DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 15

MANAGED CARE ORGANIZATIONS

EFFECTIVE JUNE 14, 1991

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Oregon

DEPARTMENT OF INSURANCE AND FINANCE

"Expertise in the Public Interest"

June 21, 1991

TO: ALL INTERESTED PARTIES

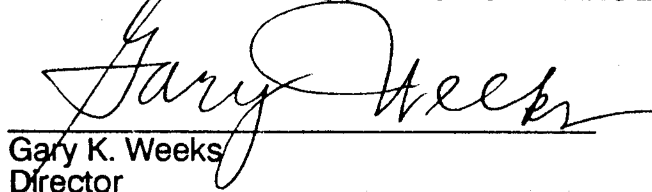
SUBJECT: TYPOGRAPHICAL ERROR IN OAR 436-15-020 (6)(d)

A typographical error has been found in the first sentence of the above referenced rule. Please amend it to read as follows:

"When any insurer or other non-qualifying employer, or any member of its staff, exclusively contracts with a single MCO to provide it with business."

Dated this 21 Day of June, 1991

DEPARTMENT OF INSURANCE & FINANCE



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DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MANAGED CARE ORGANIZATIONS

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 15

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, organized to provide health care services or organized to provide administrative support services to those entities providing health care services. An entity solely organized to become a Managed Care Organization under these rules is not, in and of itself, a health care provider.

(10) "Health Care Services" means medical or surgical treatment, nursing, hospital and optometrical services.

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

(12) "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. "Insurer" also includes any third party claims administrators acting as representatives or agents of the insurer or self-insured employer other than an organization formed, owned, or operated by a health care provider.

(13) "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.

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

(15) "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.

(16) "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.

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

(18) "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.

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

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Amended 12/12/90, as Admin. Order 31-1990, eff. 12/26/90
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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 which must exist for the director to conclude that an MCO is or will be formed by an insurer or other non-qualifying employer include any one or more of the following:

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

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

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

(5) For the purposes of this rule, factors which must exist for the director to conclude that an MCO is or will be owned by an insurer or other non-qualifying employer include any one or more of the following:

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

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

(6) For purposes of this rule, factors which must exist for the director to conclude that an MCO is or will be operated by an insurer or other non-qualifying employer include any one or more of the following:

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

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

(c) When any insurer or other non-qualifying employer, or any member of its staff, provides MCO services other than as allowed by section (8) of this rule;

{ED. NOTE: The first sentence of (d) below was corrected as shown on the agency notice dated 6/21/91, located at the front of this document. The corrected sentence is: "When any

insurer or other non-qualifying employer, or any member of its staff, exclusively contracts with a single MCO to provide it with business."}

(d) When any insurer or other non-qualifying employer, or any member of its staff, exclusively contracts with a single insurer to provide it with business. For purposes of this subsection, "exclusively" means 75 percent or more of the workers covered by the MCO are insured with that insurer. An MCO will have up to 180 days from the effective date of its first contract to meet this requirement; or

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

(7) For purposes of this rule, "staff" is any individual who is a regular employee of 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.

(8) Notwithstanding the provisions of sections (4), (5), and (6) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer provided services must be in accordance with protocols and standards established by the certified MCO program and approved by the director. For purposes of this rule, the insurer cannot provide managed care services related to dispute resolution and physician peer review.

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Amended 12/12/90, as Admin. Order 31-1990, eff. 12/26/90
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436-15-080 Suspension; Revocation

(1) Pursuant to Section 12, Chapter 2, Oregon Laws 1990, Special Session, the certification of a managed care organization issued by the director may be suspended or revoked by the director 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 or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or ORS 656.745;

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

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

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

(2) For the purpose of this rule:

(a) "Suspension" and its variations meat,-, a stopping by the director of the MCO's authority to enter into new contracts with insurers for a specified period of time. The suspension period may be imposed for a period up to a maximum of one year.

(b) "Revocation" and its variations means a permanent revocation of an MCO's certification to provide services under these rules.

(c) "Show-Cause Hearing" means an informal hearing with the director or designee at which the MCO may be heard and present evidence regarding the Director's intent to suspend or revoke its MCO certification.

(3) A show-cause hearing may be held at any time the director has reason to believe an MCO has failed to comply with its obligations under ORS Chapter 656, these rules, or orders of the director.

(4) Suspension or revocation under this rule will not be made until the MCO has been given notice and the opportunity to be heard through a show-cause hearing before the director and "show-cause" why it should be permitted to continue to provide services under these rules. The process shall be as follows:

(a) The Director shall provide the MCO written notice of an intent to suspend the MCO's certification and the grounds for such action. The notice shall also advise the MCO of their right to participate in a show cause hearing and the date, time and place of the hearing. The notice shall be sent by certified mail at least 30 days prior to the scheduled date of the hearing.

(b) After the show-cause hearing the director may issue a proposed and final order suspending the MCO or may initiate revocation proceedings pursuant to section (5) of this rule. Upon suspension, the MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension.

(c) Prior to the end of the suspension period the division shall determine if the MCO is in compliance. 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 without further hearing or revocation proceedings may be initiated.

(d) A suspension may be set aside prior to the suspension period designated end, if the director is satisfied of the MCO's ability and commitment to comply with ORS Chapter 656 and the rules promulgated pursuant thereto and is in compliance.

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

(a) Before revocation of certification under this section becomes effective, the director shall give the MCO notice that the certification will be revoked stating the grounds for the revocation. The notice shall be served on the MCO in the manner provided by ORS 656.427 (3). The revocation shall become effective within 10 days after receipt of such notice by the MCO unless within such period of time the MCO corrects the grounds for the revocation to the satisfaction of the Director or appeals in writing to the department.

(b) If the MCO appeals, the director shall set a date for a hearing and shall give the MCO at least ten days notice of the time and place of the hearing. Within thirty days after the hearing, the director shall either affirm or disaffirm the revocation and give the MCO written notice thereof by registered or certified mail.

(c) If revocation is affirmed on review by the director, the revocation is effective ten days after the MCO receives notice of the affirmance unless the MCO petitions for judicial review of the affirmance pursuant to ORS 183.310 to 183.550.

(d) If the revocation is affirmed following judicial review, the revocation is effective ten days after entry of the final decree of affirmance.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for three (3) years or longer, it may petition the director to restore its authority by submitting a plan and application in the form and format as provided in OAR 436-15-009.

(7) Notwithstanding section (4) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show-cause hearing. Such order shall be final, unless the MCO requests a hearing. The process for review shall be as provided in OAR 436-15-008(2), except the parties shall have 90 days from the date of mailing or other service of an order within which to submit their request for hearing.

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

(9) Appeals of proposed and final orders of suspension issued under this rule shall be made as provided in OAR 436-15-008(2).

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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.

(c) Suspension or revocation of the MCO's certification pursuant to OAR 436-15-080.

(2) 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 impose one or more of the sanctions as provided in section (1) of this rule.

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