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

In the Matter of the Amendment of OAR: • 436-009, Oregon Medical Fee and Payment • 436-010, Medical Services • 436-015, Managed Care Organizations	))))	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 amendments to the rules were announced in the Secretary of State's *Oregon Bulletin* dated Feb. 1, 2024. On Feb. 21, 2024, a public rulemaking hearing was held as announced, by teleconference and videoconference at 3 p.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Marie Rogers, from the Workers' Compensation Division, was the hearing officer. The record was held open for written comment through February 27, 2024.

Testimony list:

Exhibit	Testifying
1	Ann Klein, Majoris Health Systems
2	Transcript of hearing (no public testimony)
3	Elaine Schooler, SAIF
4	Kevin Anderson, SBH Legal

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

Testimony: OAR 436-010-0270 ***Exhibit 1***

"Majoris would like to request consideration that the MCO also be included in the notice from the insurer on whether they approve the surgery, as part of the proposed change to rule 0270."

Response to testimony in Exhibit 1: Thank you for your testimony. The division agrees that it is reasonable to include the MCO in the list of parties the insurer has to notify. Accordingly, we added "MCO" to the list of parties in OAR 436-010-0270(4)(k) that the insurer has to notify.

Testimony: OAR 436-010-0270(4)(k) ***Exhibit 3***

"For claims enrolled in an MCO, when there is a surgery request, proposed OAR 436-010-0270(4)(k) would require an insurer to inform an injured worker, their representative and the provider whether the insurer approves the surgery within 30 days from the date the MCO pre-certifies the surgery as medically appropriate."

"… an insurer's ability to approve a surgical procedure depends on the facts of the specific claim, the accepted condition(s), and the type of procedure requested. At times, a surgery may be requested to determine the existence of possible new or omitted conditions, may be diagnostic, and/or curative. Often an Independent Medical Evaluation (IME) is utilized to assist the insurer in determining the relationship between the surgery and the accepted conditions. An IME often takes more than 30 days to occur from the date it is scheduled and then additional time is needed for the examining provider to draft the report…"

"To account for scheduling, performance of the examination, and time to prepare the report, SAIF suggests that 45 days would be an appropriate time period for an insurer to respond once the MCO pre-certifies the surgery as medically appropriate. Generally, an MCO responds within 7-14 days regarding the appropriateness of the requested surgery. A 45 day time period to review and approve/disapprove the surgery would align the processing time period to that of a compensability determination where IMEs are often utilized."

"In addition, the proposed rule requires an insurer to respond within 30 days of the MCO's decision. However, an insurer may not receive the MCO's decision for several days due to mail and/or technological delays. SAIF proposes that the insurer's duty to approve or disapprove the surgery begin on the date the insurer receives the MCO's decision pre-certifying the surgery. This ensures that crucial days are not lost due to mail or technical delays."

"The proposed rule is also unclear as to what the insurer is approving with regard to the requested surgery. Is the insurer approving the medically appropriateness of the surgery as determined by the MCO? Is the insurer approving the compensability of the surgery? As written, it is unknown what the insurer is approving. Based on the advisory meeting, it is SAIF's understanding that the insurer would approve or disapprove whether the surgery is a compensable medical service that is causally related to the accepted conditions. SAIF proposes the division clarify what the insurer is approving with respect to the surgery."

"The proposed rule also lacks language regarding an injured worker's appeal rights and responsibilities if an insurer disapproves the surgery. Without specific language regarding appeal rights and a time line to appeal the disapproval, the effectiveness of a disapproval on subsequent requests for the same procedure is unclear. SAIF proposes a 60 day time period to request review of the insurer's disapproval to align it with the time period to contest a decision by the MCO. See OAR 436-015-0110(6)."

Testimony: OAR 436-010-0270(4)(k) ***Exhibit 4***

"…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."

Response to testimony in Exhibits 3 & 4: Thank you for your testimony.

The division agrees that it may take an insurer more than 30 days to make a compensability decision and finds 45 days from the mailing date of the MCO decision a reasonable timeframe. Starting the timeframe with the mailing date rather than with the receiving date is consistent with the timeframe start date to appeal an MCO decision under OAR 436-015-0110.

The purpose of this rule is to provide clarity whether or not the insurer approves the compensability of a surgery. If the insurer believes an MCO surgery approval is not appropriate, the insurer is required to appeal the MCO decision within 30 days to the MCO. The division added language to OAR 436-010-0270(4)(k) to clarify.

The division agrees that the rule as proposed lacks language regarding an injured

worker's appeal rights and responsibilities if an insurer disapproves the surgery. Accordingly, the division added appeal language mirroring the requirement listed in OAR 436-010-0290(2)(c) (palliative care denial).

The division does not believe that OAR 436-010-0270(4)(k) is overly burdensome in requiring the employer/insurer/administrator to make a compensability determination on every proposed invasive treatment request. This is similar to compensability determinations an insurer makes routinely on bills for medical services that the insurer receives.

Dated this 5th day of March, 2024.

Exhibit
"1"

LOISEAU Marie A * DCBS

From: Ann Klein <aklein@majorishealthsystems.com>
Sent: Wednesday, February 7, 2024 2:18 PM
To: DCBS WCD Policy * DCBS
Cc: Lisa Johnson
Subject: RE: Proposed rules published: OAR 436-009, 010, and 015

You don't often get email from aklein@majorishealthsystems.com. Learn why this is important

Majoris would like to request consideration that the MCO also be included in the notice from the insurer on whether they approve the surgery, as part of the proposed change to rule 0270.

Thank you,

Ann Klein
President
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aklein@majorishealthsystems.com

Majoris Health Systems
PO Box 1728 | Lake Oswego, OR | 97035

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Exhibit "2"

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

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR: 436-009, 436-010, 436-015	))))	TRANSCRIPT OF TESTIMONY

The proposed amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated February 1, 2024. On February 21, 2024, a public rulemaking hearing was held as announced at 3 p.m. via teleconference from the Labor & Industries Building, 350 Winter Street NE, Salem, Oregon. Marie Rogers from the Workers' Compensation Division, was the hearing officer. The record will be held open for written comment through February 27, 2024.

INDEX OF WITNESSES

Witnesses **Page**

TRANSCRIPT OF PROCEEDINGS

Marie Rogers:

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.

The time is now 3:01 p.m. on Wednesday, Feb. 21, 2024. We are conducting this hearing from Conference Room F in the Labor & Industries Building in Salem, Oregon. However, we are also doing so virtually, by video and telephone conferencing. We are making an audio 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

The department has:

- Summarized the proposed rule changes and prepared estimates 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 Feb. 1, 2024.

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 Feb. 27, 2024, and will make no decisions until all of the testimony is considered.

We are ready to receive public testimony.

Is there anyone on the call today who would like to testify at this time?

I'm seeing no hands and hearing no voices. I'll ask again: is there anyone on the call who would like to testify at this time?

OK. I am hearing no one. In a moment I will recess the hearing, but we will resume for additional testimony if anyone wishes to testify before the hearing ends, which will be at 4 p.m. today.

Again, the record remains open for written testimony through and including Feb. 27. You may submit testimony in any written form. I encourage you to submit your testimony by email or as attachments to email, and that would be to our policy email address, which is wcd.policy@dcbs.oregon.gov. However, you may also use US mail. We will acknowledge all testimony received.

This hearing is recessed at 3:05 p.m.

The hearing is resumed at 3:58 p.m.

Is there anyone on the call who would like to testify today before we close?

I'm hearing no one, but I will ask again: is there anyone on the call who would like to testify today?

OK. Hearing no one, the time is 3:58 p.m.

Having heard no one, I am going to adjourn today's meeting.

Thank you so much for coming.

Transcribed from a digital audio recording by Marie Rogers, February 22, 2024.

Exhibit
"3"

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February 27, 2024

MARIE LOISEAU
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 rulemaking hearing for OAR 436-009, -010, -015

Dear Ms. Loiseau,

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, and -015. We appreciate the division's approach to ensuring injured workers have appropriate access to care, that medical providers are adequately incentivized to treat injured workers, and to maintain a balanced system based on cost-effective strategies and timely review of processes and payments. SAIF offers the following written comments for the division's consideration. For issues not specifically raised below, SAIF has no questions or concerns.

OAR 436-010-0270(4)(k)

For claims enrolled in an MCO, when there is a surgery request, proposed OAR 436-010-0270(4)(k) would require an insurer to inform an injured worker, their representative and the provider whether the insurer approves the surgery within 30 days from the date the MCO pre-certifies the surgery as medically appropriate.

As discussed by SAIF at the advisory meeting, an insurer's ability to approve a surgical procedure depends on the facts of the specific claim, the accepted condition(s), and the type of procedure requested. At times, a surgery may be requested to determine the existence of possible new or omitted conditions, may be diagnostic, and/or curative. Often an Independent Medical Evaluation (IME) is utilized to assist the insurer in determining the relationship between the surgery and the accepted conditions.

An IME often takes more than 30 days to occur from the date it is scheduled and then additional time is needed for the examining provider to draft the report. SAIF's ability to review requested medical services is a critical function to ensure that appropriate and related treatment is covered while excluding unrelated or unreasonable treatment.

To account for scheduling, performance of the examination, and time to prepare the report, SAIF suggests that 45 days would be an appropriate time period for an insurer to respond

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once the MCO pre-certifies the surgery as medically appropriate. Generally, an MCO responds within 7-14 days regarding the appropriateness of the requested surgery. A 45 day time period to review and approve/disapprove the surgery would align the processing time period to that of a compensability determination where IMEs are often utilized.

In addition, the proposed rule requires an insurer to respond within 30 days of the MCO's decision. However, an insurer may not receive the MCO's decision for several days due to mail and/or technological delays. SAIF proposes that the insurer's duty to approve or disapprove the surgery begin on the date the insurer receives the MCO's decision pre-certifying the surgery. This ensures that crucial days are not lost due to mail or technical delays.

The proposed rule is also unclear as to what the insurer is approving with regard to the requested surgery. Is the insurer approving the medically appropriateness of the surgery as determined by the MCO? Is the insurer approving the compensability of the surgery? As written, it is unknown what the insurer is approving. Based on the advisory meeting, it is SAIF's understanding that the insurer would approve or disapprove whether the surgery is a compensable medical service that is causally related to the accepted conditions. SAIF proposes the division clarify what the insurer is approving with respect to the surgery.

The proposed rule also lacks language regarding an injured worker's appeal rights and responsibilities if an insurer disapproves the surgery. Without specific language regarding appeal rights and a time line to appeal the disapproval, the effectiveness of a disapproval on subsequent requests for the same procedure is unclear. SAIF proposes a 60 day time period to request review of the insurer's disapproval to align it with the time period to contest a decision by the MCO. See OAR 436-015-0110(6).

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
Trial Attorney
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F: 503.584.9576
elasch@saif.com

Exhibit "4"

SBH LEGAL

KEVIN J. ANDERSON
Licensed in Oregon
Direct Dial: 503.595.2130
kanderson@sbhlegal.com

February 27, 2024

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