DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 15

MANAGED CARE ORGANIZATIONS

EFFECTIVE DECEMBER 26, 1990

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436-15-001 Authority For Rules

These rules are promulgated under the director's general rule-making authority of ORS 656.726(3) and specific authority under ORS 656.245, 656.248, 656.252, 656.254, 656.268, 656.325, 656.327, ORS 656.794(3), and Sections (12) & (13), Chapter 2, Oregon Laws 1990, Special Session.

Hist: Filed 6/19/90, as Admin. Order 5-1990, eff. 7/1/90 (Temporary)
Amended 12/12/90, as Admin. Order 31-1990, eff. 12/26/90

436-15-002 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 (MCO) to injured workers within the workers' compensation system.

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436-15-003 Applicability of Rules

(1) These rules are effective December 26, 1990 to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.268, 656.325, 656.327, 656.794 and Sections (12) & (13), Chapter 2, Oregon Laws 1990, Special Session, and govern all managed care organizations.

(2) The provisions of these rules shall be applicable to all managed care organizations and services rendered thereby, subsequent to the effective date of these rules.

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436-15-005 Definitions

For the purposes of these rules unless the context requires otherwise:

(1) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

(a) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or a board certified oral surgeon licensed by the Oregon Board of Dentistry; or

(b) A medical doctor, doctor of osteopathy or oral surgeon practicing in and licensed under the laws of another state; or

(c) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon; or

(d) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits, during that 30 day period, whichever first occurs, a doctor or physician of chiropractic practicing and licensed under the laws of another state; or

(e) A person authorized to be an attending physician, in accordance with a managed care organization contract.

(2) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(3) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury or illness of which an employer has notice or knowledge.

(4) "Claimant" means the worker making a claim.

(5) "Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in diagnosis and/or treatment. A consulting physician may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensation injury.

(6) "Department" means the Oregon Department of Insurance and Finance, consisting of the Board, the Director and all their assistants and employees.

(7) "Director" is the director of the Department of Insurance and Finance or the director's delegate for the matter.

(8) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance, consisting of the Compliance Section, Evaluation Section, Medical Review and Abuse Section, and Rehabilitation Review Section.

(9) "Health Care Provider" means an entity or group of entities, such as a medical clinic, a hospital, or group of medical clinics or hospitals, organized to provide a facility for medical care and medical services.

(10) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(11) "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 which has been certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

(12) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or related services such as any medication, crutch, prosthesis, brace, support or physical restorative device.

(13) "Medical Service provider" means a person duly licensed by any state to practice one or more of the healing arts in that state.

(14) "Peer Review" means the evaluation of the care provided to a worker by review of the pertinent records and/or personal interview with the attending physician or consultant. Such evaluation shall be conducted by a group designated by the MCO or the director which must include, but is not limited to, members of the same healing art.

(15) "Physician" or "Doctor" means a person duly licensed by any state to practice one or more of the healing arts in that state within the limits of the license of the licentiate.

(16) "Primary Care Physician" means a general practitioner, family practitioner, or internal medicine practitioner.

(17) "Report" means medical information transmitted in written form containing relevant subjective and objective findings. Reports may take the form of brief or complete

narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(18) "Worker" means a subject worker as defined in ORS 656.005.

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436-15-006 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.

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436-15-008 Administrative Review

(1) Any person aggrieved by a proposed order or proposed assessment of civil penalty of the division issued pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing shall be granted unless the request is in writing and specifies the grounds upon which the person requesting said hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the administrator of the Workers' Compensation Division within 20 days of receipt by the aggrieved person of notice of the proposed order or assessment. No hearing shall be granted unless the request is received by the administrator within said 20 days of receipt of notice.

(2) Any person aggrieved by an action or order of the division pursuant to these rules where such action or order qualifies for review by hearing before the director as a contested case, may request review pursuant to ORS 183.310 through 183.550 as modified by these rules pursuant to ORS 183.315(1). When the matter qualifies for review as a contested case, the process for review shall be as follows:

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing shall be granted unless the request is in writing and specifies the grounds upon which the action or order is contested and is received by the administrator within 30 days of the action or from the date of mailing or other service of an order.

(b) The hearing shall be conducted by the director or the director's designee.

(c) Any order in a contested case issued by another person on behalf of the director is a proposed order subject to revision by the director. The director may allow objections to the proposed order to be filed for the director's consideration within 30 days of the mailing date or other service of the proposed order.

(3) Any party aggrieved by an action taken by persons other than the division pursuant to these rules other than as described in sections (1) & (2) of this rule, may request administrative review by the division on behalf of the director. The process for administrative review of such matters shall be as follows:

(a) The request for administrative review shall be made in writing to the administrator of the Workers' Compensation Division within 90 days of the action. No administrative

review shall be granted unless the request is in writing and specifies the grounds upon which the action is contested and is received by the administrator within 90 days of the contested action unless the director or his designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) The review, including whether the request is timely and appropriate, may be conducted by the administrator, or the administrator's designee, on behalf of the director.

(c) In the course of said review the person conducting the review may require or allow such input or information from the parties or others as he or she deems to be helpful.

(d) The person conducting the review will specify in his determination if a person aggrieved may request a contested case hearing before the director pursuant to ORS 183.310.

(e) Any request for a contested case hearing before the director regarding a review determination made pursuant to this section must comply with the procedures provided in section (2) above.

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436-15-009 Formation/Certification Process

(1) Any health care provider or group of medical service providers wishing to establish a managed care organization must complete a three step process as follows:

(a) Submit a "Notice of Intent to Form" to the division, to ensure compliance with Section 12 (9), Chapter 2, Oregon Laws 1990, Special Session in a form and format as prescribed by the director.

(b) Submit a proposed plan of operation to the division which outlines the manner in which the managed care organization will meet the qualifications of Section 12, Chapter 2, Oregon Laws 1990, Special Session and OAR 436-15-030. If the plan is approved by the division, the managed care organization will have authorization to proceed to acquire the necessary services to meet the certification requirements.

(c) Submit an application for certification. Once the managed care organization has met the criteria for certification, a formal application must be submitted for approval by the division. Upon approval, the managed care organization will be allowed to contract with insurers in Oregon to provide medical services for injured workers.

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436-15-010 Notice of Intent to Form

(1) Any health care provider or group of medical service providers initiating a managed care organization pursuant to Section 12, Chapter 2, Oregon Laws 1990, Special Session, shall submit a "Notice of Intent to Form" to the division, by Certified Mail, in a form and format as prescribed by the director. The notice shall include, but not be limited to:

(a) Identity of the person or persons who participate in discussions intended to result in the formation of a 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.

(d) A time certain when the application for certification will be submitted to the division. The application for certification must be submitted within 120 days of the filing of the Notice of Intent to Form.

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436-15-020 Qualifying

(1) Any health care provider or group of medical service providers as defined in these rules may make written application to the director to become certified as a managed care organization (MCO) to provide managed care to injured workers for injuries and diseases compensable under ORS Chapter 656. To obtain certification, the applicant must:

(a) Submit a written plan for the MCO, along with 4 copies, to the administrator, Workers' Compensation Division, in which the applicant outlines the manner in which the proposed MCO will meet the requirements of Section 12, Chapter 2, Oregon Laws 1990, Special Session and OAR 436-15-030.

(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 proposed MCO and the title and name of the person to be the administrator of the financial affairs of the proposed MCO.

(c) If the plan for the proposed MCO is approved by the director, the applicant must be incorporated pursuant to the laws of the State of Oregon and provide satisfactory evidence of same to the administrator as the administrator shall require.

(2) 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 a MCO.

(3) The director may revoke the certification of an MCO if the director, at any time, determines that said MCO was formed or is 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.

(4) For purposes of this rule, factors upon which the director may conclude that an MCO has been formed by an insurer or other non-qualifying employer include, but are not limited to, the following:

(a) If 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) If, the 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.

(c) If the 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.

(d) If any insurer or other non-qualifying employer, or any member of its staff, provides administrative services, supplies or facilities to the MCO.

(e) If an insurer or other non-qualifying employer, or any member of its staff, prior to certification of the MCO, contracts with said MCO to provide it with business.

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

(a) If 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 or services of any kind to the MCO.

(b) If 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.

(6) For purposes of this rule, factors upon which the director may conclude that an MCO is operated by an insurer or other non-qualifying employer include, but are not limited to:

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

(b) If 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) If any insurer or other non-qualifying employer, or any member of its staff, performs administrative duties for the MCO as required in OAR 436-15-030.

(d) If any insurer or other non-qualifying employer, or any member of its staff, provides business to the MCO that amounts to more than 50 percent of the MCO's gross revenue as reflected in any fiscal year.

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

(7) For purposes of this section, "staff" is any individual who is a regular employee for an insurer or other non-qualified employer under this rule, or who is a regular employee of any parent or subsidiary entity of an insurer or non-qualified employer under this rule as well. "Staff" also includes any individual who was a regular employee of an insurer or other non-qualified employer under this rule or a regular employee of any parent or subsidiary entity thereof within the 12 months immediately prior to the date of the relevant "Notice of Intent to Form a Managed Care Organization" or any relevant time thereafter.

(8) An employer shall be determined to be "an employer other than a health care provider" when the employer does not own and operate a hospital or medical clinic.

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436-15-030 Applying for Certification

(1) A health care provider or group of medical service providers applying for certification as a managed care organization (MCO) must submit a written application, along with 4 copies, to the division to become a managed care organization. The application must include specific information to ensure the MCO will be able to meet the provisions of subsections (a) through (q) of this section as follows:

(a) The MCO must provide a list of the names 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 individuals will act as attending physicians within the MCO.

(b) The MCO must provide a description of the times, places and manner of providing services under the plan. This plan must provide at least an adequate number of each category of medical service providers. For purposes of these rules, the categories include chiropractic, dentist, naturopath, optometrist, osteopath, physician and podiatrist, as defined in ORS 676.110. The requirements of this section must be met unless the MCO shows evidence that a lack of a type of provider exists in an area and that the minimum number is not available. The number of providers should be adequate as necessary to:

(A) Include a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan and to ensure that 90 percent of all workers within the MCO are able to receive care by an attending physician within a reasonable distance of the employer's place of business or job site so that each injured worker can:

(B) Receive initial treatment by an attending physician within 24 hours.

(C) Receive initial treatment by an attending physician in the MCO plan within 5 working days, subsequent to treatment by a non-attending physician, outside the MCO.

(D) Receive treatment by an MCO physician in cases requiring emergency in-patient hospitalization.

(E) Receive information/advice on a 24 hour basis regarding medical services within the MCO plan.

(F) Include a minimum number of each category of other medical service providers to ensure that the worker has a choice of at least 3 providers within each category.

(G) Provide access to medical providers for workers in rural areas, considering the normal patterns of travel.

(H) Provide services that meet quality, continuity and other treatment standards prescribed by the director which will provide all medical and health care services in a manner that is timely, effective and convenient for the worker.

(I) Provide specialized medical services the MCO is not otherwise able to provide including a description of the times, places and manner of providing such services.

(c) The application must include copies of contract agreement(s), or other documents signed by the managed care organization and each participating medical service provider/health care provider representative, which verify membership.

(d) The MCO must designate a 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.

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

(e) The MCO application must 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 centralized communication liaison, or as otherwise provided by the contract.

(f) The MCO must provide satisfactory evidence of ability to meet the financial requirements necessary to insure delivery of service in accordance with the plan.

(g) The MCO must provide a procedure within the managed care organization plan to provide financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(h) The MCO must provide 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 comlaints of workers,

(B) Physician peer review;

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

(i) The MCO shall provide a program involving cooperative efforts by the workers, the employer, the insurer, and the managed care organization to promote early return to work for injured workers.

(j) The MCO shall provide a program involving cooperative efforts by the workers, the employer and the managed care organization to promote workplace safety and health consultative and other services. The program shall include:

(A) Identification of how the managed care organization 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 437-01-015(50); 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 437-01-1030 or OAR 437-01-1050.

(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 437-01-1030 or OAR 437-01-1050.

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

(k) The MCO must provide a procedure for workers to receive compensable medical treatment from a primary care physician 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.

(1) The MCO must include a program which provides adequate methods of peer review and utilization review to prevent inappropriate or excessive treatment to include at least, but not be limited to:

(A) Pre-admission review program, which requires physicians to obtain prior approval of all elective admissions to the hospital and of all elective surgeries prior to surgery being performed.

(B) Individual case management programs, which search for 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 to include, but not be limited to, 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 with the same diagnosis.

(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 obtained prior to repeat surgeries.

(m) The MCO plan must include a procedure to provide services that meet quality, continuity and other treatment standards prescribed by the director and will provide all medical and health care services that may be required by ORS Chapter 656, in a manner that is timely, effective and convenient for the worker.

(n) The MCO plan must include a procedure for internal dispute resolution, to include a method to resolve complaints by injured workers, medical providers, and insurers.

(o) 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 436-15-040 and 436-10.

(p) The MCO plan must include a program which specifies the criteria and process for peer review.

(q) The MCO plan must include a procedure approved by the Director to notify the division of the commencement or termination of membership in the organization.

(2) The MCO shall also submit a copy of the MCO certification of incorporation and a copy of the MCO by-laws.

(3) Each application for certification shall be accompanied by a non-refundable fee of $1,500 which will be deposited in the Insurance and Finance Fund.

(4) 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 436-15-050.

(5) Once all certification requirements have been met, within 45 days of receipt of all required information the director will notify the applicant of the effective date of the certification as a managed care organization. If the certification is denied, the applicant will be provided with the reason therefore.

(6) The application for certification for a managed care organization shall not be approved if:

(a) The organization is formed, owned or operated by a workers' compensation insurer or an employer other than a health care provider or group of medical service providers; or

(b) The organization fails to meet the requirements of these rules.

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436-15-035 Coverage Responsibility of a MCO

(1) A managed care organization shall provide comprehensive medical services to all injured workers covered by the insurer/MCO contract, subject to geographical limitations of the MCO certification. Employees who reside outside the geographical boundaries of the MCO shall not be subject to the insurer/MCO contract.

(2) Notwithstanding the requirements of section (1), failure of the managed care organization to provide such medical services does not relieve the insurers of their responsibility to ensure benefits are provided injured workers under ORS 656.001 to 656.794.

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436-15-040 Reporting Requirements For a MCO

(1) In order to ensure the managed care organization complies with the requirements of this section, by March 1 of each year, each managed care organization shall submit to the division:

(a) The most recent audited financial statement or annual report.

(b) Updated membership listings by category of provider, including provider names, specialty, address, phone number, and social security number.

(c) A list of all hospitals utilized by the plan.

(d) A listing of any sanctions or punitive actions taken by the MCO against its members.

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

(f) A report of utilization review performed in accordance with the requirements of utilization and treatment standards pursuant to Section 14, Chapter 2, Oregon Laws 1990, Special Session, showing cases reviewed, the issues involved, and the action taken.

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

(2) 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.

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436-15-050 Notice of Place of Business in State; Records MCO Must Keep in Oregon

(1) Every managed care organization that is certified to provide medical services as required by Section 12, Chapter 2, Oregon Laws 1990, Special Session shall give the division

notice of one location and mailing address in this state where the managed care organization keeps records of the following:

(a) Updated membership listings of all MCO members.

(b) All records necessary to ensure compliance with the certification requirements in accordance with OAR 436-15-030.

(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 insurer's contract with the MCO is cancelled for any reason, all MCO records as identified in section (1), relating to treatment provided to workers within the managed care organization must be forwarded to the insurer upon request.

(4) Individual MCO members must maintain claimant medical records. The records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided within each set of records. The records shall contain:

(a) Objective and subjective findings;

(b) Complete case history of the services rendered (diagnostic and therapeutic procedures employed) to each claimant, and the time involved if the procedure being billed is based upon time; and

(c) Documentation by the attending physician that addresses the worker's time loss status, ability for early return to work, and a plan to manage all facets of care being provided.

(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.

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436-15-060 Commencement/Termination of Members

(1) Prospective new members of a managed care organization shall submit an application to the managed care organization. The directors, executive director, or administrator may approve the application for membership pursuant to the bylaws of the managed care organization. The certified managed care organization 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.

(2) Individual members may elect to terminate their participation in the managed care organization or be subject to cancellation by the managed care organization pursuant to the bylaws of the managed care organization. Upon termination of a member, the managed care organization 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.

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436-15-070 Primary Care Physicians Who Are Not MCO Members

(1) The MCO shall authorize a physician who is not a member of the MCO to provide medical services to a worker at time of injury if the physician qualifies as a primary care physician. For the purposes of this rule, the physician must:

(a) Qualify in accordance with OAR 436-15-005 (1) as an attending physician and must be a general practitioner, a family practitioner, or an internal medicine specialist.

(b) Maintain the worker's medical records;

(c) Have a documented history of treatment of that worker;

(d) Agree to comply with all terms and conditions regarding services performed by the MCO; and

(e) Agree 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) For purposes of this rule, the primary care physician 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 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 through a private health plan, prior to the date of injury, the requirements of subsections (1)(b) & (c) shall be deemed to be met.

(3) Nothwithstanding 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 who are not MCO members, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker shall select one physician to treat the compensable injury as the primary care physician.

(4) Any questions or disputes relating to the worker's selection of a primary care physician who is not a MCO member shall be resolved pursuant to OAR 436-15-110.

Hist: Filed 6/19/90, as Admin. Order 5-1990, eff. 7/1/90 (Temporary)
Amended 12/12/90, as Admin. Order 31-1990, eff. 12/26/90

436-15-080 Suspension; Cancellation; Revocation

(1) Notwithstanding Section 12, Chapter 2, Oregon Laws 1990, Special Session, the certification of a managed care organization issued by the director may be suspended, cancelled, or revoked by the director after giving 30 days notice if:

(a) Service under the plan is not being provided in accordance with the terms of the certified plan.

(b) The plan for providing medical or health care services fails to meet the requirements of these rules.

(c) There is a change in legal entity of the managed care organization which does not conform to the requirements of these rules.

(d) The managed care organization fails to comply with Section 12, Chapter 2, Oregon Laws 1990, Special Session, these rules, or the requirements contained in OAR 436-10 and requirements of utilization and treatment standards pursuant to ORS 656.248.

(e) The managed care organization commits any violation for which a civil penalty could be assessed under ORS 656.745; or

(f) Any false or misleading information is submitted by the managed care organization or any member of the organization.

(2) The director may revoke the certification of a MCO if, at any time, the director determines that said MCO was formed or is 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.

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

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436-15-090 Charges and Fees

(1) Billings for medical services under a managed care organization shall be submitted in the form and format as prescribed in OAR 436-10-090. Except as provided in sections (2) and (3) of this rule, the payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to OAR Chapter 436, Division 10, Medical Service Rules.

(2) The adjusted cost/charge ratio as described in OAR 436-10-090(1) need not be applied to the inpatient hospital and outpatient surgical services provided by hospitals who are, by contract, members of a managed care organization. Hospitals which form, own or operate an MCO shall receive reimbursement for inpatient hospital and outpatient surgical services provided to injured workers covered by another MCO comparable to, or less than, the amount reimbursed for like services provided within their own MCO. For the purposes of this rule, when an MCO formed, owned or operated by a hospital, has contracts with insurers with differing reimbursement rates "comparable reimbursement" shall be the average of the contracted rates.

(3) The adjusted cost/charge ratio as described in OAR 436-10-090(l) shall be applied to the inpatient hospital and outpatient surgical services provided by hospitals who are not members of a managed care organization and for services provided to workers not under a managed care organization.

(4) Notwithstanding section (1) of this rule, fees paid for medical services provided by primary care physicians who are not MCO members 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 Chapter 436, Division 10, Medical Service rules.

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436-15-100 Monitoring/Auditing

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

(2) All records of the managed care organization 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.

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436-15-110 Dispute Resolution/Complaints of Rule Violation

(1) Disputes which arise between any party and a managed care organization shall first be processed through the dispute resolution process of the managed care organization. Disputes must be in writing and filed within 30 days of the dispute. If the dispute cannot be resolved, or one of the parties so requests in writing, the director may assist in resolution. The director may issue an order to resolve the dispute. If no resolution is made after all avenues have been exhausted, any party aggrieved by an action under this section may request an administrative review by the director as per OAR 436-15-008.

(2) Complaints pertaining to violations of these rules shall be directed in writing to the division. The division will 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.

(3) The division shall 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 436-10-047.

(4) 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 436-15-120.

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436-15-120 Sanctions and Civil Penalties

(1) If the director finds any violation of OAR 436-15-040, 436-15-050, 436-15-090, 436-15-100(2), 436-15-110, 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 managed care organization:

(a) Reprimand by the director;

(b) Civil penalty of up to $5000 for failure to comply with ORS 656.001 to 656.794. Each day a violation continues shall constitute a separate violation. All penalties collected under this section shall be paid into the Insurance and Finance Fund. In determining the amount of penalty to be assessed, the director shall consider:

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

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violation.

(2) If the conduct as described in (1) above is found to be repeated and willful, the director may suspend or revoke the certification of the managed care organization.

(3) If a managed care organization continues to utilize the services of a health care practitioner whose license has been suspended or revoked by the licensing board for

violation of professional and/or ethical standards, the managed care organization's certification may be suspended or revoked.

(4) The director shall investigate the allegations and may seek advice from the Workers' Compensation Management-Labor Advisory Committee, practitioner's licensing boards, or professional associations. At the completion of the investigation, the director may adopt the recommendations of the Workers' Compensation Management-Labor Advisory Committee, licensing board, professional association, and may assess civil penalties as provided in (1) above.

(5) If a managed care organization at any time is found to be formed, owned, operated or otherwise controlled by an insurer, the managed care organization's certification will be revoked.

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436-15-130 Service of Orders

(1) When the director suspends or revokes certification of a managed care organization pursuant to OAR 436-15-080, or assesses a civil penalty under the provisions of OAR 436-15-120, the order, including a notice of the party's appeal rights, shall be served upon the party.

(2) The order shall be served by delivering a copy to the party through certified mail or in any manner provided by Oregon Rules of Civil Procedure (7)(D).

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