OREGON TRIAL LAWYERS ASSOCIATION
In the Service of Justice

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Exhibit "6"

February 17, 2026

WCD Rules Coordinator
350 Winter Street NE
P.O. Box 14480
Salem, OR 97309-0405

Dear WCD Rulemaking:

In 2025, MLAC convened an Access to Care Subcommittee to focus on why more and more providers are refusing to participate in the workers' compensation system, which is a massive crisis. The number one issue raised by providers was the inability to get responses from insurers when preauthorization was needed.

OTLA proposed an expanded preauthorization rule patterned on 436-010-0250 (attached as Exhibit A), which currently only applies to elective surgeries. This concept was supported by the majority of the committee, and went into the committee's recommendations to MLAC.

The proposed amendments to OAR 436-010-0270 (attached as Exhibit B do not align with the elective surgery rules, or the recommendations of the MLAC Subcommittee.

The elective surgery rule gives the insurer seven days to respond. The proposed rule would allow 14 days. There is no good policy reason for making the response time longer for more routine services than we do for surgeries.

The elective surgery rule provides a standard form for the request, a standard form for the response, and a deadline for the IME if one is requested. The proposed rule only provides a standard form for the request. It is essential for the process to be spelled out to provide clarity for all involved. The proposed rule does not spell out the process if an insurer requests an examination. The rules should be the same.

The elective surgery rule states that if the insurer does not respond, the insurer is barred from later challenging the appropriateness of the surgery, or whether the surgery is excessive or ineffectual. They can still challenge claim relatedness. This provision is not in the proposed rule, but it should be. This is an essential way to incentivize compliance with the rules.

The proposed rule inserts a deadline for the worker to file an appeal, even if the insurer fails to respond!

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Perhaps the most critical thing that is left out of the proposed rule is a way to prove the insurer received the request. During the Subcommittee and Advisory Committee meetings, OTLA asked that there be a standard procedure with a presumption of receipt if proof of sending can be provided. Without a way to prove an insurer received what the provider sent, the rule will be ineffective.

Finally, there is no good policy reason to limit the types of medical services that can be requested. For example, sometimes a new attending might want to get preauthorization for their own visit. The proposed rule would not allow that. This rule would not cover electro diagnostic testing, for example. There are many others. The rule should strive to be as inclusive as possible. OTLA has been requesting a rule applicable to all services for many years, and each time there has been a change it has only been to add one or two more types of services.

OTLA would propose the following amendments to align the rules and address the other issues we have raised:

(3) Preauthorization

(a) Unless otherwise provided by an MCO, a medical provider may submit a completed Form XXX to the insurer **to the email or facsimile address provided by the insurer.** ~~for preauthorization of physical therapy, occupational therapy, speech and language therapy, referral to a specialist physician, or diagnostic imaging studies, other than plain film X-rays.~~ The insurer must respond to the provider's request in writing within **7** ~~14~~ days of receipt of the request **that the proposed service is: (A) approved; (B) not approved and a consultation is requested by using Form 3228 (Elective Surgery Response); or (C) disapproved by using Form XXX. (d) If the insurer does not complete Form XXX (e.g., no specific date or consultant name) or communicate approval to the recommending provider within seven days of receiving the notice of request for authorization, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual..** ~~The response must state whether the service is preauthorized or not preauthorized.~~ Preauthorization is not a guarantee of payment.

(b) When form XXX is received, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice. If the insurer requests a consultation, it must be completed within 28 days after sending Form XXX to the physician.

(c) The insurer must notify the recommending provider of the consultant's findings within seven days of the consultation and inform the provider whether the services are approved or denied.

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(d) If the insurer fails to respond to the provider within 7 ~~14~~ days of **the provider's proof of sending** ~~receiving~~ Form XXX: (A) The preauthorization request is considered denied; and (B) The requesting provider or worker may request authorization from the director ~~within 60 days from the date the request was first submitted to the insurer.~~ When the provider requests authorization from the director, the provider must include a copy of the original request and may include any other supporting information.

If it is necessary to hold off on implementation of this rule so that these concerns can be discussed and addressed, OTLA would prefer that to having the rule enacted as proposed.

Sincerely,

Keith Semple
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Exhibit A- Elective Surgery Rule

OAR 436-010-0250 Elective Surgery (1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health. (2) Except as otherwise provided by the MCO:

(a) The attending physician, authorized nurse practitioner, or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. To notify the insurer of the proposed surgery, the provider has the option of using Form 5425 (Elective Surgery Notification) or using their own form that includes the data gathered on Form 5425.

(b) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

(c) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery: (A) Is approved; (B) Is not approved and a consultation is requested by using Form 3228 (Elective Surgery Response); or (C) Is disapproved by using Form 3228.

(d) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery. 436-010-0250 Page 29 436-010-0250 ORDER NO. 24-051 DEPARTMENT OF CONSUMER AND BUSINESS SERVICES WORKERS' COMPENSATION DIVISION MEDICAL SERVICES RULES

(e) If the insurer requests a consultation, it must be completed within 28 days after sending Form 3228 to the physician.

(f) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.

(g) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.

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(h) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must send either the signed and dated Form 3228 or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(i) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

(j) Surgery that must be performed before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases, the attending physician or authorized nurse practitioner should try to notify the insurer of the need for emergency surgery.

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Exhibit B- Proposed Rule

(3) Preauthorization

(a) Unless otherwise provided by an MCO, a medical provider may submit a completed Form XXX to the insurer for preauthorization of physical therapy, occupational therapy, speech and language therapy, referral to a specialist physician, or diagnostic imaging studies, other than plain film X-rays. The insurer must respond to the provider's request in writing within 14 days of receipt of the request. The response must state whether the service is preauthorized or not preauthorized. Preauthorization is not a guarantee of payment.

(b) If the insurer fails to respond to the provider within 14 days of receiving Form XXX: (A) The preauthorization request is considered denied; and (B) The requesting provider or worker may request authorization from the director within 60 days from the date the request was first submitted to the insurer. When the provider requests authorization from the director, the provider must include a copy of the original request and may include any other supporting information.