Exhibit
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February 25, 2026

MARIE ROGERS
POLICY ANALYST/RULES COORDINATOR
WORKERS' COMPENSATION DIVISION
DEPT. OF CONSUMER & BUSINESS SERVICES
350 WINTER ST. NE
SALEM, OR 97312

Re: Written comments regarding WCD's Proposed Changes to OAR 436-009, -010, -015, and -035

Dear Ms. Rogers,

SAIF Corporation thanks the Workers' Compensation Division (WCD) for the opportunity to provide written comments related to the Proposed Changes to OAR 436-009, -010, -015, and -035. SAIF offers the following written comments for the division's consideration.

OAR 436-009-0060(2)

The proposed change would require an insurer to pay for an addendum report from a WRME provider. As drafted, the proposed change conflicts with ORS 656.325(1)(e), which states that "[t]he cost of the examination and the examination report shall be paid by the insurer or self-insured employer." The statute only requires an insurer to pay for the examination report, not an addendum report. The proposed change is an impermissible expansion of the statute.

In addition, an addendum report is undefined in the proposed rule. Without a definition, a party may argue that any concurrence letter or request for clarification from the WRME provider constitutes an addendum report, which must be paid by the insurer.

Currently, OAR 436-060-0147 sets forth the process of obtaining a WRME including questions that must be provided to a WRME provider and the timeline for issuing the examination report. The rules do not establish a process for an addendum report. Because an addendum report is issued after the examination report and potentially in response to later submitted questions, the submission of additional questions and the timing of the report would conflict with OAR 436-060-0147. *See also* *Craig A. Olsen*, 19 CCHR 90 (2014) (finding an insurer was not responsible for the cost of a WRME addendum report).

For these reasons, SAIF respectfully requests WCD remove the proposed changes and maintain the current language for WRME costs that are paid by the insurer or self-insured employer.

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OAR 436-010-0230(4) and 436-010-0270(3)

The proposed rules expand the medical services that are subject to a preauthorization request. SAIF appreciates WCD's proposed rule that narrows the type of services that may be subject to preauthorization and the creation of a preauthorization form. However, SAIF still has concerns regarding the proposed rule.

First, the proposed rule only allows an insurer to approve or disapprove a preauthorization request. SAIF proposes WCD include an option for an insurer to defer its decision until it receives additional information or records that are needed prior to approving the service. OAR 436-010-0240(4)(d) highlights the concern as it requires a medical provider to respond within 14 days of a request for progress reports, diagnostic studies, or relevant medical records. A situation may arise where an insurer receives a request for preauthorization of a medical service but is unable to respond within 14 days because the insurer requests additional information or records from the requesting medical provider who also has 14 days to respond to the insurer's request. In this situation, the insurer may not meet the 14 day deadline as it waits for a timely response or records from the medical provider. A response that the insurer's approval is deferred until receipt of the required records or information provides flexibility to all parties and a response that is based on complete information.

In addition, SAIF suggests the preauthorization form allow an insurer to partially approve a preauthorization request. For example, a provider may request 12 physical therapy visits and the insurer may preauthorize 6 physical therapy visits based on the medical opinions in that claim.

Proposed OAR 436-010-0230(4)(b)(A) and 436-010-0270(3)(c)(A) state that if an insurer fails to respond then the request is considered denied. SAIF proposes stating the request is considered disapproved or not preauthorized rather than denied. This maintains consistency within the administrative rules where medical services may be disapproved[1] and a claim may be denied.[2]

Additionally, it is unclear from the proposed rules whether the insurer may respond to a request for director review and what information an insurer may or may not provide as part of the director's review. SAIF also assumes that if the director preauthorizes a medical service that does not mean the service is compensable or would otherwise be paid by the insurer. Preauthorization is not a guarantee of payment. Clarification as to the process of director review would be beneficial to insurers, medical providers, and injured workers.

OAR 436-010-0270(1)(c)

SAIF appreciates aligning the notice provisions of OAR 436-010-0270(1)(c) with 436-060-0015(8) when a worker is deemed medically stationary. However, expanding the providers who must be sent a copy of the notice is overly burdensome and unworkable.

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[1] *See* OAR 436-010-0210(7), 436-010-0250(2)(c)(C), 436-010-0270(5)(k)(A), OAR 436-010-0290(2)(b)-(e).
[2] *See* OAR 436-010-0005(21), 436-010-0008(2)(a)(C), 436-010-0270(1)(b), (5)(d)(E) and (e), 436-010-0280(7)

The proposed rule expands the list of providers who must be sent a copy of the medically stationary notice and is not feasible as drafted. In 2025, SAIF closed approximately 7,670 disabling claims based on a determination the worker was medically stationary[3]. SAIF's system automatically sends a copy of the medically stationary notice to the attending physician or authorized nurse practitioner. There is no mechanism through which SAIF can automate the identification of every provider or interpreter who submits a bill to SAIF within the last 90 days. The proposed rule would require a time-consuming manual review of every claim and every billing received within the last 90 days and manually adding the providers and/or interpreter to the medically stationary notice. This runs counter to the intent of the proposed change, which was to simplify the notice requirement so duplicative notices are not sent under different administrative rules. As drafted, the expansion of who must be copied on the notice has the opposite effect.

In addition, the proposed rule requires the insurer to notify all actively treating medical providers, which is defined as any provider or interpreter who bills the insurer within the last 90 days. Unfortunately, the insurer's receipt of a billing does not indicate the treatment occurred close in the time to the medically stationary determination. Under OAR 436-009-0010(2)(d), a medical provider may submit a bill for payment within 12 months of the date of service and the insurer may not reduce payment. SAIF receives billings up to, and more than, 12 months after the date of service. Under the proposed rule, an insurer would be required to send the notice to a medical service provider who treated an injured worker within 15 months of the medically stationary date (i.e. provider bills within 12 months of the service and within 90 days the worker is medically stationary). SAIF may also receive a bill for a service that was provided beyond the billing time periods and would still be obligated to send the billing provider a copy of the letter. The effect is that a notice may be sent to providers including emergency room and urgent care providers who treated a worker once and are no longer involved in the worker's medical care. This increases the administrative burden for those providers who are not involved in the worker's care and creates confusion as to the basis for the notice. In addition, SAIF may receive a single billing sheet for multiple interpreter services throughout the past month for different workers. The billing statements would have to be individually and manually reviewed to identify whether SAIF must send a copy of the letter.

For these reasons, SAIF urges WCD to maintain the current providers (i.e. attending physician or nurse practitioner) who must be notified when a worker is medically stationary as the proposed rule is unworkable and would lead to administrative burden and confusion.

OAR 436-015-0037(3)(e)(A)

SAIF maintains that a timely transition of care from a non-MCO provider to an MCO provider is important to ensure injured workers continue to recover from their injury. SAIF remains concerned that by extending the time period that an injured worker may treat with their current provider from 14 days to 30 days will further delay the transition of care to an MCO provider and delay workers' access to care and recovery.

[3] In 2025, SAIF issued approximately 3,900 administrative claim closures in addition to the 7,670 claims that were closed based on a determination the worker was medically stationary.

Effective date

To successfully implement the proposed changes, SAIF will need to gather experts from multiple divisions to adjust and update our internal processes and workflows, educate adjusters, and change and test existing computer systems to align with the timelines and responses to ensure system changes work as intended. The impact of the proposed changes is significant when layered onto existing projects and programs. As a result, an effective date of April 1st would be administratively burdensome and challenging to meet. Taking into consideration the scope of the changes proposed, current workloads, training requirements, and existing IT projects, SAIF respectfully requests an October 1, 2026 effective date.

As always, SAIF appreciates the WCD's engagement and commitment to the rulemaking process as well as its collaborative approach. Thank you for your consideration of SAIF's comments as the division proceeds with its review of the issues raised.

Sincerely,

/s/ Elaine Schooler
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