



# Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
350 Winter St. NE  
PO Box 14480  
Salem, OR 97309-0405  
1-800-452-0288 or 503-947-7810  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

April 17, 2008

## Proposed Changes to Workers' Compensation Rules

The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436, affecting hearings before the director, medical services and fee schedules, managed care organizations, workers' compensation insurance coverage, insurers' record keeping and reporting, the Preferred Worker Program, and electronic data interchange of medical bill payment records.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** May 19, 2008, 9:00 a.m.
- Where is the hearing?** Labor & Industries Building  
350 Winter Street NE, Room 260 (2<sup>nd</sup> Floor),  
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:  
Fred Bruyns, rules coordinator  
Workers' Compensation Division  
350 Winter Street NE (for courier or in-person delivery)  
PO Box 14480, Salem, OR 97309-0405  
Email - [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us)  
Phone - (503) 947-7717; Fax - (503) 947-7581

**The closing date for written comments is May 22, 2008.**

### How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>

Or call (503) 947-7627 to get free paper copies

### Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING HEARING**  
A Statement of Need and Fiscal Impact accompanies this form.

Department of Consumer and Business Services,  
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns<sup>FB</sup>  
Rules Coordinator

PO Box 14480, Salem, OR 97309-0405;  
350 Winter Street NE, Rm 27, Salem, OR 97301-3879

(503) 947- 7717  
Fax (503) 947-7581

Rules Coordinator

Address

Telephone

**RULE CAPTION**

**Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.**

Hearing date	Time	Location	Hearings Officer
May 19, 2008	9:00 a.m.*	Room 260 (2 <sup>nd</sup> Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns

**\*NOTE: The hearing will begin at 9:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through May 22, 2008.**

**The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.**

**RULEMAKING ACTION**

**ADOPT:** OAR 436-050-0025

**AMEND:** OAR 436-001, 436-009, 436-010, 436-015, 436-050, 436-160 and 436-030-0003, 436-040-0003, 436-045-0003, 436-110-0320, 436-110-0330, 436-110-0240<sup>FB</sup>

**REPEAL:** OAR 436-040-0100

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656

Stats. Implemented

**RULE SUMMARY**

**General changes to OAR chapter 436:** The agency proposes to correct typographical and citation errors, delete duplicate requirements, clarify or relocate some provisions, and streamline processes. To the extent that these changes may substantially affect the meaning of the rules, they are described below.

**The agency proposes to amend OAR chapter 436, division 001, "Procedural Rules Governing Rulemaking and Hearings." These proposed rules address:** The applicability of the rules; notice of rulemaking; distribution of exhibits; content of exceptions; stay of director review; time limits for attorneys to submit statements of services; and administrative law judge authority to approve settlements and dismiss cases.

**The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules." These proposed rules address:** Adoption of updated medical fee schedules and resources for the payment of health care providers; time frames for refunds of overpaid medical bills and related appeal rights; compensability of lumbar artificial disc replacements; electronic data interchange medical reporting requirements; adjustment of the conversion factors for evaluation/management (increase) and surgery (decrease); reduction of the maximum allowable fee for brand and generic drugs from 88% to 83.5% of the average wholesale price; and reduction of the dispensing fee from \$8.70 to \$2.00.

**The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules address:** Treatment and time-loss authority time limits applicable to several health care provider types; how the enrollment of a nonsubject worker in an MCO affects the worker's maximum number of choices of attending physician; contraindications to lumbar artificial disc replacement; and requirements for the worker's social security number on Form 827.

**The agency proposes to amend OAR chapter 436, division 015, “Managed Care Organizations” (MCOs). These proposed rules address:** MCO certification requirements relevant to the definition of the terms “group” (of medical service providers) and “non-qualifying employer”; requirements for MCOs to contract with multiple insurers; documentation requirements for prospective MCOs (applicants); MCO quarterly data reporting; wording of appeal rights notices that MCOs must provide to parties that may appeal an MCO's decision; appeal time frames; and the process for making complaints about rule violations.

**The agency proposes to amend OAR chapter 436, division 030, “Claim Closure and Reconsideration,” division 040, “Workers with Disabilities Program,” and division 045, “Reopened Claims Program.” These proposed rules:** Correct the applicability provisions in rules 030-0003, 040-0003, and 045-0003; and repeal OAR 436-040-0100, “Suspension and Revocation of Authorization to Issue Guaranty Contracts” (because this rule duplicates OAR 436-050-0015).

**The agency proposes to amend OAR chapter 436, division 050, “Employer/Insurer Coverage Responsibility.” These proposed rules address:** The definition of “complete records”; service of penalty orders; the definition of “owner of the private home” to include any person related by an Oregon registered domestic partnership; effect on a guaranty contract of an employer’s cancellation of coverage; in-state claims processing requirements and allowance for claims to be “dispatched” from any location, record-keeping, including record-keeping for supplemental disability benefits; elimination of the requirement to include workers’ social security numbers on lists of claims provided to the director when an insurer or self-insured employer transfers claims to a new processor/location; that excess insurance coverage may include a deductible endorsement acceptable to the director; time frames for a self-insured municipality to provide its annual report to the director; notice to the director when the self-insured employer changes its operation in a manner that affects its workers’ compensation claims liability; and in-state record-keeping, claims processing, auditing procedures, and required reporting of contact information specific to self-insured employers.

**The agency proposes to amend OAR chapter 436-110, “Preferred Worker Program.” These proposed rules address:** Issuance of Preferred Worker cards to workers determined eligible before claim closure; and time frames for insurers to request claim cost reimbursement from the Workers’ Benefit Fund.

**The agency proposes to amend OAR chapter 436-160, “Electronic Data Interchange.” These proposed rules address:** Requirements for trading partner agreements; address reporting requirements; adding and deleting coverage for non-subject workers; time frames for notice to the director of guaranty contract terminations (correction to ten days from seven days to be consistent with requirements in OAR 436-050); elimination of the requirement that insurers submit cancellations of medical bills before resubmitting; and EDI medical reporting requirements.

**Request for public comment:** The Workers’ Compensation Division requests public comment on whether other options should be considered for achieving the rules’ substantive goals while reducing the negative economic impact of the rules on business.

Address questions to:

Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us)

Proposed rules are available on the Workers’ Compensation Division’s Web site:

<http://wcd.oregon.gov/policy/rules/rules.html#proprules>

or from WCD Publications, 503-947-7627 or fax 503-947-7630.

**May 22, 2008**  
Last Day for Public Comment

/s/ John L. Shilts  
Authorized Signer and Date

4/10/08

**John L. Shilts, Administrator, Workers’ Compensation Division**  
Printed name

\*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

Secretary of State  
**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Consumer and Business Services,  
Workers' Compensation Division

OAR CHAPTER 436

**Agency and Division**

**Administrative Rules Chapter Number**

In the Matter of	)
The Amendment of OAR:	)
436-001, Procedural Rules Governing Rulemaking and Hearings	)
436-009, Oregon Medical Fee and Payment Rules	)
436-010, Medical Services	)
436-015, Managed Care Organizations	)
436-030, Claim Closure and Reconsideration	)
436-040, Workers with Disabilities Program	)
436-045, Reopened Claims Program	)
436-050, Employer/Insurer Coverage Responsibility	)
436-110, Preferred Worker Program	)
436-160, Electronic Data Interchange	)

**Rule Caption:**

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

**Statutory Authority:** ORS 656.726(4)

**Other Authority:**

**Statutes Implemented:** ORS chapter 656

**Need for the Rule(s):** The agency is proposing changes: to update the medical fee schedules as required by ORS 656.248; to implement House Bill 2007 affecting domestic partners; to begin to implement Senate Bill 559 affecting how insurers report proof of workers' compensation insurance coverage to the agency; to establish standards for electronic data interchange of medical and coverage data; to ensure insurers and self-insured employers keep sufficient records in Oregon for agency audits; to streamline certain procedures affecting the Preferred Worker Program; and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

**Documents Relied Upon, and where they are available:** "Issues" documents presented to stakeholder advisory committees; advisory committee meeting minutes; written advice from advisory committee members and other interested parties. These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

**Fiscal and Economic Impact, including Statement of Cost of Compliance:** Unless stated otherwise, references to "insurers" (below) include "self-insured employers." The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by OAR chapter 436:

**OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules"**

- Adoption by reference of Centers for Medicare & Medicaid Services (CMS) 2008 Medicare Resource-Based Relative Value Scale (RBRVS), Addendum B and Addendum C, 72 Federal Register No. 227, Nov. 27, 2007, as the fee schedule for payment of medical service providers, except as otherwise provided in the rules

**The agency projects, due to some changes in the CMS relative value units for 2008, that adoption of the RBRVS would decrease overall medical payments that are subject to the RBRVS by approximately \$350,000, or -0.18%.**

- Increasing the conversion factor for the service category "Evaluation/Management" (E&M) from \$59.79 to \$64.79 and decreasing the conversion factor for Surgery from \$93.66 to \$86.44

The agency projects an annual increase in E&M reimbursements of approximately \$2 million and a decrease in Surgery reimbursements of approximately \$2 million. Data available to the agency shows payments for E&M services average 9% above the maximums allowed during calendar year 2007, while payments for surgery average 26% below the maximums allowed. The purpose of these changes is to better align these components of the fee schedule with reimbursement generally received for the services provided, as required under ORS 656.248(1); in addition, access to high quality E&M services is critical in promoting early, effective treatment, improving long-term outcomes, and promoting early return to work.

- Maintaining the other conversion factors at 2007 levels

Overall, the agency projects that keeping the conversion factors at 2007 levels will result in reduced net income for some medical providers, because providers' business costs are rising. Between 2006 and 2007, the Physicians' Services Component of the Consumer Price Index increased by 4.04%. Relative to increasing the conversion factors by the 2006-2007 CPI increase, 4.04% is the approximate, potential, maximum effect on Oregon medical providers as a whole; effects on individual providers may be more or less depending on the types of services provided. However, available medical billing data shows that average payments in the following service categories are below the maximums allowed during calendar year 2007: Surgery, Radiology, Lab & Pathology, Medicine, Physical Medicine and Rehabilitation, and Multidisciplinary/Other Oregon-Specific Codes. For those medical providers that bill below the maximums, maintaining the 2007 levels will have no direct fiscal impact.

- Reducing the maximum allowable fee for brand and generic drugs from 88% to 83.5% of the average wholesale price (AWP); reducing the dispensing fee from \$8.70 to \$2.00

Under ORS 656.248(1), the director must adopt fee schedules that “\* \* \* represent reimbursement generally received for the services provided.” The proposed rates are more consistent with rates paid for brand name drugs in other parts of the health care system, while generic drug fees would remain above fees under some widely accepted benefit plans. The agency projects that proposed rule changes would reduce annual drug payments by approximately \$3.6 million, or 21.8% of total pharmacy payments.

- Restricting compensability of lumbar artificial disc replacements

Under ORS 656.245(3), the director may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded, or experimental. Based on the advice of the Medical Advisory Committee, the director proposes to exclude artificial disc replacements from compensability unless the devices and the patients meet specific conditions – with the goal to improve patient outcomes. Improved patient outcomes should lower overall medical costs paid by insurers. Restrictions affecting artificial disc replacement could have a slight negative fiscal impact on surgeons who perform disc replacements, though surgeons may perform other procedures on patients that do not meet the criteria for disc replacement. Artificial disc replacement is not a commonly used procedure, so the overall fiscal impact should be small.

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#### OAR chapter 436, division 010, “Medical Services”

- Contraindications to lumbar artificial disc replacement

See analysis under OAR 436-009 regarding “Restricting compensability of lumbar artificial disc replacements”

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#### OAR chapter 436, division 015, “Managed Care Organizations” (MCOs)

- Reduced documentation requirements for prospective MCOs (applicants)

The agency projects a small savings for applicant MCOs.

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#### OAR chapter 436, division 050, “Employer/Insurer Coverage Responsibility”

- Required record-keeping for supplemental disability benefits (SDB)

The agency projects that insurers that have elected to process SDB will incur small initial costs to establish record-keeping procedures, plus some on-going costs to track eligibility and payments. The

majority of insurers have elected to refer affected claims to the agency's contracted agent for processing; for these companies there would be no fiscal impact. The few companies that process their own SDB claims are reimbursed by the agency for SDB claims costs from the Workers' Benefit Fund. Included in these reimbursements is an administrative cost factor, most recently 17.15%, which is intended to cover the costs to process claims, including associated record-keeping.

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**OAR chapter 436-110, "Preferred Worker Program"**

- Issuance of Preferred Worker cards to workers determined eligible before claim closure  
**The agency projects a small positive fiscal impact on affected workers - those who can receive Preferred Worker cards earlier and use them to obtain employment.**
  - Expanded time frames for insurers to request claim cost reimbursement from the Workers' Benefit Fund  
**The agency projects a small positive fiscal impact on employers whose insurers can obtain reimbursement of claims costs even if the insurer is informed about eligibility late – after existing deadlines for requesting reimbursement would have expired. Affected insurers would reimburse their insured employers for any premiums and premium assessments paid during the premium exemption period.**
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**Regarding additional proposed changes to chapter 436, including amendments to OAR 436-001, 030, 040, 045, and 160**

**The agency estimates that additional changes will not have a significant economic impact on any persons or businesses, including small businesses.**

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**How were small businesses involved in the development of this rule?**

Representatives of small businesses participated in the stakeholder advisory committee. Small businesses affected by these rules are primarily medical providers and pharmacies.

**Cost of compliance effect on small businesses:**

**Estimated number of small businesses subject to the proposed rule:**

Based on available data, we estimate approximately 12,000 medical providers and 110 pharmacies are small businesses, as defined in ORS 183.310(10).

**Identify the types of businesses and industries with small businesses subject to the proposed rule:**

Oregon medical providers  
Oregon pharmacies

**Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:**

**Reporting:** The proposed changes do not require increased reporting for small businesses.

**Record-keeping:** The proposed changes do not require increased record-keeping for small businesses.

**Other administrative activities and costs of professional services:**

The agency projects that, due to some changes in the Centers for Medicare & Medicaid Services (CMS) relative value units for 2008, adoption of the CMS schedule would decrease overall medical payments that are subject to the schedule by approximately \$350,000, or -0.18%.

The agency projects that increasing the conversion factor for the service category Evaluation/Management (E&M) from \$59.79 to \$64.79 will increase reimbursements for E&M services by approximately \$2 million.

The agency projects that decreasing the conversion factor for Surgery from \$93.66 to \$86.44 will decrease reimbursements for surgical services by approximately \$2 million.

Overall, the agency projects that keeping the remaining conversion factors at 2007 levels will result in reduced net income for some medical providers, because providers' business costs are rising. Between 2006 and 2007, the Physicians' Services Component of the Consumer Price Index increased by 4.04%. Relative to increasing the conversion factors by the 2006-2007 CPI increase, 4.04% is the approximate, potential, maximum effect on Oregon medical providers as a whole; effects on individual providers may be more or less depending on the

**Statement of Need and Fiscal Impact**  
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types of services provided. However, available medical billing data shows that average payments in the following service categories are below the maximums allowed during calendar year 2007: Surgery, Radiology, Lab & Pathology, Medicine, Physical Medicine and Rehabilitation, and Multidisciplinary/Other Oregon-Specific Codes. For those medical providers that bill below the maximums, maintaining the 2007 levels will have no direct fiscal impact.

The agency projects that reducing the maximum allowable fee for drugs from 88% to 83.5% of the average wholesale price, and reducing the dispensing fee from \$8.70 to \$2.00 would reduce annual drug payments by approximately \$3.6 million, or 21.8% of total pharmacy payments.

**Extent of economic impact:** The proposed changes to the conversion factors and pharmacy fees for brand name drugs would better align the medical fee schedules with reimbursement generally received for the services provided, as required under ORS 656.248(1). The proposed changes to pharmacy fees for generic drugs continue to provide a significantly higher reimbursement than some widely accepted pharmacy benefit plans. There is no basis to say that economic impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

**Identify equipment, supplies, labor and increased administration required for compliance with the proposed rule:**

**Equipment:** The proposed changes do not require the purchase of equipment to achieve compliance.

**Supplies:** The proposed changes do not require the purchase of supplies to achieve compliance.

**Labor:** The proposed changes do not require that small businesses hire additional staff to achieve compliance.

**Administration:** The proposed changes do not require increased administration to achieve compliance.

**Extent of economic impact:** There is no basis to say that any impacts would be “significantly adverse” (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

**Administrative Rule Advisory Committee consulted:**

Yes, advisory committees met on Jan. 25, Feb 11, and Feb. 25, 2008.

The agency asked the committees for advice on the economic impacts of the discussed changes, including impacts on small businesses.

/s/ John L. Shilts

4/10/08

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

ORDER NO. XX-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
*Proposed* PREFERRED WORKER PROGRAM RULES

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EXHIBIT "A"  
OREGON ADMINISTRATIVE RULES  
CHAPTER 436, DIVISION 110, RULES 0240, 0320, & 0330

**Revisions are marked as follows:**

Deleted text has a "strike-through" style, as in	<del>Deleted</del>
Added text is bold and underlined, as in	<b><u>Added</u></b>

**436-110-0240 Insurer Participation in the Preferred Worker Program**

(1) The insurer of the employer at injury must be an active participant in providing reemployment assistance. Participation includes issuing notices of the assistance available from the Preferred Worker Program.

(2) The insurer must notify the worker and employer at injury in writing of the reemployment assistance available from the fund. A notice must be issued:

(a) Within five days of a worker's release for work after the worker has been declared medically stationary by the attending physician;

(b) Upon determination of eligibility or ineligibility of the worker for vocational assistance under OAR 436-120; and

(c) Upon approval of a Claim Disposition Agreement.

(3) Pursuant to section (2) of this rule, the Notice to the Worker must appear in bold type and contain the following language:

**The Preferred Worker Program helps Oregon's injured workers get back to work. To find out whether you qualify, contact the Preferred Worker Program at one of the telephone numbers, fax numbers, or addresses listed below.**

**For the Salem office call: (503) 947-7588, 1-800-445-3948, ~~(503) 947-7993 (TTY)~~, or FAX (503) 947-7581.**

**For the Medford office call: (541) 776-6032, 1-800-696-7161, or FAX (541) 776-6022.**

**Or write the Preferred Worker Program at: 350 Winter Street NE, P.O. Box 14480, Salem, Oregon 97309-0405; or 1840 Barnett Road, Suite C, Medford, Oregon 97504-8293.**

(4) Under section (2) of this rule, the Notice to the Employer must appear in bold type and contain the following language:

**If your worker is unable to return to regular work because of injury-caused limitations, you may be eligible for the Preferred Worker Program incentives including Premium Exemption, Claim Cost Reimbursement, Wage Subsidy, and Worksite Modification, which you may use to re-employ your worker. You must request Preferred Worker Program assistance from the Workers' Compensation Division within 180 days of the worker's claim closure date. To find out about the Preferred Worker Program, contact the program at one of the telephone numbers,**

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
*Proposed* PREFERRED WORKER PROGRAM RULES

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fax numbers, or addresses listed below.

For the Salem office call: (503) 947-7588, 1-800-445-3948, (503) 947-7993 (TTY), or FAX (503) 947-7581.

For the Medford office call: (541) 776-6032, 1-800-696-7161, or FAX (541) 776-6022.

Or write the Preferred Worker Program at: 350 Winter Street NE, P.O. Box 14480, Salem, Oregon 97309-0405; or 1840 Barnett Road, Suite C, Medford, Oregon 97504-8293.

(5) The insurer must provide the division with Preferred Worker information in the form and format the director prescribes in OAR 436-030, upon the following:

(a) Claim closure according to ORS 656.268;

(b) Within 30 calendar days from the insurer's receipt of the earliest Opinion and Order of an Administrative Law Judge, Order on Reconsideration, Order on Review by the Board, decision of the Court of Appeals, or stipulation which grants initial permanent disability after the latest opening of the worker's claim; and

(c) Approval of a Claim Disposition Agreement according to ORS 656.236 and documented medical evidence indicates permanent disability exists as a result of the injury or disease, and the worker is unable to return to regular employment.

Stat. Auth.: ORS 656.340, 656.622, 656.726(4)  
Stats. Implemented: ORS 656.340(1), (2), (3); 656.622; 656.726(4)  
Hist: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07  
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

#### 436-110-0320 Preferred Worker Identification Card

(1) The division issues a Preferred Worker Identification card to eligible workers. The card identifies the worker as being eligible to offer an employer Preferred Worker Program assistance. If a Preferred Worker loses the card, the division will issue a replacement card.

(2) The division issues this card as follows:

(a) Automatically at the time of claim closure based upon insurer submission of Preferred Worker information as specified in OAR 436-110-0240(5);

(b) When the worker or their representative request a card, and the worker is eligible ~~Prior to claim closure when the worker has available, immediate employment with an employer who meets the eligibility criteria under OAR 436-110-0310(1); or~~

(c) Any other time the division finds a ~~Upon request by the worker eligible or their representative any time after claim closure.~~

(3) The division may inactivate a Preferred Worker card if:

(a) The Preferred Worker card was issued in error; or

(b) Any reason for ending Preferred Worker Program eligibility as specified in OAR 436-110-0310(4) applies.

Stat. Auth.: ORS 656.622, 656.726(4)

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**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
***Proposed* PREFERRED WORKER PROGRAM RULES**

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Stats. Implemented: ORS 656.622  
Hist: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07  
Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx

**436-110-0330 Claim Cost Reimbursement**

(1) Claim Cost Reimbursement provides reimbursement to the insurer for claim costs when a Preferred Worker files a claim for injury or occupational disease while employed under Premium Exemption as follows:

(a) Reimbursements will be made for the life of the claim;

(b) Reimbursable claim costs include disability benefits, medical benefits, vocational costs in accordance with OAR 436-120-0720, Claim Disposition Agreements in accordance with ORS 656.236, Disputed Claim Settlements in accordance with ORS 656.289, stipulations, as well as attorney fees awarded the worker or the worker's beneficiaries, and administrative costs;

(c) Reimbursable claims costs for denied claims include costs incurred up to the date of denial, but are limited to benefits the insurer is obligated to pay under ORS 656 and diagnostic tests, including ~~insurer~~ **independent** medical examinations necessary to determine compensability of the claim;

(d) The administrative cost factor to be applied to claim costs will be as published in *Bulletin 316*; and

(e) The claim must not be used for ratemaking, individual employer rating, dividend calculations, or in any manner that would affect the employer's insurance premiums or premium assessments with the present or a future insurer. The insurer must be able to document that claim data will not affect the employer's rates or dividend.

(2) The insurer must request Claim Cost Reimbursement as follows:

(a) ~~All~~ Requests for reimbursement must be made within one year of the quarter within which payment was made, **or within six months following notification by the employer that a preferred worker incurred an injury or disease, regardless of the date payment was made;**

(b) Quarterly reimbursement requests must be in the format the director prescribes by bulletin; and

(c) Reimbursement documentation must include, but not be limited to:

(A) Net amounts paid. "Net amounts" means the total compensation paid less any recoveries including, but not limited to, third party recovery or reimbursement from the Retroactive Program, Reopened Claims Program, or the fund;

(B) Payment certification statement; and

(C) Any other information the division deems necessary.

(3) Requests for reimbursement must not include:

(a) Claim costs for any injury which did not occur while the worker was employed with Premium Exemption;

(b) Costs incurred for conditions completely unrelated to the compensable claim;

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**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
***Proposed* PREFERRED WORKER PROGRAM RULES**

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- (c) Costs incurred due to inaccurate, untimely, unreasonable, or improper processing of the claim;
  - (d) Penalties, fines or filing fees;
  - (e) Disposition amounts in accordance with ORS 656.236 (CDA) and 656.289 (DCS) not previously approved by the division;
  - (f) Costs reimbursed or outstanding requests for reimbursement from the Reopened Claims Program, Retroactive Program, or the fund; or
  - (g) Reimbursable Employer-at-Injury Program costs.
- (4) Periodically, the division will audit the physical file of the insurer to validate the amount reimbursed. Reimbursed amounts must be refunded to the division and, as applicable, future reimbursements denied if, upon audit, any of the following is found to apply:
- (a) Reimbursement has been made for any of the items specified in section (3) of this rule;
  - (b) If claim acceptance as a new injury rather than an aggravation is questionable and the rationale for acceptance has not been reasonably documented;
  - (c) The separate payments of compensation have not been documented;
  - (d) The insurer included claim costs in any dividend or retrospective rating or experience rating calculations;
  - (e) The insurer is unable to provide applicable records relating to experience rating, retrospective rating, or dividend calculations at the time of audit or within 14 working days thereafter.
- (5) If the conditions described in subsections (4)(a) through (e) of this rule are corrected and all other criteria of the rules are met, eligibility for reimbursement may be reinstated. If reimbursement eligibility is reinstated, any moneys previously reimbursed and then recovered will be reimbursed again according to these rules.
- (6) If an employer fails to notify its insurer of the "Preferred Worker" status when the *Form 801* is submitted or fails to send its insurer a copy of the *Preferred Worker Identification Card*, and later notifies its insurer that the injury or disease was incurred by a Preferred Worker, the insurer must correct all records previously filed which include claim costs in any dividend, retrospective rating, or any claim valuation for experience rating performed.
- (7) A Claim Disposition Agreement according to ORS 656.236, a Disputed Claim Settlement according to ORS 656.289, or any stipulation or agreement of a claim subject to claim cost reimbursement from the fund must meet the following requirements for reimbursement:
- (a) The insurer must obtain prior written approval of the disposition from the division. The proposed disposition must be submitted to the division prior to submitting the disposition to the Workers' Compensation Board or administrative law judge for approval;
  - (b) A claim's future liability and the proposed contribution from the fund must be a

**ORDER NO. XX-XXX**

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
***Proposed* PREFERRED WORKER PROGRAM RULES**

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reasonable projection, as determined by the division, in order to be approved for reimbursement from the fund; and

(c) A request for approval of the proposed disposition must include:

(A) The original proposed disposition, containing appropriate signatures and appropriate signature lines for division and Workers' Compensation Board or administrative law judge approval, which specifies the proposed assistance from the fund;

(B) A written explanation of how the calculations for the amount of assistance from the fund were made; and

(C) Other information as required by the division.

Stat. Auth.: ORS 656.726(4), 656.622

Stats. Implemented: ORS 656.622

Hist.: Amended 11/1/07 as WCD Admin. Order 07-066, eff. 12/1/07

Amended xx/xx/xx as WCD Admin. Order xx-xxx, eff. xx/xx/xx