Managed Care Organizations Oregon Administrative Rules Chapter 436, Division 015

Effective November 28, 2006

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Revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~

Added text is bold and underlined, as in **Added**

HISTORY LINES: These rules include only the most recent "History" lines. A rule's history line shows when the rule was last revised and its effective date. To obtain a "Chapter 436 revision history index," please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: http://www.wcd.oregon.gov/policy/rules/history.html

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BEFORE THE DIRECTOR
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

In the Matter of the Amendment of Oregon Administrative Rules (OAR):	)	**ORDER OF ADOPTION**
Order No.	)	
436-015, Managed Care Organizations 06-059	)	

The Director of the Department of Consumer and Business Services, under the general rulemaking authority in ORS 656.726(4), and in accordance with the procedure provided by ORS 183.335, amends OAR chapter 436, division 015.

On August 14, 2006, the Workers' Compensation Division filed with the Secretary of State a *Notice of Proposed Rulemaking/Hearing* and *Statement of Need and Fiscal Impact*. The division mailed copies of the *Notice* and *Statement* to interested persons and legislators in accordance with ORS 183.335 and OAR 436-001-0009, and posted copies to its Web site. The Secretary of State included notice of the public hearing in its September 2006 *Oregon Bulletin*.

On September 21, 2006, a public hearing was held as announced. In addition, the record was held open for written testimony through September 27, 2006. A summary of the public testimony is on file and available for public inspection upon request during regular business hours, 8:00 a.m. to 5:00 p.m., Monday through Friday, in the Administrator's Office, Workers' Compensation Division, Labor & Industries Building, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405, (503) 947-7717.

RULE SUMMARY

These rules have been amended to:

- Define treatment guidelines, treatment standards, and treatment protocols;
- Clarify that protocols and guidelines may be made available to the director online under specified conditions;
- Require that the managed care organization plan include a summary of the process used by the managed care organization to develop and review treatment guidelines, standards, and protocols; and
- Require that the managed care organization include with its annual report to the director, copies of either all treatment protocols and guidelines, or any new and any revised treatment protocols and guidelines, adopted by the MCO during the previous calendar year, or a written statement that no new or revised treatment protocols or guidelines were developed or used during the calendar year.

FINDINGS

Having reviewed and considered the record and being fully informed, I make the following findings:

a) The applicable rulemaking procedures have been followed.

b) These rules are within the director's authority.

c) The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

IT IS THEREFORE ORDERED THAT

1) Amendments to OAR chapter 436, division 015, as set forth in Exhibit "A", are attached, incorporated by reference, and **adopted on this 19th day of October 2006, to be effective November 28, 2006.**
2) A certified copy of the adopted rules will be filed with the Secretary of State.
3) A copy of the amended rules with revision marks will be filed with the Legislative Counsel under ORS 183.715 within ten days after filing with the Secretary of State.

DATED this 19th day of October 2006.

DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES

/s/ John L. Shilts
John L. Shilts, Administrator
Workers' Compensation Division

Under the Americans with Disabilities Act guidelines, alternative format copies of these rules will be provided to qualified individuals upon request.

If you have questions about these rules or need them in an alternate format, contact the Workers' Compensation Division at (503) 947-7810.

Distribution: WCD-ID, MC, NM, S0, S1, S4, S7

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 015

436-015-0001 Authority For Rules

These rules are promulgated under the director's general rule-making authority of ORS 656.726 (4) and specific authority under ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02, as Admin. Order 02-053, eff. 4/1/02

436-015-0002 Purpose

The purpose of these rules is to establish and provide policies, procedures, and requirements for the administration, evaluation, and enforcement of the statutes relating to the delivery of medical services by managed care organizations (MCOs) to injured workers within the workers' compensation system.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0003 Applicability of Rules

(1) These rules shall be applicable on or after the effective date to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794, and govern all MCOs and insurers contracting with an MCO.

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99

436-015-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.

(1) "GSA" means a geographic service area.

(2) "Health Care Provider" means an entity or group of entities, organized to provide health care services or organized to provide administrative support services to those entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.

(3) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with these rules.

(4) "Primary Care Physician" means a physician qualified to be an attending physician

according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.

(5) "Treatment Guidelines" means general treatment recommendations or a range of treatment options, thought to be acceptable by most physicians and providers, that are available to assist medical providers in determining appropriate medical treatment for a medical condition.

(6) "Treatment Protocols" means detailed treatment criteria, developed through consensus of physicians and providers, about what is acceptable medical treatment for a medical condition.

(7) "Treatment Standards" means the MCO's certified plan, expectations and clinical requirements, generally agreed to be acceptable by physicians and providers, to which medical providers agree to comply. This includes, but is not limited to, the MCO's internal process, terms and conditions, treatment guidelines and treatment protocols.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: **Amended 10/19/06 as Admin. Order 06-059, eff. 11/28/06**

436-015-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0008 Administrative Review

(1) Any party may request that the director provide voluntary mediation after a request for administrative review or hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, administrative review shall continue.

(2) Administrative review before the director: The process for administrative review of such matters shall be as follows:

(a) Any party that disagrees with an action taken by an MCO pursuant to these rules must first use the dispute resolution process of the MCO. If the party does not appeal the MCO's decision, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision.

(b) The aggrieved party shall file a written request for administrative review with the administrator of the Workers' Compensation Division within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process. If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party may request administrative review within 60 days of the failure of the MCO to issue a decision. The request must specify the grounds upon which the action is contested.

(c) The director shall create a documentary record sufficient for judicial review. The director may require and allow the parties to submit such input and information appropriate to complete the review.

(d) The director shall review the relevant information and issue an order. The order shall specify that it will become final and not subject to further review unless a written request for hearing is filed with the administrator within 30 days of the mailing date of the order.

(3) Hearings before an administrative law judge: Any party who disagrees with an order under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing.

In the review of orders issued pursuant to ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be remanded to the MCO for further evidence taking, correction, or other necessary action if the administrative law judge or director determines the record has been improperly, incompletely, or otherwise insufficiently developed.

(4) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) The party shall file a written request for a hearing with the administrator of the Workers' Compensation Division within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

(5) Hearings on the suspension or revocation of an MCO's certification:

(a) At a hearing on a notice of intent to suspend issued pursuant to OAR 436-015-0080(2), the MCO must show cause why it should be permitted to continue to provide services under these rules.

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings pursuant to OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director shall issue an order withdrawing the notice.

(B) If the MCO disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(C) OAR 436-001 applies to the hearing.

(b) A revocation issued pursuant to OAR 436-015-0080(5) shall become effective within

10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for hearing with the administrator of the Workers' Compensation Division.

(A) If the MCO appeals, the administrator shall set a date for a hearing and shall give the MCO at least ten days notice of the time and place of the hearing. At hearing, the MCO shall show cause why it should be permitted to continue to provide services under these rules.

(B) Within thirty days after the hearing, the director shall issue an order affirming or withdrawing the revocation.

(C) If the MCO disagrees with the order, it may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order.

(D) OAR 436-001 applies to the hearing.

(c) An emergency revocation issued pursuant to OAR 436-015-0080(7) is effective immediately. The MCO must file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. OAR 436-001 applies to the hearing.

Stat. Auth.: ORS 183.310 thru 550 and ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/1/05 as Admin. Order 05-072, eff. 1/1/06

436-015-0009 Formed/Owned/Operated

(1) No MCO formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider will be certified as an MCO.

(2) For purposes of this rule, factors which may be considered in determining that an MCO is or will be formed by an insurer or other non-qualifying employer may include, but are not limited to, the following:

(a) When an insurer or other non-qualifying employer or any member of its staff directly participates in the formation, certification, or incorporation of the MCO;

(b) When an insurer or other non-qualifying employer or any member of its staff selects, nominates, assumes a position as, or acts in the role of, a director, officer, agent, or employee of the MCO; or

(c) When an insurer or other non-qualifying employer, or any member of its staff, arranges for, lends, guarantees, or otherwise provides financing for any of the organizational costs of the MCO.

(3) For the purposes of this rule, factors which must exist for the director to conclude that an MCO is or will be owned by an insurer or other non-qualifying employer may include but are not limited to the following:

(a) When any insurer or other non-qualifying employer or any member of its staff or immediate family members thereof arranges for, lends, guarantees, or otherwise provides financial support to the MCO. For purposes of this rule, financial support does not include contracted fees for services rendered by an MCO; or

(b) When any insurer or other non-qualifying employer or any member of its staff or immediate family members thereof has any ownership or similar financial interest in or right to

payment from the MCO.

(4) For purposes of this rule, factors which must exist for the director to conclude that an MCO is or will be operated by an insurer or other non-qualifying employer may include, but are not limited to, the following:

(a) When any insurer or other non-qualifying employer or any member of its staff makes or exercises any control over business, operational, or policy decisions of the MCO;

(b) When any insurer or other non-qualifying employer or any member of its staff possesses or controls the ownership of voting securities of the MCO. Possession or control shall be presumed to exist if any person, directly or indirectly, holds the power to vote or holds proxies of any other person representing ten percent or more of the voting securities of the MCO;

(c) When any insurer or other non-qualifying employer or any member of its staff provides MCO services other than as allowed by section (6) of this rule;

(d) When an MCO contracts predominately with a single insurer to provide it with business. An MCO will have up to one year from the effective date of its first contract to meet the requirement of having contracts with more than one insurer;

(e) When any insurer or other non-qualifying employer, or any member of its staff, enters into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or

(f) When any insurer or other non-qualifying employer, or any member of its staff, directs or interferes with the MCO's delivery of medical and health care services.

(5) For purposes of this rule, "staff" is any individual who is a regular employee of an insurer or other non-qualified employer or who is a regular employee of any parent or subsidiary entity of an insurer or non-qualified employer.

(6) Notwithstanding the provisions of sections (2), (3), and (4) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be in accordance with protocols and standards established by the certified MCO program and approved by the director. For purposes of this rule, the insurer cannot provide or participate in provision of managed care services related to dispute resolution, service utilization review, or physician peer review.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0010 Notice of Intent to Form

(1) Any health care provider or group of medical service providers initiating an MCO pursuant to ORS 656.260, shall submit a "Notice of Intent to Form" to the division, by certified mail, in a form prescribed by the director. The notice shall include but is not limited to:

(a) Identity of the person or persons who participate in discussions intended to result in the formation of an MCO. If the person is a member of a closely held corporation, the notice should include the identity of the shareholders.

(b) The name, address, and telephone number of a contact person.

(c) A synopsis of the information which will be shared in discussions preceding the application for MCO certification.

(2) The application for certification must be submitted within 120 days of the filing of the Notice of Intent to Form.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0020 Qualifying

(1) Any health care provider or group of medical service providers as defined in these rules must qualify as an MCO prior to submission of an application for certification. To qualify, the applicant must:

(a) Submit a proposed plan for the MCO, along with 4 copies, to the administrator of the Workers' Compensation Division in which the applicant outlines the manner in which the proposed MCO will meet the requirements of ORS 656.260 and OAR 436-015-0030;

(b) Identify in the plan the specific persons to be directors of the proposed MCO, the person to be the president of the proposed MCO, the title and name of the person to be the day-to-day administrator of the MCO, and the title and name of the person to be the administrator of the financial affairs of the proposed MCO; and

(c) Provide affidavits signed by each person identified in subsection (1)(b) above which certifies that the individual has no interest in an insurance company pursuant to OAR 436-015-0009.

(2) If the proposed plan for the MCO is approved by the director, the applicant shall be authorized to proceed to acquire the necessary services to meet the certification requirements.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0030 Applying for Certification

(1) A health care provider or group of medical service providers applying for certification as an MCO must submit to the director, within 120 days of the filing of the Notice of Intent to Form, the following:

(a) Four copies of an application which includes specific information indicating the manner in which the MCO will be able to meet the provisions of these rules;

(b) The MCO certification of incorporation and a copy of the MCO by-laws;

(c) A non-refundable fee of $1,500 which will be deposited in the Department of Consumer and Business Services Fund; and

(d) The approved MCO plan.

(2) The MCO shall provide a description of the initial GSA. The GSA shall be designated by a listing of the postal zip codes in the service area.

(3) The MCO plan shall provide a description of the times, places, and manner of providing services under the plan adequate to ensure that workers governed by the MCO shall be

able to:

(a) Access an MCO provider panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;

(b) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner within 24 hours of the MCO's knowledge of the need or a request for treatment;

(c) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner in the MCO within 5 working days, subsequent to treatment by a physician outside the MCO;

(d) Receive treatment by an MCO physician in cases requiring emergency in-patient hospitalization;

(e) Receive information on a 24-hour basis regarding medical services available within the MCO which shall include the worker's right to receive emergency or urgent care, and the hours of regular MCO operation if assistance is needed to select an attending physician or answer other questions;

(f) Seek treatment from any category of medical service provider as defined in subsection (6)(a) of this rule and have a choice of at least 3 medical service providers within each category. The worker shall also have at least 3 choices, as needed, of ancillary service providers including, but not limited to, physical therapists and psychologists. Treatment by all medical service providers including attending physicians will be governed by the MCO treatment standards and protocols;

(g) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;

(h) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographical service area. Such workers may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category and if they agree to the terms and conditions of the MCO;

(i) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker; and

(j) Receive specialized medical services the MCO is not otherwise able to provide. The application must include a description of the times, places, and manner of providing such specialized medical services.

(4) The MCO plan must provide a procedure which allows for workers to receive compensable medical treatment from a primary care physician or authorized nurse practitioner who is not a member of the MCO. The procedure must identify the criteria the MCO will use for approval or disapproval of such treatment, and provide written notice of the MCO physician qualification procedures to the worker.

(5) The MCO shall provide:

(a) Copies of contract agreement(s) or other documents signed by the MCO and each participating medical service provider/health care provider representative which verify membership; and

(b) A list of the names, addresses, and specialties of the individuals who will provide services under the managed care plan together with appropriate evidence of any licensing, registration or certification requirements for that individual to practice. This list shall indicate which medical service providers will act as attending physicians in each GSA within the MCO; and

(c) Copies of all treatment standards**,** ~~and~~ protocols**, and guidelines** ~~developed or used~~ **adopted** by the MCO, including ~~those~~ **protocols and guidelines** from any companies~~, if any,~~ from whom the MCO ~~has~~ **may have** purchased the**m,** ~~use of treatment standards and protocols~~ for the director review and approval under ORS 656.260(4)(a). The MCO must provide these copies at no cost to the director. **The MCO may meet the requirements of this subsection if the protocols and guidelines adopted by the MCO are available online through the MCO or through a company from whom the MCO has purchased them. If the MCO chooses this option, the MCO must ensure the director has access to them at no cost to the director. The online protocols and guidelines must be complete and not in an abbreviated version. Standards, protocols, and guidelines approved by the director are for certification purposes only and may not necessarily apply to an individual case dispute regarding medical services brought before the director.**

(6) The MCO plan shall provide:

(a) An adequate number of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractor, dentist, naturopath, optometrist, osteopath, physician, and podiatrist, as listed in ORS 676.110. The requirements of this section must be met unless the MCO shows evidence that the minimum number is not available within a GSA.

(b) A process that allows workers to select a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010. If the MCO has fewer than three authorized nurse practitioners from which workers can choose within a GSA, the MCO must allow workers to seek treatment outside the MCO from authorized nurse practitioners, consistent with the MCO's treatment and utilization standards. Treatment must also be consistent with ORS 656.245(2)(b)(C), which limits the authorization of treatment of the worker by a nurse practitioner to 90 days and authorization of payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the initial claim. Such authorized nurse practitioners are not themselves bound by the MCO's treatment and utilization standards; however, workers are subject to those standards.

(c) A program which specifies the criteria for selection and de-selection of physicians and the process for peer review. The processes for terminating a physician and peer review shall provide for adequate notice and hearing rights for any physician.

(7) The MCO plan must provide adequate methods for monitoring and reviewing contract matters between its providers and the MCO to ensure appropriate treatment or to prevent

inappropriate or excessive treatment including but not limited to:

(a) A program of peer review and utilization review to prevent inappropriate or excessive treatment including, but not limited to, the following:

(A) A pre-admission review program of elective admissions to the hospital and of elective surgeries.

(B) Individual case management programs, which identify ways to provide appropriate care for less money for cases which are likely to prove very costly, such as physical rehabilitation or psychiatric care.

(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, time loss of claimant, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile shall not be released to anyone outside the MCO without the physician's specific written consent except that the physician's profile shall be released to the director without the necessity of obtaining such consent.

(D) Concurrent review programs, which periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary.

(E) Retrospective review programs, which examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate.

(F) Second surgical opinion programs which allow workers to obtain the opinion of a second physician when elective surgery is recommended. Second surgical opinions must be required prior to repeat surgeries.

(b) A quality assurance program which includes, but is not limited to:

(A) A system for resolution and monitoring of problems and complaints which includes, but is not limited to, the problems and complaints of workers and medical service providers;

(B) Physician peer review which shall be conducted by a group designated by the MCO or the director and which must include, but is not limited to, members of the same healing art in which the physician practices;

(C) A standardized claimant medical record keeping system designed to facilitate entry of information into computerized databases for purposes of quality assurance.

(c) A program for monitoring and reviewing other contract matters that meets the requirements of ORS 656.260(4) and which are not covered under peer review, service utilization review, dispute resolution, and quality assurance.

(8) The MCO plan must include a procedure for internal dispute resolution to resolve complaints by enrolled injured workers, medical providers, and insurers in accordance with OAR 436-015-0110. The internal dispute resolution procedure shall include a provision allowing the waiver of the time period to appeal a decision to the MCO upon a showing of good cause.

(9) **The MCO plan must include a summary of the process used by the MCO to develop and review treatment standards, protocols, and guidelines. This summary must include, but is not limited to:**

(a) A description of the medical expertise or specialties of the clinicians involved;

(b) A description regarding what the protocols and guidelines are based on;

(c) The criteria used by the MCO in selecting the conditions for which the MCO implements treatment protocols and guidelines;

(d) A description of the criteria used by the MCO to determine when it needs to review or revise its treatment standards, protocols, and guidelines;

(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes;

(f) Sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning; and

(g) A description of how the MCO will ensure the worker continues to receive appropriate care in a timely, effective and convenient manner throughout the dispute resolution process.

~~(9)~~ **(10)** The MCO plan shall provide other programs that meet the requirements of ORS 656.260(4) including:

(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled injured workers; and

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program shall include:

(A) Identification of how the MCO will promote such services.

(B) A method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer.

(C) A method by which an MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001.

(D) A provision that all notifications to the insurer from the MCO shall be considered as a request to the insurer for services as detailed in OAR 437-001.

(E) A provision that the MCO shall maintain complete files of all notifications for a period of 3 years following the date that notification was given by the MCO.

~~(10)~~ **(11)** The MCO shall establish one place of business in this state where the organization administers the plan, keeps membership records and other records as required by OAR 436-015-0050.

~~(11)~~ **(12)** The MCO plan must include a procedure for timely and accurate reporting to the director necessary information regarding medical and health care service costs and utilization in accordance with OAR 436-015-0040 and OAR 436-009.

~~(12)~~ **(13)** The MCO shall designate an in-state communication liaison for the department and the insurers at the MCO's established in-state location. The responsibilities of the liaison shall include, but not be limited to:

(a) Coordinating and channeling all outgoing correspondence and medical bills;

(b) Unless otherwise provided by the MCO contract, providing centralized receipt and distribution of all reimbursements back to the MCO members and primary care physicians; and

(c) Serving as a member on the quality assurance committee.

~~(13)~~ **(14)** The MCO must provide satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.

~~(14)~~ **(15)** The MCO plan shall describe the reimbursement procedures for all services provided in accordance with the MCO plan. The members must comply with the following billing and report processing procedures:

(a) Submit all bills in accordance with the MCO contract with the insurer.

(b) Submit all reports and related correspondence to the insurer's authorized claims processing location with copies to the MCO in-state communication liaison or as otherwise provided by the contract.

~~(15)~~ **(16)** The MCO plan shall provide a procedure within the MCO plan to provide financial incentives to reduce service costs and utilization without sacrificing the quality of service.

~~(16)~~ **(17)** The MCO plan must describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers within the plan and how workers can access those providers.

~~(17)~~ **(18)** Within 45 days of receipt of all information required for certification, the director shall notify the applicant of the effective date of the certification and the initial geographical service area of the MCO. If the certification is denied, the applicant will be provided with the reason therefore.

~~(18)~~ **(19)** The application for certification for an MCO shall not be approved if the MCO fails to meet the requirements of these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: **Amended 10/19/06 as Admin. Order 06-059, eff. 11/28/06**

436-015-0035 Coverage Responsibility of an MCO

(1) An MCO shall provide comprehensive medical services in accordance with its certification to all enrolled injured workers covered by the insurer/MCO contract.

(2) The director shall designate an MCO's initial GSA and approve any expansions to the MCO's service area. Injured workers shall not be governed by an MCO until the director has approved the geographical service area. GSAs shall be established by postal zip code. The MCO may only provide contract services to those GSAs approved by the director.

(3) Any expansion of an MCO's GSA must be approved by the director. The request for

expansion must identify the postal zip code areas of the proposed expansion and include evidence that the MCO has an adequate provider panel in the new areas which meet the minimum requirements as set forth in OAR 436-015-0030. An MCO may be authorized by the director to expand the GSA without the minimum categories of medical service providers when the MCO establishes that there are not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards. Such providers, unlike primary care physicians, cannot be required to comply with the terms and conditions regarding services performed by the MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards.

(4) An MCO may contract only with an insurer as defined in OAR 436-010-0005. When an MCO contracts with an insurer to provide services, the contract shall specify those employers governed by the contract. The MCO/insurer contract must include the following terms and conditions:

(a) The contract must specify who is governed by the contract;

(b) The insured's place of employment must be within the authorized geographical service area;

(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location shall be governed by the same MCO(s). When insurers contract with multiple MCOs each worker shall have initial choice at time of injury to select which MCO will manage their care except when the employer provides a coordinated health care insurance program as defined in OAR 436-010-0005.

(d) Workers enrolled in an MCO shall receive medical services in the manner prescribed by the terms and conditions of the contract; and

(e) To ensure continuity of care, the contract shall specify the manner in which injured workers will receive medical services on open claims including but not be limited to the following:

(A) Upon enrollment, allowing the worker to continue to treat with a non-qualified medical service provider for at least seven days after the mailing date of the notice of enrollment; and

(B) Upon termination or expiration of the MCO/insurer contract, allows the workers to continue treatment in accordance with ORS 656.245(4)(a).

(5) Notwithstanding the requirements of this rule, failure of the MCO to provide such medical services does not relieve the insurers of their responsibility to ensure benefits are provided injured workers under ORS chapter 656.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0040 Reporting Requirements For an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO

shall provide the director with a copy of the entire text of any MCO/insurer contract agreement, signed by the insurer and the MCO, within 30 days of execution of such contracts. Amendments, addendums, and cancellations, together with the entire text of the underlying contracts, shall be submitted to the director within 30 days of execution.

(2) Notwithstanding section (1), when an MCO/insurer contract agreement contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination, or workers will no longer be subject to the contract after it expires or terminates without renewal pursuant to ORS 656.245(4)(a).

(3) Any amendment to the approved MCO plan**, including changes to the MCO summary of the process used by the MCO to develop and review treatment standards, protocols, or guidelines under OAR 436-015-0030(9),** must be submitted to the director for approval. The MCO shall not take any action based on the amendment until the amended plan is approved**.**~~with the following exception:~~

~~(a) Within 30 days of implementation, the MCO must provide copies of any new or revised treatment standards and protocols developed or used by the MCO, including those from any companies, if any, from whom the MCO has purchased the use of treatment standards and protocols . The MCO must provide these copies at no cost to the director.~~

(4) Within 45 days of the end of each calendar quarter, each MCO shall provide the following information, current on the last day of the quarter, in a form and format as prescribed by the director: specify quarter being reported, MCO certification number, membership listings by category of medical service provider (in coded form), including provider names, specialty (in coded form), Tax ID number, Oregon license number, business address and phone number. (All fields are required unless specifically excepted by bulletin.) When a medical provider has multiple offices, only one office location in each geographical service area needs to be reported. In addition, the updated membership listing shall include the names and addresses of all health care providers participating in the MCO.

(5) By April 30 of each year, each MCO shall provide the director with the following information for the previous calendar year:

(a) A summary of any sanctions or punitive actions taken by the MCO against its members;

(b) A summary of actions taken by the MCO's peer review committee;~~ and~~

(c) An affidavit that the approved MCO plan is consistent with the MCO's business practices, and that any amendments to the plan have been approved by the director~~.~~ **; and**

(d) Copies of either all treatment protocols and guidelines, or any new and any revised treatment protocols and guidelines, adopted by the MCO during the previous calendar year. The MCO must provide these copies at no cost to the director. The MCO may meet the requirements of this subsection if the protocols and guidelines adopted by the MCO are available online through the MCO or through a company from whom the MCO has purchased them. If the MCO chooses this option, the MCO must notify the director and ensure the director has access to them at no cost to the director. The MCO must ensure

the online protocols and guidelines are complete and not in an abbreviated version. If the MCO did not adopt any new or any revised treatment protocols and guidelines during the previous calendar year, the MCO must provide a written statement to this effect.

(6) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.

(7) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: **Amended 10/19/06 as Admin. Order 06-059, eff. 11/28/06**

436-015-0050 Notice of Place of Business in State; Records MCO Must Keep in Oregon

(1) Every MCO shall give the division notice of one in-state location and mailing address where the MCO keeps records of the following:

(a) Updated membership listings of all MCO members;

(b) Records of any sanctions or punitive actions taken by the MCO against its members;

(c) Records of actions taken by the MCO's peer review committee;

(d) Records of utilization reviews performed in accordance with the requirements of utilization and treatment standards pursuant to ORS 656.260 showing cases reviewed, the issues involved, and the action taken;

(e) A profile analysis of each provider in the MCO listed by the International Classifications of Disease-9-Clinical Manifestations (ICD-9-CM) diagnosis;

(f) A record of those enrolled injured workers receiving treatment by non-panel primary care physicians or authorized nurse practitioners authorized to treat pursuant to OAR 436-015-0070; and

(g) All other records as necessary to ensure compliance with the certification requirements in accordance with OAR 436-015-0030.

(2) Records retained as required by section (1) of this rule must be maintained at the authorized in-state location for 3 full calendar years.

(3) If the MCO/insurer contract is canceled for any reason, all MCO records, as identified in section (1), relating to treatment provided to workers within the MCO must be forwarded to the insurer upon request. The records included in subsections (1)(b), (c), (d), and (e) of this rule are confidential in accordance with ORS 656.260(6) through (10).

(4) Individual MCO providers must maintain claimant medical records as provided by OAR 436-010-0240.

(5) Nothing in this section is intended to otherwise limit the number of locations the MCO may maintain to carry out the provisions of these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04

436-015-0060 Commencement/Termination of Members

(1) Prospective new members of an MCO shall submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership pursuant to the membership requirements of the MCO. The MCO shall verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee shall be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by primary care physicians or authorized nurse practitioners who provide services under OAR 436-015-0070.

(2) Individual members may elect to terminate their participation in the MCO or be subject to cancellation by the MCO pursuant to the membership requirements of the MCO plan. Upon termination of a member, the MCO shall:

(a) Make alternate arrangements to provide continuing medical services for any affected injured workers under the plan.

(b) Replace any terminated member when necessary to maintain an adequate number of each category of medical service provider.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04

436-015-0070 Primary Care Physicians and Authorized Nurse Practitioners Who Are Not MCO Members

(1) The MCO shall authorize a nurse practitioner or physician who is not a member of the MCO to provide medical services to an enrolled worker if:

(a) The nurse practitioner qualifies as an authorized nurse practitioner under ORS 656.245 and OAR 436-010-0005 or the physician qualifies as a primary care physician under ORS 656.260(4)(g);

(b) The nurse practitioner or physician agrees to comply with all terms and conditions regarding services governed by the MCO. For purposes of this section, the phrase "all terms and conditions regarding services governed by the MCO" means MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services in accordance with OAR 436-015-0090. However, the MCO's terms and conditions may not place limits on the length of services unless such limits are stated in ORS chapter 656; and

(c) The nurse practitioner or physician agrees to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require.

(2) The MCO cannot deny authorization of a primary care physician or authorized nurse practitioner based on past practices.

(3) The primary care physician or authorized nurse practitioner who is not a member of the MCO will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's or nurse practitioner's medical records show

treatment has been provided to the worker prior to the date of injury. Additionally, if an injured worker has selected a primary care physician or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.

(4) Notwithstanding section (1), for those workers receiving their medical services from a facility which maintains a single medical record on the worker, but provides treatment by multiple primary care physicians or authorized nurse practitioners who are not MCO members, the requirements of sections (1) and (3) will be deemed to be met. In this situation, the worker shall select one physician or authorized nurse practitioner to treat the compensable injury as the primary care physician or authorized nurse practitioner.

(5) Any questions or disputes relating to the worker's selection of a primary care physician or authorized nurse practitioner who is not an MCO member shall be resolved pursuant to OAR 436-015-0110.

(6) Any disputes relating to a worker's non-MCO primary care physician's, non-MCO authorized nurse practitioner's, or other non-MCO physician's compliance with MCO standards and protocols shall be resolved pursuant to OAR 436-015-0110.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/1/05 as Admin. Order 05-072, eff. 1/1/06

436-015-0080 Suspension; Revocation

(1) Pursuant to ORS 656.260, the certification of a managed care organization issued by the director may be suspended or revoked if:

(a) The director finds a serious danger to the public health or safety;

(b) The MCO is providing services not in accordance with the terms of the certified MCO plan;

(c) There is a change in legal entity of the MCO which does not conform to the requirements of these rules;

(d) The MCO fails to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, or orders of the director.

(e) The MCO or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or 656.745;

(f) Any false or misleading information is submitted by the MCO or any member of the organization;

(g) The MCO continues to utilize the services of a health care practitioner whose license has been suspended or revoked by the licensing board; or

(h) The director determines that the MCO was or is formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider as defined in these rules.

(2) The director shall provide the MCO written notice of an intent to suspend the MCO's

certification.

(a) The notice shall:

(A) Describe generally the acts of the MCO and the circumstances that would be grounds for suspension;

(B) Advise the MCO of their right to participate in a show cause hearing and the date, time, and place of the hearing.

(b) The notice shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served at least 30 days prior to the scheduled date of the hearing.

(3) The show cause hearing on the suspension shall be conducted as provided in OAR 436-015-0008 (5).

(4) An order of suspension shall suspend the MCO's authority to enter into new contracts with insurers for a specified period of time up to a maximum of one year. During the suspension, the MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension.

(a) A suspension may be set aside prior to the end of the suspension period if the director is satisfied of the MCO's current compliance, ability, and commitment to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan.

(b) Prior to the end of the suspension period the division shall determine if the MCO is in compliance with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan. If the MCO is in compliance the suspension will terminate on its designated date. If the MCO is not in compliance the suspension may be extended beyond one year without further hearing or revocation proceedings may be initiated.

(5) The process for revocation of a MCO shall be as follows:

(a) The director shall provide the MCO with notice of an order of revocation. The order shall:

(A) Describe generally the acts of the MCO and the circumstances that are grounds for revocation; and

(B) Advise the MCO that the revocation shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for the revocation to the satisfaction of the director or files an appeal as provided in OAR 436-015-0008(5).

(b) The order shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served.

(c) A show cause hearing on the revocation shall be conducted as provided in OAR 436-015-0008(5).

(d) If revocation is affirmed, the revocation is effective ten days after service of the order

upon the MCO unless the MCO appeals.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for 3 years or longer, it may petition the director to restore its authority by making application as provided in these rules.

(7) Notwithstanding section (5) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show-cause hearing. Such order shall be final, unless the MCO requests a hearing. The process for review shall be as provided in OAR 436-015-0008(5).

(8) Insurer contractual obligations to allow a managed care organization to provide medical services for injured workers are null and void upon revocation of the MCO certification by the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/1/05 as Admin. Order 05-072, eff. 1/1/06

436-015-0090 Charges and Fees

(1) Billings for medical services under an MCO shall be submitted in the form and format as prescribed in OAR 436-009. The payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to OAR 436-009.

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by primary care physicians who qualify under ORS 656.260(4)(g) or authorized nurse practitioners who qualify under ORS 656.245(6) shall not be less than fees paid to MCO providers for similar medical services. Fees paid to medical providers who are not under contract with the MCO, shall be subject to the provisions of OAR 436-009.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04

436-015-0095 Insurer's Rights and Duties

Insurers shall also comply with OAR 436-010 and 436-009 when carrying out their duties under these rules.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

436-015-0100 Monitoring/Auditing

(1) The division shall monitor and conduct periodic audits of an MCO as necessary to ensure the compliance with the MCO certification and performance requirements.

(2) All records of an MCO and their individual members shall be disclosed upon request of the director. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99

436-015-0110 Dispute Resolution/Complaints of Rule Violation

(1) Disputes which arise between any party and an MCO shall first be processed through the dispute resolution process of the MCO.

(2) The MCO shall promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary shall include at least the following:

(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;

(b) The types of issues the MCO will consider in its dispute resolution process;

(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and

(d) Advise that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) Notification must be provided to the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute pursuant to this rule; or

(b) Issues any decision pursuant to this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO shall send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice shall include the following paragraph, in bold text:

> **NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.**

(5) If an MCO receives a complaint or dispute which is not included in the MCO dispute resolution process, the MCO shall, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director pursuant to OAR 436-015-0008. The notice shall include the following paragraph, in bold text:

> **NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter which we handle. To pursue this issue, you must request administrative review of the issue by the director of the Department of Consumer**

and Business Services (DCBS). Send written requests for review to: DCBS, Workers' Compensation Division, Medical Review Unit, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days of your receipt of this notice, you will lose all rights to appeal the decision. For assistance, injured workers may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant. All others, or those who are calling from outside Oregon, should call 1-503-947-7585 (TTY 503-947-7993).

(6) The time frame for resolution of the dispute by the MCO shall not exceed 60 days from the date of receipt of the dispute by the MCO until issuance of the final decision by the MCO. After the MCO resolves a dispute pursuant to ORS 656.260(14), the MCO shall notify all parties to the dispute in writing, including the worker's attorney where written notification has been provided by the attorney with an explanation of the reasons for the decision. This notice shall inform the parties of the next step in the process, including the right of an aggrieved party to seek administrative review by the director pursuant to OAR 436-015-0008. The notice shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days of your receipt of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Review Unit, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. If you have questions, call a Workers' Compensation Division Benefit Consultant at (503)947-7585 (TTY 503-947-7993) or (toll-free in Oregon) 1-800-452-0288.

(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO shall notify the parties of the next step in the process, including the right of an aggrieved party to seek administrative review by the director pursuant to OAR 436-015-0008 including the appeal rights provided in (6) above.

(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further the dispute resolution process. Any of the parties also may request in writing that the director assist in resolution if the dispute cannot be resolved by the MCO.

(9) Complaints pertaining to violations of these rules shall be directed in writing to the Compliance Section of the division. The division may return the complaint to the originating party for completion if the complaint does not satisfy the requirements of this rule. The complaints must:

(a) State the grounds for alleging rule violation;

(b) Include the specific contention of error;

(c) State the complainant's request for correction and relief; and

(d) Include sufficient documentation to support the complaint.

(10) The division may investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330.

(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.

Stat. Auth.: ORS 656.726(4); **Stats. Implemented:** ORS 656.260
Hist: Amended 12/1/05 as Admin. Order 05-072, eff. 1/1/06

436-015-0120 Sanctions and Civil Penalties

(1) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against any MCO:

(a) Reprimand by the director;

(b) Civil penalty of up to $5000 for failure to comply with ORS 656.001 to 656.990. Each day a violation continues shall constitute a separate violation. All penalties collected under this section shall be paid into the Department of Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker, insurer, or medical provider;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violation.

(c) Suspension or revocation of the MCO's certification pursuant to OAR 436-015-0080.

(2) If the director determines that an insurer has entered into a contract with an MCO which violates OAR 436-015 or the MCO's certified plan, the insurer shall be subject to civil penalties as provided in ORS 656.745.

Stat. Auth.: ORS 656.726(4); **Stats. Implemented:** ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

Secretary of State
Certificate and Order for Filing
PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on October 19, 2006 by the
Date prior to or same as filing date

Department of Consumer and Business Services
Workers' Compensation Division — OAR chapter 436
Agency and Division — Administrative Rules Chapter No.

Fred Bruyns — (503) 947-7717
Rules Coordinator — Telephone

350 Winter Street NE, PO Box 14480, Salem OR 97309-0405
Address

to become effective November 28, 2006 (Date upon filing or later) Rulemaking Notice was published in the September 2006 (Month and Year) *Oregon Bulletin*.**

Revised requirements affecting managed care organizations' treatment guidelines, standards, and protocols.
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION
List each rule number separately, 000-000-0000.

AMEND: OAR 436-015-0005, 436-015-0030, 436-015-0040

ORS 656.726(4)
Statutory Authority — Other Authority

ORS 656.260; Enrolled Senate Bill 670 – Oregon Laws 2005, chapter 364
Statutes being Implemented

RULE SUMMARY

These rules have been amended to:

- Define treatment guidelines, treatment standards, and treatment protocols;
- Clarify that protocols and guidelines may be made available to the director online under specified conditions;
- Require that the managed care organization plan include a summary of the process used by the managed care organization to develop and review treatment guidelines, standards, and protocols; and
- Require that the managed care organization include with its annual report to the director, copies of either all treatment protocols and guidelines, or any new and any revised treatment protocols and guidelines, adopted by the MCO during the previous calendar year, or a written statement that no new or revised treatment protocols or guidelines were developed or used during the calendar year.

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; or e-mail fred.h.bruyns@state.or.us. Rules are available on the internet: http://www.wcd.oregon.gov/policy/rules/rules.html

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630.

/s/ John L. Shilts — 10/19/06
Authorized Signer — Date

John L. Shilts, Administrator, Workers' Compensation Division
Printed name

*With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules.

**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. ARC 930-2005