Exhibit "4"

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Via E-mail
Marie Loiseau, Policy Analyst / Rules Coordinator
Workers' Compensation Division
Department of Consumer and Business Services
350 Winter St. NE
Salem, OR 97312

Re: Written Comments Regarding WCD's Rulemaking Hearing for OAR 436-009, -010, -015

Dear Ms. Loiseau:

Thank you for the opportunity to provide written comments regarding the proposed changes to OAR 436-009, -010, and -015. We appreciate the Division's approach to ensure Oregon's workers' compensation system ensures medical care to injured workers while maintaining a balanced system and considering the needs of the employers, insurers, and administrators involved in the system.

We opposed proposed rule OAR 436-010-0270(4)(k) which would require our clients to approve within 30 days of an MCO pre-certifying the surgery as medically appropriate.

SAIF provided testimony that the surgery responses are very fact specific and depend on the nature of the claim. Often, our clients rely on an IME to help sort out whether the proposed treatment qualifies as palliative care, curative care, or diagnostic care which each carry their own separate standards for approving surgery. A surgery may be proposed as one of these types of surgery, but in fact be another type. For example, injections while not often seen as a full "surgery" often require facilities similar to a surgical center and while the doctor proposing the treatment may consider it palliative care to treat the injury, it is really diagnostic to determine the source of the ongoing issues. The proposed rule is overly burdensome in requiring the employer/insurer/administrator to make a compensability determination on every proposed invasive treatment request.

Because of the varying standards involved in reviewing these treatments, our clients again rely on getting an independent second opinion through an IME to

address the proposed treatment. An IME often takes more than 30 days to occur from the date it is scheduled, and with a worker requiring a 10-day notice to attend a mandatory examination, the window created by your new rule is functionally only a 20-day window to make a compensability determination.

The proposed rule conflicts with ORS 656.267 which allows for 60 days to investigate a claim before making a compensability determination. While the standard for determining compensability of a surgery or a new/omitted condition are different, in practice the disapproval of a surgery as not compensably related to a claim involves much of the same investigation needed for a partial denial of the underlying condition. For example, if the claim is accepted for a lumbar strain and we get a request for a lumbar discectomy, we are obligated to evaluate the condition and evaluate the causal relationship of the condition to the injury even without an expansion request. We should be afforded 60 days to make that decision.

Responses to surgery requests often vary based on the case as noted above. The general practice in OAR 436-009, -010, and -015, is that the attending physician determines the care needed, sends medical bills to the insurer for review, and after the treatment is completed, the insurer can review to determine if they were compensably related to the claim. Requiring this response flips that process and could delay a worker's treatment.

Thank you for your consideration of our comments and for your efforts in addressing the concerns raised by all the parties on this issue.

Sincerely,

Kevin J. Anderson

KJA:hgp