, legislators, and others. Cases requiring translation or advocacy are referred to the Office of the Ombudsman for Injured Workers.

Civil penalties

The department issues civil penalties to insurers and self-insured employers that do not meet acceptable performance standards. In 2013, the department issued 1,290 citations with penalty amounts of more than $750,000 – record high figures. Stipulated agreements, which may encompass various violations of rules and statutes under ORS Chapters 656 and 731 (workers' compensation and insurance law, respectively), and set up various performance expectations, are not included in these statistics.