STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

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| In the Matter of the Amendment of:<br>• 436-009, Oregon Medical Fee and Payment<br>• 436-010, Medical Services<br>• 436-015, Managed Care Organizations<br>• 436-035, Disability Rating Standards | )<br>)<br>)<br>) | SUMMARY OF TESTIMONY AND AGENCY RESPONSES |

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency's conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated February, 2026. On February 18, 2026, a public rulemaking hearing was held as announced, by teleconference and videoconference and at 11:30 a.m. Marie Rogers, from the Workers' Compensation Division, was the hearing officer. The record was held open for written comment through February 25, 2026.

**Testimony list:**

| Exhibit | Testifying |
|---|---|
| 1 | Transcript of hearing (Ann Klein, Majoris Health Systems, Jovanna Patrick, Sydney Montanaro, and Keith Semple, Oregon Trial Lawyers Association) |
| 2 | Andrea K. Knight, Edmunson Barnhart Knight |
| 3 | Elaine Schooler, SAIF Corporation |
| 4 | Misty Bergenstock, Endeavor Psychiatry |
| 5 | Ann Klein, Majoris Health Systems |
| 6 | Keith Semple, Oregon Trial Lawyers Association |

**NOTES about the summaries of testimony:** The summaries paraphrase and combine similar testimony. This means that the summary represents some but not all of the views expressed in the exhibits listed above the summary.

****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 ques"tions, 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).****

**Response:** Thank you for your testimony. An addendum report means additional information is added to a medical report to either clarify, correct, or supplement the report, i.e., the addendum becomes part of the medical report. The worker and the WRME provider should have access to the entire IME report. If the insurer requests an addendum report from the IME provider after the WRME provider examined the worker and authored their report, the worker should be entitled to receive clarification or supplemental information from the WRME provider in response to the IME addendum. In return, the WRME provider is entitled to receive payment from the insurer for the time spent authoring the addendum report. In *Craig A. Olsen*, 19 CCHR 90 (2014) claimant's questions were submitted after the exam, but not in response to an IME addendum report, and therefore, the ALJ found the insurer not liable for payment for the WRME addendum report. The amended descriptor of OSC W0001, only makes a WRME addendum report payable when authored in response to an IME addendum report, and WCD does not believe the amended descriptor or W0001 conflicts with statute. Therefore, WCD publishes the amended W0001 descriptor as proposed.

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**Testimony: OAR 436-010-0230** ***Exhibit 2***

****The preauthorization rule should provide a clear and unambiguous method for obtaining a preauthorization decision, when requested by a provider. Any provider who is authorized to treat injured workers should be able to request preauthorization from the insurer for any medical services they feel need to be provided to diagnose and/or treat the injury.*

*A request for preauthorization is a request for confirmation of payment. The proposed rule currently states that the preauthorization is not confirmation of payment. If it is not a confirmation of payment, then how helpful is it to the providers and the injured worker?*

*Moreover, the rule should mirror the procedure and time allowed for Insurer response to*

*elective surgery requests. The Insurer should response in 7 days, rather than 14 so that the rules align. Aligning the rules would make the implementation of the rule clear to all involved. Similarly, the Insurer should be barred from contesting reasonableness should they fail to response to the provider's preauthorization request.****

**Testimony: OAR 436-010-0230(2) & OAR 436-010-0270(3),** ***Exhibit 3***

****[T]he 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 disapproved1 and a claim may be denied.*

*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.****

**Testimony: OAR 436-010-0270** ***Exhibit 6***

****The proposed amendments to OAR 436-010-0270 […] 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!*

*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.****

**Response:** Thank you for your testimony. WCD drafted the proposed preauthorization rule based on the issue submitted and the discussion at the rules advisory committee meeting. However, during testimony, many stakeholders raised additional discussion points that WCD believes warrant further conversation. Therefore, WCD will not make any changes to current preauthorization regulations. Instead, WCD will ask stakeholders for additional input at a future rules advisory committee meeting.

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**Testimony: OAR 436-010-0270(1)(c)** ***Exhibit 3***

*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.*

*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 stationary3. 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.*

**Response:** Thank you for your testimony. WCD agrees that it may not be feasible to require an insurer to notify *every* provider and interpreter. Based on disputes received by WCD, ancillary care providers are the type of provider that are most often unaware that a worker has become medically stationary. Therefore, this published rule will require an insurer to only notify actively treating ancillary care providers besides the attending physician/authorized nurse practitioner.

WCD also agrees that using receipt of a provider's bill within the last 90 days may be a problematic way to determine whether a provider is an "actively treating" provider. Since ancillary care providers must submit a treatment plan within 7 days of beginning treatment, a current treatment plan lends itself to identify an actively treating ancillary care provider. Hence, when a worker becomes medically stationary, the published rule requires an insurer to notify an ancillary care provider who submitted a current treatment plan to the insurer as required under OAR 436-010-0270.

**Testimony: OAR 436-010-0280** ***Exhibit 4***

*Closing examinations are not routine clinical encounters. They determine medically stationary status, permanent impairment, and statutory benefit entitlement, with real world, significant, and lasting consequences for the worker. Because they directly affect workers' legal rights, they require heightened standards of neutrality and reliability.*

*Closing exams are adjudicatory in nature: They function as essentially forensic evaluations that determine statutory benefits. Lowering evidentiary standards at this stage undermines procedural fairness.*

*The MCO-only limitation is arbitrary: If non-physician clinicians are qualified to perform closing exams, there is no rational basis to restrict that authority to MCO claims. If non-physician clinicians are not qualified, allowing it only within MCO structures, where cost-containment incentives are strongest, is especially concerning.*

*Structural conflict of interest: MCOs operate within insurer-aligned systems. Expanding closure authority within that framework risks eroding neutrality in disability determinations. Increased downstream litigation: Any short-term efficiency gains are likely to be offset by increased reconsiderations, IMEs, and hearings due to disputes over impairment findings. Two-tiered claim system: The rule creates different standards for claim closure depending solely on claim pathway, undermining uniformity in Oregon's workers' compensation system. Irreversibility of harm: Once a claim is closed with a potentially reduced impairment finding, the burden shifts to the worker to challenge it. This increases the likelihood that inaccurate impairment determinations will become practically final due to procedural burden, economic pressure, and time-sensitive medical findings. The proposal prioritizes administrative efficiency and cost containment over adjudicatory integrity.*

*Closing examinations determine statutory rights and should remain subject to the highest standards of independence and reliability. For these reasons, the rule should be rejected. If not rejected, meaningful guardrails, like including mandatory physician concurrence and independent oversight, are essential to protect fairness and system stability*

**Response:** Thank you for your testimony. In light of HB 4040 (2026), which will become effective as soon as the Governor signs the bill, WCD will not implement the rule changes as proposed. Rather, WCD will revise OAR 436-010-0280 once HB 4040 becomes effective.

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**Testimony: OAR 436-015-0037(3)(e)(A)** ***Exhibit 3***

****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.****

**Testimony: OAR 436-015-0037** ***Exhibit 5***

*Majoris disagrees that the expansion of time a worker may treat outside the network following enrollment will improve the transition into network or improve worker care. Instead, it is likely it will merely shift the timeline for when the transition happens. Based on historical patterns, many workers tend to wait until deadlines approach before taking action. Consequently, the primary effect in many cases would simply be an extension of overall timelines.*

*Majoris acknowledges Oregon faces provider-shortage constraints, and that can impact an injured worker's transition into the MCO network. The MCO is one of the tools for injured workers in navigating those challenges, and transition into the network as quickly as possible supports better continuity of care.*

*Additionally, the commentary submitted stating all clinics are scheduling 30+ days out is not reflective of Majoris' experience. For workers in the acute injury phase, our team reports most clinics are scheduling 2-4 weeks out, though they acknowledge this is less consistent in certain areas of the state. As well, older injuries often see a longer lead time. However, most claims are enrolled early in the claim lifecycle, when clinics are more open to taking on their injury. Jovanna Patrick utilized Oregon Occupational Medicine as a data point in her 02/18/26 public comments, and I contacted their office afterwards for clarification. For injuries less than 90 days old they are currently scheduling one to two weeks out. For their newest clinic it may even be same week. For injuries greater than 90 days, prior to scheduling they do require a records review to ensure the injury falls within their scope of practice, which lengthens the scheduling process.*

*This demonstrates the common discrepancy in experience for workers with newer injuries, versus those further out, or for those with attorney representation. Our records indicate that approximately 17% of enrolled workers have legal representation, highlighting that worker attorney insights are informed by a limited segment of overall program activity.*

*The medical care landscape has changed over the years. That does not mean the system and structures we have in place are broken. For the majority of workers enrolled, Majoris sees a straightforward transition into the MCO network. While there is a subset of workers that require more time and support to make that change, Majoris has seen no data to indicate there is a pattern of workers suddenly unable to access necessary treatment or time loss benefits. While it is impossible to craft something that is perfect for 100% of scenarios, we believe the 14-day timeframe remains an appropriate balance to providing final treatment outside network while encouraging quick transition into network for ongoing care needs.*

**Response:** Thank you for your testimony. As you state, the medical care landscape has changed over the years, and Oregon faces provider-shortage constraints, and that can impact an injured worker's transition into the MCO network. While you point to one clinic that, for injuries less than 90 days old, currently schedules one to two weeks out, you also testify that your team reports most clinics are scheduling two to four weeks out. Considering that most clinics are scheduling two to four weeks out, extending the time period that an injured worker may treat with their current provider from 14 days to 30 days seems very reasonable. Accordingly, WCD publishes the rule as proposed.

**Testimony: OAR 436-009, 010, 015** ***Exhibit 3***

*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.*

**Response:** Thank you for your testimony. Since WCD is not making any changes to the preauthorization requirements and the published rules do not require insurers to notify *every* actively treating provider of a worker becoming medically stationary, WCD believes an effective date of April 1, 2026, is not administratively burdensome and challenging to meet. Accordingly, the effective date will remain April 1, 2026.

**Dated this 27 day of March, 2026.**

Exhibit "1"

**BEFORE THE DIRECTOR OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES OF THE STATE OF OREGON**

**PUBLIC RULEMAKING HEARING**

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| In the Matter of the Amendment of OAR:<br>• OAR 436-009, Oregon Medical Fee and Payment<br>• OAR 436-010, Medical Services<br>• OAR 436-015, Managed Care Organizations<br>• OAR 436-035, Disability Rating Standards | ) | TRANSCRIPT OF TESTIMONY |

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated February 2, 2025. On February 18, 2026, a public rulemaking hearing was held as announced at 11:30 a.m. via video and telephone conference. Marie Rogers, from the Workers' Compensation Division, was the hearing officer. The record will be held open for written comment through February 25, 2026.

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**TRANSCRIPT OF PROCEEDINGS**

**Marie Rogers, Workers' Compensation Division (WCD):**

Good afternoon and welcome. This is a public rulemaking hearing.

My name is Marie Rogers, and I'll be the presiding officer for the hearing today.

The time is now 11:30 a.m. on Wednesday, February 18, 2026. We are conducting this hearing virtually, by video and telephone conferencing. We are making a recording of the hearing.

The Workers' Compensation Division of the Department of Consumer and Business Services proposes to amend chapter 436 of the Oregon Administrative Rules, specifically:

- OAR 436-009, Oregon Medical Fee and Payment
- OAR 436-010, Medical Services
- OAR 436-015, Managed Care Organizations
- OAR 436-035, Disability Rating Standards

The department has:

- Summarized the proposed rule changes and prepared an estimate of fiscal and economic impacts in the notice of proposed rulemaking filed with the Oregon Secretary of State;
- Published rulemaking notice to its postal and electronic mailing lists;
- Notified Oregon legislators as required by ORS chapter 183; and
- Posted public notice and the proposed rules to its website.

The Oregon Secretary of State:

- Published the hearing notice in its *Oregon Bulletin* dated February 2, 2026.

This hearing is not a meeting for back and forth discussion. Today's hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including February 25, 2026, and will make no decisions until all of the testimony is considered. Please note that, based on testimony received, the division may retain or revise current proposed rule language—or could decide to retract a rule change and revisit in a future rulemaking.

As with every rulemaking, the division will address all testimony received in a Testimony and Response document and publish that document on our website.

You may submit testimony in any written form. I encourage you to submit your testimony by email or as attachments to email. Those would come to me at marie.a.rogers@dcbs.oregon.gov. However, you may also use US mail. The email and physical address are on the Notice of Proposed Rulemaking. I will acknowledge all testimony received.

We are ready to receive public testimony.

Is there anyone who would like to testify at this time?

I see a hand from Ann Klein. Ann, would you like to take yourself off of mute and testify today?

**Ann Klein, Majoris Health Systems:**

Yes, thank you.

I would just like to reiterate some concerns that we highlighted previously regarding the proposal to change in the managed care organization chapter 436-015 to extend the time a worker can continue to treat outside network from 14 days to 30 days following enrollment.

We absolutely acknowledge and in fact have testified on the fact that Oregon does face provider shortages.

We also feel that the MCO is one of the strong tools within the system to support workers and navigating those challenges; our key concern in extending this time frame is that it won't materially impact or improve availability, but it will negatively lengthen the timelines and shift over the efforts of transitioning into network. And that, for us, is contrary to our goal of supporting smooth transition and good continuity of care, where really we think best practices as much as possible is to get that worker established in network as close to their original date of injury as possible.

So we do retain those concerns specific to delaying that transition and also delaying the ability, or inspiration, really, for the worker to reach out to the MCO and notify us that they may need help making that transition.

**Marie Rogers, WCD**

Thank you, Ann. I see a hand from Jovanna Patrick. Jovanna would you like to provide testimony?

**Jovanna Patrick, Oregon Trial Lawyers Association (OTLA)**

Yes, thank you for the record, Jovanna, Patrick, I represent workers and am part of OTLA.

I would just like to speak to Miss Klein's comments.

You know, I support the 30-day extension.

I think it's really important. MLAC went through a big process in the last year and what we found is it's really hard to transition and to find a new provider when a worker's put in an MCO. And so additional time is practical. I see this a lot. Workers have a hard time calling people.

And in my experience, it used to be you call an MCO doctor, they'd say, "Here's an appointment. Come on in." What I'm always getting now - almost across the board - is "I won't—" the doctor's office "won't see the worker until the adjuster sends me the entire claim file, we have the chance to review it and then we decide if we want to accept the worker or not." That process takes some time, understandably: for the documents to get sent, or the doctor to review them.

Oregon Occupational Medicine was out a month last time I checked—or just reviewing documents to decide. And so also the practical considerations. Mail is slower than it used to be. So workers, it takes them, you know, four to seven days to get the letter telling them they have 14 days. So, now we have less time.

And then I appreciate that the MCO was helpful in finding a doctor and that we can ask the MCO to help us find a doctor. And then they have 14 days to do it.

So if you add the mailing timeline, the time to request them so you'll find the doctor and the MCO's 14 days, we're well past the 14 days the worker has and now the worker's suffering. While no wage loss, no treatment. They can't get back to work. And that's a real problem.

I also really appreciate that the MCO can find us doctors and that we can ask them for it. But, you have to remember that one of the key tenets of workers' compensation is worker choice.

So if, because of this strict 14-day deadline, the truth is the only way a worker can get a doctor is to call the MCO and have the MCO suggest a doctor or schedule them, that really interferes with the worker's ability to choose, and to take time to look at the list, to research the doctors and maybe pick a doctor that they want and make the effort to get in there.

So, that's why additional time makes a lot of sense and it will help those workers and the MCO not having to scramble and let doctors have time to make a decision on whether they want to accept workers without the workers suffering a loss of benefits when their claim is accepted and they should be receiving benefits.

Thank you.

I appreciate your time.

**Marie Rogers, WCD**

Thank you, Jovanna.

Is there anyone else on the call today who would like to provide testimony?

I am seeing no hands.

I take it back. Jovanna would you like to provide additional testimony today?

**Jovanna Patrick, OTLA**

Yes, I'm looking for Keith Semple on this list and I'm not seeing him. And we were planning to discuss testimony on the preauthorization rule.

That's up right now, right? I'm not mistaking that?

**Marie Rogers, WCD**

Yes, yes, we would be taking testimony for the preauthorization rules today.

I don't see Keith either, and I don't have the lobby enabled. So it's not like he's waiting for admittance.

I am happy to put the hearing in recess and if Keith joins us later, he can provide testimony upon joining or if you'd like to provide testimony, Jovanna, you're welcome to do so.

**Jovanna Patrick, OTLA**

Yes, thank you.

I will go ahead and do that.
Just give me one moment because we were discussing it by e-mail and I had expected to follow up on his comments rather than make the initial ones myself.
So we are submitting a document—our comments. They've been submitted with OTLA's logo, I think.
Yeah, but I'd like to comment on some of those here.
So we're very concerned about this rule.
We don't feel like the rule encapsulates what the MCO, what the—excuse me—what MLAC had felt was needed, and what MLAC talked about all summer—last summer.

We appreciate that the rule is working on some changes and allowing preauthorization, but what we heard at the MCO meet—I'm sorry, I keep saying MCO—at the MLAC meetings over and over again was that from doctors that they cannot get insurers to respond to their requests for treatment.

We heard frankly terrifying testimony from Doctor Bowman, who's on MAC, who does surgeries and is well in the worker's comp system. He talked about how he basically has to trick the MCO or the insurer to approve post-surgical rehab in cases so that clients don't get adhesive capsulitis after a shoulder surgery.

We're talking about fully accepted claims and a doctor who knows everything about the system and he feels like he has to like trick his way into getting workers the treatment they need.

We heard from Doctor Takacs that insurers never respond and that they have like a full-time worker who knows how to do this and is constantly on them.

We heard from insurers and adjusters who get phone calls and faxes and emails, and it's just like, way too much information to try to respond in time. And sometimes they need something additional.

So the system doesn't really work. The whole idea with preauthorization—at least that I understood coming out of MLAC—was that we were going to try to make it a streamlined process where anyone, any provider in the system who wants preauthorization, can ask for it.

They can ask for it from an insurer, and there's some deadline and some mechanism to complain when it doesn't happen. We wanted it to—the suggestions we made as OTLA were that we allow it to be similar to the elective surgery rules where there's a request, it can be done by fax or e-mail. That way there's a clear indication of what is—what needs to be requested. And there's documentation that it's been done, and then there's a clear deadline to respond. And if there's not a response, it's taken just like surgery, elective surgery, that insurers can no longer challenge reasonableness of necessity.

And there's an appeal process. So right now, as written, the rule really looks like only certain providers can request it. There's only certain treatments that are allowed, and workers have the 60-day deadline from notice, even though we're often working with insurers who try to get what is needed to approve it, and that's problematic.

And so, we have suggested a rewrite of the rule. We feel like this is not ready to go to final rule. And that we ask that it be pulled back and more thought and discussion be given.

OTLA has proposed some changes in our letter—some significant changes—that would pull this in line with the surgical questions, with the way elective surgeries are done so that they're streamlining and frankly it will hold everyone accountable.

Because right now—what happens? I had worker who needed carpal tunnel release. Everyone agreed she needed it. She waited like five or six months, and now she's having a worse result.
And what the way it happened, I call the doctor. She says she's not getting surgery. I called the doctor. They say they don't have what they need. I call the insurer. They say they'll look at it. They say they never got the request. The provider sends me six or seven requests that they had fax cover sheet confirmation. Insurers attorney says they can't find it. We do this for like four or five months until we finally say yes, she needs surgery.

That is a broken system that is not the way it should work. And the rule, as written, doesn't fix that problem. Instead it puts a burden on the worker to somehow know when it was received and appeal, even though we oftentimes find out about these things way after the fact because we couldn't possibly know what the insurer doesn't have and they haven't sent us. So we feel like this rule is not ready to go to final rule. It needs a lot more discussion.

And I believe that Keith is getting on now to make some additional comments.

Thank you.

**Marie Rogers, WCD**

Thank you, Jovanna.

I will look for Keith's hand here.

I do want to also note that the proposed change does not limit the request to certain providers, but instead only limits the request to certain medical services. But the intent of the preauthorization rule is to create a standardized process for submitting requests for preauthorization. So we do appreciate that. And I look forward to seeing the letter. And as with the transcript for today's hearing, all testimony received—that will get published on our website and we will take all of that into consideration when deciding next steps for these rules.

Is there anyone on the call currently who would like to provide testimony today?

**Jovanna Patrick. OTLA**

And I don't mean to interrupt, but I just talked to Keith in text and he said he couldn't find the link. So I just emailed it to him. So I do believe he will be entering and would like to make some comments if that's permitted. Thank you.

**Marie Rogers, WCD**

Yeah, absolutely permissible.
I plan to leave the hearing open till noon today. I do see that Sydney Montanaro has her hand raised.

**Sydney Montanaro, OTLA**

***issues with audio***

I'm so sorry. I don't know what happened.
I didn't even change anything.
My name is Sydney Montanaro.
I'm a fellow member of OTLA and I'm just gonna add on to some of the testimony that Jovanna just gave.
I just wanted to reaffirm some of the concerns we have with this rule.
I wanted to highlight the lack—the specification that only certain treatment can be preauthorized.
Jovanna did touch on that, but I think it's important to highlight that further—that there are a number of types of procedures that are requested that just don't fall within this rule. That would be like nerve conduction studies, spinal cord stimulators, nerve stimulators, those are the kinds of procedures I often see requested where there's just a lot of back and forth with the insurer receiving the request, and then there's a lot of confusion on whether it's being approved or not.

So, the lack of inclusion of just any—limiting—having this rule limited to only certain services I think is a real problem and I just wanted to highlight that. I also wanted to highlight the 60-day deadline for a claimant which would be extremely challenging to track for an unrepresented worker, let alone for a worker represented by an attorney. It's not clear how someone would learn of that deadline, and that that's a real problem. This rule, as Jovanna pointed out, also doesn't solve that problem of just trying to understand when an insurer has actually received a request to authorize something, and so having some

kind of presumption is really important because this is an issue that's just coming up over and over and over again for workers, doctors and attorneys on both sides.

That's all. Thank you.

**Marie Rogers, WCD**

Thank you, Sydney and I do see Keith's hand. Keith Semple, would you like to provide testimony today? You are on mute, Keith. Let me see if I can unmute you.

OK, I see Keith has put in the chat that he will provide written comment. Which, I will reiterate: we are accepting written comments through the 25th of February next week.

And anything submitted to us as well as the transcript for today's hearing will be published on our website. OK. Let me see. Thank you everyone for the engagement today.

Is there anyone else on the call who would like to provide testimony today?

OK. I'm hearing no one and seeing no hands.

So, I will put the hearing in recess for the final 10 minutes here. I did want to leave it open until noon today in case we did have late arrivals.

Again, just reiterating the record remains open for written testimony through and including February 25th. And that would be for emailed and mailed testimony.

I'm gonna recess the hearing at 11:49.

OK, this hearing is resumed at 11:58.

I didn't see any hands or see anyone new arrive while we were in recess. But I'll call one last time for testimony today. OK, I am seeing no one, so I just want to reiterate anyone who would like to submit written comments for the proposed rules should submit them to me: Marie.a.Rogers@dcbs.org.gov. And anything received will be considered and posted on our website along with our response to that testimony.

So thank you all for coming.

I appreciate the engagement today. This hearing is adjourned.

Transcribed from a digital audio recording by Marie Rogers, February 18, 2026.

Exhibit "2"

EDMUNSON BARNHART KNIGHT

ATTORNEYS AT LAW | 1143 Oak Street, Suite 300 | Eugene, OR 97401
PHONE: (541) 485-0203 | FAX: (541) 484-9779 | EBKLAW.COM

February 24, 2026

Sent via email: wcd.policy@dcbs.oregon.gov
Attn: Marie Rogers
Workers' Compensation Division
350 Winter Street NE
PO Box 14480
Salem, OR 97309-0405

To Whom It May Concern:

I am writing to provide comment on the proposed amended medical services rule 0230 regarding preauthorizations. My practice is entirely focused on representing injured workers in Oregon. I offer my comments from my perspective as a representative of injured workers for the past 19 years.

I appreciate the efforts of those involved in the rulemaking and review process. Thank you. However, I have concerns with the proposed rule. Please consider a revision to the rule or retraction of the rule for additional revision after comment.

First, it is my understanding that the need for the preauthorization rulemaking came about as a call for help from many stakeholders, but namely from providers who want to be able to assist injured workers in their diagnosis, treatment and recovery from work-related injuries. The providers are finding the ability to effectively and efficiently treat injured workers to be considerably obstructed for lack of a process to obtain preauthorization for many desired medical services.

I often hear providers and injured workers complain of a significantly delayed or complete lack of response to requests for preauthorization for medical services from insurers.

The preauthorization rule should provide a clear and unambiguous method for obtaining a preauthorization decision, when requested by a provider. Any provider who is authorized to treat injured workers should be able to request preauthorization from the insurer for any medical services they feel need to be provided to diagnose and/or treat the injury.

A request for preauthorization is a request for confirmation of payment. The proposed rule currently states that the preauthorization is not confirmation of payment. If it is not confirmation of payment, then how helpful is it to the providers and the injured worker?

Moreover, the rule should mirror the procedure and time allowed for Insurer response to elective surgery requests. The Insurer should respond in 7 days, rather than 14 so that the rules align. Aligning the rules would make implementation of the rule clear to all involved. Similarly, the Insurer should be barred from contesting reasonableness should they fail to respond to the provider's preauthorization request.

It is well within the rights of injured workers to be able to treat and diagnose their conditions. Further work is needed to perfect the wording of the preauthorization rule to create a clear framework for preauthorization requests.

Thank you for your consideration.

Respectfully,

Andrea K. Knight

Exhibit
"3"

saif Work. Life. Oregon.

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
Assistant General Counsel
P: 503.673.5344
F: 503.584.9576
elasch@saif.com

**Misty Bergenstock, Endeavor Psychiatry, February 25, 2026**

**Exhibit "4"**

Response to proposed Amendment to rule 0280 regarding closing exams.

In the current proposed rules, Majoris is requesting the rules be changed to allow for NPs, PAs and Naturopaths to complete closing exams.

We oppose the proposed rule permitting Managed Care Organizations (MCOs) to authorize PAs, NPs, and NDs to perform workers' compensation closing examinations.

Closing examinations are not routine clinical encounters. They determine medically stationary status, permanent impairment, and statutory benefit entitlement, with real world, significant, and lasting consequences for the worker. Because they directly affect workers' legal rights, they require heightened standards of neutrality and reliability.

**Closing exams are adjudicatory in nature:** They function as essentially forensic evaluations that determine statutory benefits. Lowering evidentiary standards at this stage undermines procedural fairness.

**The MCO-only limitation is arbitrary:** If non-physician clinicians are qualified to perform closing exams, there is no rational basis to restrict that authority to MCO claims. If non-physician clinicians are not qualified, allowing it only within MCO structures, where cost-containment incentives are strongest, is especially concerning.

**Structural conflict of interest**: MCOs operate within insurer-aligned systems. Expanding closure authority within that framework risks eroding neutrality in disability determinations.

**Increased downstream litigation:** Any short-term efficiency gains are likely to be offset by increased reconsiderations, IMEs, and hearings due to disputes over impairment findings.

**Two-tiered claim system:** The rule creates different standards for claim closure depending solely on claim pathway, undermining uniformity in Oregon's workers' compensation system.

**Irreversibility of harm**: Once a claim is closed with a potentially reduced impairment finding, the burden shifts to the worker to challenge it. This increases the likelihood that inaccurate impairment determinations will become practically final due to procedural burden, economic pressure, and time-sensitive medical findings. The proposal prioritizes administrative efficiency and cost containment over adjudicatory integrity.

Closing examinations determine statutory rights and should remain subject to the highest standards of independence and reliability. For these reasons, the rule should be rejected. If not rejected, meaningful guardrails, like including mandatory physician concurrence and independent oversight, are essential to protect fairness and system stability.

Exhibit "5"

February 25, 2026

Marie Rogers
Policy Analyst/Rules Coordinator
Workers' Compensation Division
350 Winter Street NE
Salem, OR 97312

Re: Written comments regarding WCD's Proposed Changes to OAR 436-015-0037

Dear Ms. Rogers,

Thank you for providing the opportunity to submit written comments regarding the proposed change to OAR 436-015-0037. Majoris offers the following written comments for the Division's consideration.

Majoris disagrees that the expansion of time a worker may treat outside the network following enrollment will improve the transition into network or improve worker care. Instead, it is likely it will merely shift the timeline for when the transition happens. Based on historical patterns, many workers tend to wait until deadlines approach before taking action. Consequently, the primary effect in many cases would simply be an extension of overall timelines.

Majoris acknowledges Oregon faces provider-shortage constraints, and that can impact an injured worker's transition into the MCO network. The MCO is one of the tools for injured workers in navigating those challenges, and transition into the network as quickly as possible supports better continuity of care.

Additionally, the commentary submitted stating all clinics are scheduling 30+ days out is not reflective of Majoris' experience. For workers in the acute injury phase, our team reports most clinics are scheduling 2-4 weeks out, though they acknowledge this is less consistent in certain areas of the state. As well, older injuries often see a longer lead time. However, most claims are enrolled early in the claim lifecycle, when clinics are more open to taking on their injury.

Jovanna Patrick utilized Oregon Occupational Medicine as a data point in her 02/18/26 public comments, and I contacted their office afterwards for clarification. For injuries less

than 90 days old they are currently scheduling one to two weeks out. For their newest clinic it may even be same week. For injuries greater than 90 days, prior to scheduling they do require a records review to ensure the injury falls within their scope of practice, which lengthens the scheduling process.

This demonstrates the common discrepancy in experience for workers with newer injuries, versus those further out, or for those with attorney representation. Our records indicate that approximately 17% of enrolled workers have legal representation, highlighting that worker attorney insights are informed by a limited segment of overall program activity.

The medical care landscape has changed over the years. That does not mean the system and structures we have in place are broken. For the majority of workers enrolled, Majoris sees a straightforward transition into the MCO network. While there is a subset of workers that require more time and support to make that change, Majoris has seen no data to indicate there is a pattern of workers suddenly unable to access necessary treatment or time loss benefits. While it is impossible to craft something that is perfect for 100% of scenarios, we believe the 14-day timeframe remains an appropriate balance to providing final treatment outside network while encouraging quick transition into network for ongoing care needs.

Sincerely,

Ann Klein
President

**Majoris Health Systems Oregon,** Inc.
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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
ksemple@justicelawyers.com

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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.