Managed Care Organizations
Oregon Administrative Rules
Chapter 436, Division 015

Effective April 1, 2024

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Historical rules: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 015

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-015-0001 Purpose and Applicability of These Rules

(1) Purpose.

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

(2) Applicability of Rules.

(a) These rules apply on and after the effective date and govern all MCOs and insurers contracting with an MCO.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(3) Timeliness of Documents.

Timeliness of any document required by these rules to be filed with or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or emailed, it must be received by the division by 11:59 p.m. Pacific Time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(d) The date and time of receipt for electronic filings is determined under ORS 84.043.

(e) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next

day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/11/19, as Admin. Order 19-053, eff. 4/1/19
Amended 3/3/21, as Admin. Order 21-053, eff. 4/1/21
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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) "Administrative review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(2) "Come-along provider" means a primary care physician, a chiropractic physician, physician assistant, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO.

(3) "Coordinated health care program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides workers with health care benefits even if a workers' compensation claim is denied.

(4) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(5) "Geographic service area (GSA)" means an area of the state in which a managed care organization may be authorized by the director of the Department of Consumer and Business Services to provide managed care services. There are 15 geographic service areas in Oregon.

(6) "Good cause" means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.

(7) "Group of medical service providers" means individuals duly licensed to practice one or more of the healing arts who join together to provide medical services through a managed care organization, whether or not such providers have an ownership interest in the managed care organization.

(8) "Health care provider" means an entity or group of entities, organized to provide health care services or to provide administrative support services to 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.

(9) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407.

(10) "Managed care organization" ("MCO") means an organization formed to provide medical services and certified under these rules.

(11) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(12) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services.

(13) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.

(14) "Non-qualifying employer" means either:

(a) An insurer as defined in this rule, with respect to managed care services to be provided to any subject worker; or

(b) An employer as defined under ORS 656.005(13), other than a health care provider, with respect to managed care services to such employer's employees.

(15) "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.

(16) "Show-cause hearing" means an informal meeting with the director or the director's designee where the MCO is provided an opportunity to explain and present evidence regarding any proposed orders by the director to suspend or revoke the MCO's certification.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18

Amended 3/11/19, as Admin. Order 19-053, eff. 4/1/19
Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0007 Entities Allowed to Manage Care

(1) Only an MCO may provide managed care services as described in ORS 656.260(4)(d) and (21)(a), except as allowed under OAR 436-015-0009.

(2) An insurer or someone acting on behalf of an insurer may not manage the care of workers by limiting the choice of medical providers, or by requiring medical providers to abide by specific treatment standards, treatment guidelines, or treatment protocols.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0008 Request for Review before the Director

(1) The process for administrative review is as follows:

(a) Any party that disagrees with an action of an MCO must first use the MCO's dispute resolution process. 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 unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.

(b) Within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process, the aggrieved party must file a written request for administrative review with the division. The request must specify the grounds upon which the action is contested.

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 must request administrative review within 60 days of the failure of the MCO to issue a decision.

When the aggrieved party is a represented worker, and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney.

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

(d) The director will review the record and issue an order. The order must specify that it will become final within 30 days of the mailing date of the order unless a written request for hearing is filed with the division.

(2) Dispute Resolution by Agreement.

Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the director's satisfaction, the agreement must be in writing and approved by the director. If the dispute does not resolve through mediation, administrative review will continue.

(3) Physician Review (e.g., appropriateness).

If the director determines an evaluation by a physician is indicated to resolve the dispute, the director may appoint an appropriate medical service provider or panel of providers under ORS 656.325(1) to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. The worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct an evaluation must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed.

(c) When an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. No party may directly contact the physician or panel except as it relates to the examination date, time, location, and attendance. If the parties want the physician or panel to address specific questions, the parties must submit these questions to the director for screening. The director will determine the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical evaluation, and the director will not submit questions regarding such matters to the evaluating physician(s). The evaluation may include:

(A) A review of all medical records and diagnostic tests submitted;

(B) An examination of the worker; and

(C) Any necessary and reasonable medical tests.

(4) Hearings.

Except as provided in sections (5) and (6), any party that disagrees with an order under these rules may file 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 under ORS 656.260(15) and (16), no new medical evidence or issues will 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.

(5) Request for Hearing on Proposed 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 under ORS 656.745, or to a civil penalty or cease and desist order issued under ORS 656.260(21), may request a hearing by the Hearings Division of the Workers' Compensation Board (board) as follows:

(a) The party must file a written request for a hearing with the 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 will forward the request and other pertinent information to the board.

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

(6) MCO Certification Suspension or Revocation.

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

(a) At a show-cause hearing on a notice of intent to suspend issued under OAR 436-015-0080(2), the MCO must present evidence regarding 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 under OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director will issue an order withdrawing the notice.

(B) If the MCO disagrees with the order, the MCO may file 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 under OAR 436-015-0080(5) becomes effective 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 a show cause hearing with the division.

(A) If the MCO requests a hearing, the division will set a date for a show cause hearing and will give the MCO at least 10 days notice of the time and place of the hearing. At hearing, the MCO must show cause why it should be permitted to continue to provide services under these rules.

(B) Within 30 days after the hearing, the director will issue an order affirming or withdrawing the revocation.

(C) If the MCO disagrees with the order, the MCO may file 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 under OAR 436-015-0080(7) is effective immediately. The MCO may 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; ORS 656.260, 656.325, 656.704,; and 656.726(4)
Stats. Implemented: ORS 656.260, 656.325, and 656.704
Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 3/11/19, as Admin. Order 19-053, eff. 4/1/19
Minor correction under ORS 183.335(7) (WCD 16-2020), filed and eff. 11/30/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0009 Formed, Owned, or Operated

(1) The director will not certify an MCO formed, owned, or operated by a non-qualifying employer.

(2) For purposes of this rule, "staff" means any individual who is an employee of a non-qualifying employer or of any parent or subsidiary entity of a non-qualifying employer.

(3) A non-qualifying employer or any of its staff, or their immediate family, may not:

(a) Directly participate in the formation, certification, or incorporation of the MCO;

(b) Nominate, assume a position as, or act in the role of, a director, officer, agent, or employee of the MCO;

(c) Arrange for, lend, guarantee, or otherwise provide financing for any organizational costs of the MCO;

(d) Arrange for, lend, guarantee, or otherwise provide financial support to the MCO (financial support does not include contracted fees for services rendered by an MCO);

(e) Have any ownership or similar financial interest in or right to payment from the MCO;

(f) Make or exercise any control over business, operational, or policy decisions of the MCO;

(g) Possess or control the ownership of voting securities of the MCO. The director will presume possession or control exists if any person, directly or indirectly, holds the power to vote or holds proxies of any other person representing 10 percent or more of the voting securities of the MCO;

(h) Provide MCO services other than as allowed by section (4) of this rule;

(i) Enter into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or

(j) Direct or interfere with the MCO's delivery of medical and health care services.

(4) Notwithstanding section (3) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be according to protocols and standards established by the certified MCO plan. The insurer may not provide or participate in the provision of managed care services related to dispute resolution, service utilization review, or physician peer review.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0010 Notice of Intent to Form an MCO

(1) Any health care provider or group of medical service providers initiating an MCO under ORS 656.260 must submit a "Notice of Intent to Form" to the director, by certified mail. Form 2737 may be used for this purpose.

(2) The Notice of Intent to Form must include the following:

(a) The identity of each person who participates in discussions intended to result in the formation of an MCO. If the person is a member of a closely held corporation, the notice must include the identity of the shareholders;

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

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

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0030 Applying for Certification

(1) General.

The MCO must establish one place of business in Oregon where it administers the plan and keeps membership and other records as required by OAR 436-015-0050.

(2) An applicant for MCO certification must submit the following to the director:

(a) One copy of the application;

(b) A nonrefundable fee of $1,500, payable to the Department of Consumer and Business Services, which will be deposited in the Consumer and Business Services Fund;

(c) Affidavits of each person identified in section (3) of this rule, certifying that the individuals have no interest in a non-qualifying employer under OAR 436-015-0009;

(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services under the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and

(e) A complete organizational chart.

(3) MCO Application.

The application must include:

(a) The name of the MCO;

(b) The name of each person who will be a director of the MCO;

(c) The name of the person who will be the president of the MCO;

(d) The title and name of the person who will be the day-to-day administrator of the MCO;

(e) The title and name of the person who will be the administrator of the financial affairs of the MCO; and

(f) A proposed plan for the MCO, in which the applicant identifies how the MCO will meet the requirements of ORS 656.260 and these rules.

(4) MCO Plan - General.

The plan must:

(a) Identify the initial GSAs in which the MCO intends to operate (For details regarding GSAs, see http://wcd.oregon.gov/Bulletins/bul_248.pdf);

(b) Describe the reimbursement procedures for all services provided;

(c) Include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service;

(d) Describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers and how workers can access those providers;

(e) Provide a procedure to identify those providers in the panel provider listings that only accept existing patients as workers' compensation patients. This procedure is not subject to the timeframe established in subsection (f) of this section;

(f) Provide a procedure for regular, periodic updating of all MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days; and

(g) Include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization under OAR 436-015-0040 and OAR 436-009.

(5) MCO Plan – Worker Rights.

The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:

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

(c) Receive treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within five working days after the worker received treatment outside the MCO;

(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include:

(A) The worker's right to receive emergency or urgent care, and

(B) The MCO's regular hours of operation if the worker needs assistance selecting an attending physician or has other questions.

(e) 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;

(f) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographic service area. Such a worker 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 the provider agrees to the MCO's terms and conditions;

(g) 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;

(h) Receive specialized medical services the MCO is not able to provide;

(i) Receive treatment that is consistent with MCO treatment standards and protocols; and

(j) Remain eligible to receive authorized temporary disability benefits up to 14 days after the mailing date of a notice enrolling the worker's claim in an MCO under OAR 436-010-0270(4)(d).

(6) MCO Plan – Choice of Provider.

The plan must provide all of the following:

(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section's requirements unless the MCO establishes that there is 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 within a GSA or the MCO, within 14 days, is unable to provide a list of three providers willing to treat a worker

within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

(b) A process that allows workers to select an authorized nurse practitioner. If the MCO has fewer than three authorized nurse practitioners within a GSA or the MCO, within 14 days, is unable to provide a list of three authorized nurse practitioners willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from an authorized nurse practitioner, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners cannot be required to comply with the terms and conditions regarding services performed by the MCO. These authorized nurse practitioners are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

(c) A process that allows workers to select a physician assistant. If the MCO has fewer than three physician assistants within a GSA or the MCO, within 14 days, is unable to provide a list of three physician assistants willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a physician assistant, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such physician assistants cannot be required to comply with the terms and conditions regarding services performed by the MCO. These physician assistants are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.

(d) A procedure that allows workers to receive compensable medical treatment from a come-along provider authorized under OAR 436-015-0070.

(7) MCO Plan – Provider Agreement.

The plan must include:

(a) A copy of the standard provider agreement used by the MCO when a provider is credentialed as a panel provider. Variations from the standard provider agreement must be identified when the plan is submitted for director approval; and

(b) An initial list of the names, addresses, and specialties of the individuals who will provide services within the MCO. This list must indicate which medical service providers will act as attending physicians in each GSA.

(8) MCO Plan – Monitoring and Reviewing.

The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including:

(a) A program of peer review and utilization review including the following:

(A) Pre-admission review of elective admissions to the hospital and elective surgeries;

(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;

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

(D) Concurrent review programs that periodically review the care after treatment has begun, to determine if continued care is medically necessary;

(E) Retrospective review programs that examine care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and

(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.

(b) A quality assurance program that includes:

(A) A system for monitoring and resolving problems or complaints, including those identified by workers or medical service providers;

(B) Physician peer review, which must be conducted by a group designated by the MCO or the director. The group must include members of the same healing art as the peer-reviewed physician; and

(C) A standardized medical record system.

(c) A program that specifies the criteria for selection and termination of panel providers and the process for peer review. The processes for terminating a panel provider and peer review must provide adequate notice and hearing rights.

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

(9) MCO Plan – Dispute Resolution.

The plan must include:

(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers under OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing waiver of the 30-day period to appeal a decision to the MCO upon a showing of good cause; and

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

(10) MCO Plan – Treatment Standards, Protocols, and Guidelines.

The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must describe:

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

(b) The basis for protocols and guidelines;

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

(d) The criteria the MCO uses 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; and

(f) A process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.

(11) MCO Plan – Return to Work and Workplace Safety.

The plan must 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 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 must:

(A) Identify how the MCO will promote such services;

(B) Describe the 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) Describe the method by which the 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) Include a provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and

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

(12) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA(s) of the MCO. If the certification is denied**,** the director will provide the applicant with the reason for the denial.

(13) The director will not certify an MCO if the plan does not meet the requirements of these rules.

(14) Communication Liaison.

The MCO must designate an in-state communication liaison(s) to the director and the insurers at the MCO's established in-state location.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 3/11/19, as Admin. Order 19-053, eff. 4/1/19
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Amended 3/5/24 as Admin. Order 24-052, eff. 4/1/2024
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0035 Coverage Responsibility of an MCO

(1) The director will designate an MCO's initial geographic service area (GSA). GSAs are established by postal zip code (See *http://wcd.oregon.gov/Bulletins/bul_248.pdf*). The MCO may only provide contract services in those GSAs approved by the director. Workers are not subject to an MCO contract unless the director has approved the GSA.

(2) Any expansion of an MCO's service area must be approved by the director. The request for expansion must identify the new GSA and include evidence that the MCO has an adequate provider panel which meets the minimum requirements under OAR 436-015-0030.

The director may approve the MCO's new 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. Treatment provided to workers must be consistent with the MCO's treatment and utilization standards. Such providers, unlike come-along providers, cannot be required to comply with the terms and conditions regarding services performed by members of the MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0037 MCO-Insurer Contracts

(1) An MCO must provide comprehensive medical services to all enrolled workers covered by the MCO-insurer contract according to the MCO's certification.

(2) An MCO may not contract exclusively with a single insurer. However, an MCO has up to one year from the effective date of its first contract to obtain contracts with more than one insurer. If the MCO has not obtained additional contracts within this time period, the MCO must provide the director with a report documenting the MCO's efforts to obtain additional contracts.

(3) An MCO may contract only with insurers. The contract must include the following terms and conditions:

(a) Who is governed by the contract;

(b) The covered place of employment must be within the authorized geographic service area;

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

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

(e) A continuity of care provision specifying how workers will receive medical services on open claims, including the following:

(A) Upon enrollment, allowing workers to continue to treat with the current medical service providers for at least 14 days after the mailing date of the notice of enrollment; and

(B) Upon termination or expiration of the MCO-insurer contract, allowing workers to continue treatment under ORS 656.245(4)(a).

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

Stat. Auth.: ORS 656.260, 656.726(4); Stats. Implemented: ORS 656.245 and 260
Hist: Adopted 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 3/11/19, as Admin. Order 19-053, eff. 4/1/19

436-015-0040 Reporting Requirements for an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO must provide the director with a copy of the entire text of any MCO-insurer contract, signed by the insurer and the MCO, within 30 days of execution of such contracts. The MCO must submit any amendments, addenda, or cancellations to the director within 30 days of execution.

(2) When an MCO-insurer contract 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. If the MCO does not provide the director with a copy of the signed contract extension, workers will no longer be subject to the contract after it expires or terminates.

(3) The MCO must submit any amendments to the certified plan to the director for approval. The MCO must not take any action based on a proposed amendment until the director approves the amendment.

(4) Within 45 days of the end of each calendar quarter, each MCO must provide the following information to the director, current on the last day of the quarter, as described in Bulletin 247:

(a) The quarter being reported;

(b) MCO certification number; and

(c) Membership listings by category of medical service provider (in coded form), including:

(A) Provider names;

(B) Specialty (in coded form);

(C) Tax ID number;

(D) National Provider Identifier (NPI) number; and

(E) Business address and phone number. When a medical service provider has multiple offices, only one office location in each geographic service area needs to be reported.

(5) By April 30 of each year, each MCO must 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; and

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

(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of come-along providers. The MCO's report must include the following:

(a) Provider type (primary care physician, chiropractic physician, physician assistant, or authorized nurse practitioner) reported by geographic service area (GSA).

(b) The number of workers affected, reported by provider type.

(c) Date of denial or termination.

(d) One or more of the following reasons for each denial or termination:

(A) Provider failed to meet the MCO's credentialing standards within the last two years;

(B) Provider has been previously terminated from serving as an attending physician within the last two years;

(C) Treatment is not according to the MCO's service utilization process;

(D) Provider failed to comply with the MCO's terms and conditions after being granted come-along privileges; or

(E) Other reasons authorized by statute or rule.

(7) 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.

(8) 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 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 3/9/23, as Admin. Order 23-052, eff. 4/1/23
Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0050 Record Keeping and Place of Business

(1) Every MCO must give the director notice of one Oregon location and mailing address where the MCO keeps records of the following:

(a) Up-to-date membership listings of all MCO members;

(b) Sanctions or punitive actions taken by the MCO against its members;

(c) Actions taken by the MCO's peer review committee;

(d) Utilization reviews performed identifying cases reviewed, issues involved, and action taken;

(e) A profile analysis of each provider in the MCO;

(f) Enrolled workers receiving treatment by come-along providers; and

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

(2) Records required by section (1) of this rule must be retained at the authorized Oregon location for three full calendar years.

(3) Each MCO provider must maintain medical records as provided by OAR 436-010-0240.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0060 Commencement and Termination of Panel Providers

(1) Prospective new panel providers of an MCO must submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership

according to the membership requirements of the MCO. The MCO must 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 must 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 come-along providers.

(2) Individual panel providers may elect to terminate their participation in the MCO or be subject to cancellation by the MCO according to the membership requirements of the MCO plan. Upon termination of a panel provider, the MCO must:

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

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

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0065 Monitoring and Auditing

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

(2) All records of an MCO and its individual panel providers must be disclosed upon the director's request. 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 656.260, 656.726(4); Stats. Implemented: ORS 656.260
Hist: Includes content from 436-015-0100, repealed effective 4/1/18
Adopted 3/13/18, as Admin. Order 18-055, eff. 4/1/18

436-015-0070 Come-along Providers

(1) The MCO must authorize a physician, physician assistant, or nurse practitioner who is not an MCO panel provider to provide medical services to an enrolled worker if:

(a) The nurse practitioner is an authorized nurse practitioner under ORS 656.245, the chiropractic physician or physician assistant has certified to the director that the chiropractic physician or physician assistant has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);

(b) The physician, physician assistant, or authorized nurse practitioner agrees to comply with MCO treatment standards, protocols, utilization review, peer review, dispute

resolution, billing and reporting procedures, and fees for services under OAR 436-015-0090; and

(c) The physician, physician assistant, or authorized nurse practitioner agrees to refer the worker to the MCO for specialized care that the worker may require, including physical therapy.

(2) The physician, physician assistant, or authorized nurse practitioner who is not an MCO panel provider will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's, physician assistant's, or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if a worker has selected a physician, physician assistant, 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.

(3) The MCO may not limit the length of treatment authority of a come-along provider unless such limits are stated in ORS chapter 656.

(4) Notwithstanding section (1), for those workers receiving their medical services from a facility that maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians, physician assistants, or authorized nurse practitioners who are not MCO panel providers, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician, physician assistant, or authorized nurse practitioner to treat the compensable injury.

(5) Any questions or disputes relating to the worker's selection of a physician, physician assistant, or authorized nurse practitioner who is not an MCO panel provider must be resolved under OAR 436-015-0110.

(6) Any disputes relating to a come-along provider's or other non-MCO provider's compliance with MCO standards and protocols must be resolved under OAR 436-015-0110.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 6/13/22 as Admin. Order 22-055, eff. 7/1/22
Amended 11/22/23 as Admin. Order 23-056, eff. 1/1/2024See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0075 Worker Exams

When the MCO schedules a worker exam that includes a psychological evaluation, the

appointment letter must:

(1) Inform the worker that a psychological evaluation is part of the exam; and

(2) State the reason for the psychological exam.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Adopted 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0080 Suspension; Revocation

(1) Under ORS 656.260, the director may suspend or revoke an MCO's certification if:

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

(b) The MCO is not providing services according to the terms of the certified MCO plan;

(c) There is a change in legal entity of the MCO that 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 use 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 a non-qualifying employer.

(2) The director will provide the MCO written notice of intent to suspend the MCO's certification.

(a) The notice will:

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

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

(b) The director will serve the notice 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 before the scheduled date of the hearing.

(3) The show cause hearing on the suspension must be conducted as provided in OAR 436-015-0008(6).

(4) An order of suspension will 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 under the contracts in effect at the time of the suspension.

(a) The director may set aside the suspension before 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) Before the end of the suspension period the director will 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 the certification of an MCO is as follows:

(a) The director will provide the MCO with notice of an order of revocation which:

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

(B) Advises the MCO that the revocation will become effective within 10 days after service of such notice upon the MCO, unless within 10 days the MCO corrects the grounds for the revocation to the satisfaction of the director or the MCO files an appeal as provided in OAR 436-015-0008(7).

(b) The director will serve the order 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 will be conducted as provided in OAR 436-015-0008(6).

(d) If the director affirms the revocation, the revocation is effective 10 days after service of the order upon the MCO unless the MCO appeals the order.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for three years or longer, the MCO 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 will be final, unless the MCO requests a hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order revoking the MCO certification.. OAR 436-015-0008(6) outlines the process for review.

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

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Minor correction under ORS 183.335(7) (WCD 18-2020), filed and eff. 11/30/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0090 Charges and Fees

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

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by come-along providers must not be less than fees paid to MCO panel providers for similar medical services.

(3) Payments to medical providers who are not under contract with the MCO are not subject to an MCO discount.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0110 Dispute Resolution

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

(2) The MCO must 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 must 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) A statement that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) The MCO must notify the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute under this rule; or

(b) Issues any decision under this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must 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~~,~~:

(a) ~~the~~The notice must 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}. Absent a showing of good cause, 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.

(b) Effective no later than October 1, 2024, the notice listed under subsection (a) of this section must be replaced with the following notice in bold text and formatted as follows:

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 your written request for review to:

{MCO name}

{MCO 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, unless you show good cause. If you appeal within the 30-day timeframe, we will review the disputed decision and notify you of our final decision within 60 days of your request. After that, if you still disagree with our decision, you may appeal to the Department of Consumer and Business Services (DCBS) for further review. If you do not seek dispute resolution through us, you will lose your right to appeal to DCBS.

(5) If an MCO receives a complaint or dispute that is not included in the MCO dispute resolution process, the MCO must, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director under OAR 436-015-0008.

(a) The notice must include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter that 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 Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days of the mailing date of this notice, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.

(b) Effective no later than October 1, 2024, the notice listed under subsection (a) of this section must be replaced with the following notice in bold text and formatted as follows:

Notice to the worker and all other parties:

{MCO name} does not have a process to review the type of issue you have raised. To pursue this issue you must request administrative review by the Department of Consumer and Business Services (DCBS) within 60 days of the mailing date of this notice.

If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision.

Send your written request for review to:

DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(6) The time frame for resolution of the dispute by the MCO may not exceed 60 days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260(15), the MCO must notify all parties to the dispute in writing with an explanation of the reasons for the decision. If the worker's attorney has notified the insurer in writing of representation, the MCO must also send a copy of the explanation of the reasons for the decision to the attorney. This notice must inform the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008.

(a) The notice must 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 the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 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. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.

(b) Effective no later than October 1, 2024, the notice listed under subsection (a) of this section must be replaced with the following notice in bold text and formatted as follows:

Notice to the worker and all other parties:

If you want to appeal this decision, you must do so within 60 days from the mailing date of this notice.

If you do not notify the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.

Send your written request for review to:

DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(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 must notify the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008 including the appeal rights provided in (6) of this rule.

(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.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 3/5/24 as Admin. Order 24-052, eff. 4/1/2024
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-015-0120 Sanctions and Civil Penalties

(1) Complaints pertaining to violations of these rules must be sent to the director.

(2) The director may investigate an alleged rule violation. The investigation may include, but is not 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 panel of the medical provider's peers, chosen in the manner provided in OAR 436-010-0330.

(3) 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 an MCO:

(a) Reprimand by the director;

(b) Civil penalty as provided under ORS 656.745(2). In determining the amount of penalty to be assessed, the director will consider:

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

(B) Previous violations; and

(C) Evidence of willful violation; or

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

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

(5) If an insurer or someone who is not a certified MCO acting on the insurer's behalf engages in managed care activities prohibited under these rules, the director may impose a sanction or civil penalty.

Stat. Auth.: ORS 656.260, 656.726(4) | Stats. Implemented: ORS 656.260 and 656.745
Hist: Amended 12/15/08, as Admin. Order 08-064, eff. 1/1/09
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended 12/17/19 as Admin. Order 19-062, eff. 1/1/20
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.