Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR chapter 436, division 015
Managed Care Organizations

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	July 25, 2017, 1:30 to 4:30 p.m. Room F (basement), Labor and Industries Building, Salem, Oregon Dial-in number is 213-787-0529, Access code, 9221262#
Facilitator:	Fred Bruyns, Workers' Compensation Division
1:30 to 1:45	Welcome and introductions; meeting objectives
1:45 to 3:00	Discussion of issues on agenda
3:00 to 3:15	Break
3:15 to 4:15	Discussion of issues continued | Request for new issues and discussion
4:15 to 4:30	Summing up – next steps Thank you!

Attachments: **Issues document**
Draft rules

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #1

Rule: OAR 436-015

Issue: Do the rules governing managed care include requirements that are barriers to electronic communication, filing, and document management?

Background: Generally, the administrative rules should emphasize the types of information that must be communicated and not the forms the communication must take. However, workers and employers should not be required to accept electronic forms of notice.

Options:

- Define mailing and filing to include electronic delivery.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 1006)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #2

Rule: OAR 436-015

Issue: We have heard from injured workers that it is sometimes difficult to find an MCO panel provider willing to treat them for their workers' compensation injury. Would it be helpful to require the MCOs to identify in their provider directories those providers who will only see existing patients? Is it feasible to require MCOs to update that information annually?

Background: Some workers are calling multiple MCO panel providers trying to find a doctor and are told either that the provider is not accepting any new patients or that the provider only accepts workers' compensation patients that are existing patients of the provider. This is a frustration for the worker and may delay care.

At least one MCO already lists providers who only accept existing patients.

We know of one insurer who lists the MCOs' panel providers but does not indicate whether a provider accepts new patients or only existing patients.

This problem cannot be fully resolved, but it might be mitigated if MCOs and insurers identify those providers whose office policy it is to accept only existing patients for workers' comp injuries.

Options:

- Require MCOs to identify in provider directories those providers who only accept existing patients as workers' compensation patients.
- If insurers list MCO provider directories they should identify those providers who only accept existing patients as workers' compensation patients.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 422)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #3

Rule: OAR 436-015-0005

Issue: Division 015 refers to division 010 for definitions. This is cumbersome for the user of these rules. Would adding new definitions to Div 015 make these rules more user friendly?

Background: Current rules adopt Div 010 definitions by reference. It's not user-friendly to require the reader to refer to a different division of rules just for definitions. It's more efficient to have the applicable definitions contained within the division 015 rules. When WCD included the applicable definitions within the division 009 rules it was well received by stakeholders.

Options:

- Add the following definitions to 436-015-0005:
  "Administrative review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.
  "Attending physician" has the same meaning as described in ORS 656.005(12)(b).
  "Come-along provider" means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who continues to treat the worker when the worker becomes enrolled in an MCO.
  "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides workers with health care benefits even if a workers' compensation claim is denied.
  "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407.
  "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.
  "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.
  "Medical service provider" means a person duly licensed to practice one or more of the healing arts.
  "Show cause hearing" means an informal meeting with the director or designee in which the MCO will be provided an opportunity to be heard and present evidence regarding any proposed orders by the director to suspend or revoke the MCO's certification.

- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 1284)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #4

Rule: OAR 436-015- 0008(1)

Issue: Should WCD remove the requirement that requests for mediation be submitted in writing? Accepting requests by telephone can expedite resolution of disputes.

Background:
The rule allows a party to request that the director provide voluntary mediation after a request for administrative review or hearing is filed. The current rule further states that voluntary mediation requests must be in writing. However, WCD accepts requests for voluntary mediation by phone on a regular basis.

Options:

- Remove the rule language that says a party must request voluntary mediation in writing.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:
436-015-0008 Administrative Review Request for Review before the Director~~General~~

Amended and renumbered to 436-015-0008(2)

~~(1)~~**(2)** -Any party may request that the director provide voluntary mediation after a request for administrative review or hearing is filed. ~~The request must be in writing.~~ When a dispute is resolved by agreement of the parties to the director's satisfaction, ~~any~~the agreement ~~shall~~ must be ~~reduced to~~**in** writing and approved by the director. If the dispute does not resolve through mediation, administrative review ~~shall~~ will continue.

(Issue 1285)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #5

Rule: OAR 436-015-0008(2)(a)

Issue: When WCD gets a misdirected appeal that is required to go to the MCO first, the appeal period may end before the party has the opportunity to refile an appeal with the MCO.

Background:
A party that disagrees with an action taken by an MCO must first use the MCO's dispute resolution process by appealing the decision to the MCO within 30 days; otherwise, the party loses all rights to further appeal the decision. Occasionally, a party appeals an MCO action to the director rather than the MCO. If the deadline for appeal is near, the party may lose appeal rights before refiling with the MCO is feasible.

This proposal would not affect the 60 day timeframe the MCO has to issue its final decision, as the 60 day timeframe does not start until the MCO actually receives the appeal.

Options:

- Toll the time allowed for appeal for a limited period of time if the appeal is misdirected to WCD.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 1276)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #6

Rule: OAR 436-015-0008(2)(a) and 436-015-0110(4)

Issue:

- **There's an inconsistency between OAR 436-015-0008(2) and 436-010-0008(2) in regards to when the appeal period begins to run for a represented worker.**
- **There's an inconsistency between OAR 436-015-0008(2)(a) and 436-010-0008(2)(a) in regards to good cause in the event of an appeal of an initial MCO decision outside of the 30 day appeal period.**

Background:

- Current OAR 436-010-0008(2)(a)(A) states that when the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision. OAR 436-010-0008(2)(a)(B) contains a similar provision regarding appeal of a final MCO decision. The division 015 rules lack such a provision.
- 436-010-0008(2)(a) provides a good cause exception if a party fails to appeal an initial MCO decision within 30 days. Rule 0008 of division 015 rules lacks such a provision. There is currently no requirement for the MCOs to include a good cause provision under OAR 436-015-0110(4).

Options:

- Make OAR 436-015-0008(2) consistent with 436-010-0008(2) in regards to when the appeal period begins to run for a represented worker.
- Require the MCOs to include language regarding good cause in their notice of appeal rights to the worker and all other parties.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:

OAR 436-015-0008(2) ~~Administrative review before the director:~~ The process for administrative review ~~of such matters shall be~~ before the director is as follows:

(a) Any party that disagrees with an action ~~taken by~~of an MCO ~~pursuant to these rules~~ must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision, in

writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision~~.~~ unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

OAR 436-015-0110(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice must include the following paragraph, in bold text:

> **NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. Absent a showing of good cause, ~~If~~ if you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.**

(Issue 1295)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #7

Rule: OAR 436-015-0008(3)

Issue: WCD no longer appoints a physician reviewer under OAR 436-010-0330 in MCO disputes. Rather WCD may appoint a physician under ORS 656.325.

Background:
Roger D. Houser, 17 CCHR 323(2012) held that when WCD gets an MCO dispute, it may schedule an exam under 656.325. However, OAR 436-015-0008(3) does not provide for WCD to appoint a physician for review of a medical treatment or service dispute under ORS 656.260 because OAR 436-010-0330(2) only applies to physician reviews under ORS 656.245 and 656.327.

Options:

- Eliminate the reference to OAR 436-010-0330 and add the reference to ORS 656.325(1).
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:
Reason for change: The division changed its policy regarding physician reviews and MCO disputes and currently uses its authority to obtain a physician from the IME list.

436-015-0008(3) Physician review (E.g., appropriateness).

If the director determines an evaluation by a physician is indicated to resolve the dispute, the director~~, in accordance with OAR 436-010-0330,~~ may appoint an appropriate medical service provider or panel of providers under ORS 656.325(1) to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. The worker may refuse an invasive test without sanction.

(Issue 1286)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #8

Rule: OAR 436-015-0030(14)

Issue: Should MCOs be permitted to define the responsibilities of their own MCO liaison to the department and the insurers?

Background: The current rule language defining liaison responsibilities seems unnecessary as it's the MCO's responsibility to determine the liaison's responsibilities, other than the requirement that the liaison serve as a member on the MCO quality assurance committee.

Options:

- Remove subsections (a) and (b).
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:
Current 436-015-0030

(14) The MCO must designate an in-state communication liaison ~~for~~ to the department and the insurers at the MCO's established in-state location. The liaison must serve as a member on the quality assurance committee. ~~The responsibilities of the liaison include:~~

~~(a) Coordinating and channeling all outgoing correspondence and medical bills;~~

~~(b) Unless otherwise provided by the MCO contract, providing centralized receipt and distribution of all reimbursements back to the MCO members and primary care physicians; and~~

(Issue 1287)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #9

Rule: OAR 436-015-0040(1)

Issue: There is a discrepancy between the rule that requires an MCO to submit the entire text of contracts when submitting an addendum or amendment and the current practice of WCD to only require the addenda or amendments.

Background: A strict reading of the current rule requires an MCO to provide an entire copy of their contract when submitting addendums or amendments. As the division already has the original contract, this is an unnecessary requirement. In practice the division doesn't require submission of the entire contract when an amendment is filed, so this change will implement the current practice.

Options:

- Remove language concerning submission of entire text of contracts when submitting an addendum or amendment.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:
436-015-0040(1) In order to ensure the MCO complies with the requirements of these rules, each MCO ~~shall~~must provide the director with a copy of the entire text of any MCO/insurer contract ~~agreement~~, signed by the insurer and the MCO, within 30 days of execution of such contracts. ~~Amendments~~The MCO must submit any amendments, addendums, ~~and~~or cancellations~~, together with the entire text of the underlying contracts, shall be submitted~~ to the director within 30 days of execution.

(Issue 1289)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #10

Rule: OAR 436-015-0040

Issue: The director is not being notified in a timely manner when the MCO has received a notice of termination from the insurer.

Background: OAR 436-015-0040(2) provides that when an MCO/insurer contract agreement contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination, or workers will no longer be subject to the contract after it expires or terminates without renewal pursuant to ORS 656.245(4)(a).

The majority of the MCO contracts that the division oversees are "evergreen" contracts; i.e., they renew automatically from contract period to contract period without any need for action or intervention by the MCO, the insurer, or the division.

Most, if not all, MCO contracts contain a provision for advance notification when one of the parties intends to terminate the agreement prior to expiration.

There is no requirement, either in the statute or in existing administrative rules, for either the insurer (who will generally be the party terminating an existing contract) or the MCO, to notify the division when one of the parties has announced their intention to the other to either affirmatively terminate (with due notification) or refuse to renew or extend an existing MCO contract.

The division maintains records which include termination dates of MCO contracts. The division needs to be informed of terminated contracts or impending termination of MCO contracts in order to assure timely notification by insurers to enrolled workers in accordance with OAR 436-010-0270(4)(l).

Options:

- Require MCOs to notify the division within 7 days when they receive a notice of termination from the insurer.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #11

Rule: OAR 436-015-0040(4)

Issue: This rule requires that MCOs submit names and addresses of all health care providers who are participating in the MCO. "Health care providers" includes organizations, such as hospitals and DME providers, but WCD only expects the submission of information for individual medical service providers, such as medical doctors, chiropractic physicians, physical therapists, etc.

Background: Current practice doesn't require submission of names and addresses of all health care providers participating in the MCO in the quarterly reports.

Options:

- Remove language regarding the requirement to submit names and addresses of all heath care providers participating in the MCO in the quarterly reports.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:

436-015-0040(4) Within 45 days of the end of each calendar quarter, each MCO ~~shall~~must provide the following information, current on the last day of the quarter, ~~in a form and format~~ as prescribed by ~~the director: specify~~Bulletin 247:

(a) The quarter being reported~~,~~;
(b) MCO certification number~~, membership~~; and
(c) Membership listings by category of medical service provider (in coded form), including ~~provider~~:

(A) Provider names~~, specialty~~;
(B) Specialty (in coded form~~),~~);
(C) Tax ID number~~,~~;
(D) National Provider Identifier (NPI) number~~, business~~; and
(E) Business address and phone number. ~~(All fields are required unless specifically excepted by bulletin.)~~ When a medical service provider has multiple offices, only one office location in each geographical service area needs to be reported. ~~In addition, the updated membership listing shall include the names and addresses of all health care providers participating in the MCO.~~

(Issue 1290)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #12

Rule: OAR 436-015-0040(5)

Issue: Should WCD eliminate the requirement of an affidavit as part of the MCO's annual report?

Background: In the interest of regulatory streamlining, WCD no longer deems it necessary for the MCO to submit an affidavit as part of its annual report submission.

Options:

- Eliminate the requirement of an affidavit as part of the MCO's annual report.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:
436-015-0040(5)(c)

~~An affidavit that the approved MCO plan is consistent with the MCO's business practices, and that any amendments to the plan have been approved by the director.~~

(Issue 1291)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #13

Rule: OAR 436-015-0050(1)(e)

Issue: Should WCD eliminate the requirement that MCOs list provider profile analyses by diagnosis code?

Background: The current rule language requiring the MCOs to maintain a profile analysis of each provider listed by diagnosis code seems unnecessary as it is the MCO's responsibility to determine how to best perform a provider profile analysis.

Options:

- Eliminate the requirement that providers' profile analyses be listed by diagnosis code.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:

436-015-0050 ~~Notice of~~ Record Keeping and Place of Business ~~in State; Records MCO Must Keep in Oregon~~

(1) Every MCO ~~shall~~must give the ~~division~~director notice of one ~~in-state~~Oregon location and mailing address where the MCO keeps records of the following:

* * *

(e) A profile analysis of each provider in the MCO ~~listed by the International Classifications of Disease-9-Clinical Manifestations (ICD-9-CM) diagnosis;~~;

(Issue 1292)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #14

Rule: OAR 436-015-0050(3)

Issue: Should WCD modify language regarding MCO records that must be forwarded to the insurer upon request, in the event of contract cancellation?

Background: WCD believes that only MCO records relating to treatment provided to workers within the MCO need to be forwarded to the insurer, when requested, upon contract cancellation.

Options:

- Modify language regarding MCO records that must be forwarded to the insurer upon request, in the event of contract cancellation.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

Draft text:

436-015-0050 ~~Notice of~~ Record Keeping and Place of Business ~~in State; Records MCO Must Keep in Oregon~~

* * *

(3) If the MCO/insurer contract is canceled for any reason, all MCO records~~, as identified in section (1),~~[1] relating to treatment provided to workers within the MCO must be forwarded to the insurer upon request. The records included in subsections (1)(b), (c), (d), and (e) of this rule are confidential ~~in accordance with~~under ORS 656.260~~(6) through (10).~~.

(Issue 1293)

[1] **(1)** Every MCO ~~shall~~must give the ~~division~~director notice of one ~~in state~~Oregon location and mailing address where the MCO keeps records of the following: * * *

(a) Updated membership listings of all MCO members;

(b) ~~Records of any sanctions~~Sanctions or punitive actions taken by the MCO against its members;

(c) Records of actions taken by the MCO's peer review committee;

(d) Records of utilization reviews performed ~~in accordance with the requirements of utilization and treatment standards pursuant to ORS 656.260 showing~~identifying cases reviewed, the issues involved, and the action taken;

(e) A profile analysis of each provider in the MCO ~~listed by the International Classifications of Disease-9-Clinical Manifestations (ICD-9-CM) diagnosis;~~;

(f) A record of those enrolled ~~injured~~ workers receiving treatment by ~~non-panel primary care physicians or~~ authorized ~~nurse practitioners authorized to treat pursuant to OAR 436-015-0070~~come-along providers; and

(g) All other records as necessary to ensure compliance with the certification requirements ~~in accordance with~~under OAR 436-015-0030.

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #15

Rule: OAR 436-015-0050(5)

Issue: Should WCD remove section (5) of the current rule?

Background: OAR 436-015-0050 (5) states that nothing in this section is intended to otherwise limit the number of locations the MCO may maintain to carry out the provisions of these rules. WCD considers this language superfluous.

Options:

- Remove section (5) of the current rule.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 1294)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #16

Rule: OAR 436-015-0060(1)

Issue: Although chiropractic physicians may serve as come-along providers like primary care physicians, they are not listed among providers who may not be charged MCO membership or administrative fees when they provide services under OAR 436-015-0070.

Background: With passage of Senate Bill 533 (2013 Oregon Laws c.179), chiropractic physicians (DCs) were added as qualifying come-alongs. 436-015-0060(1) provides "An MCO may not require membership fees or other MCO administrative fees to be paid by primary care physicians or authorized nurse practitioners who provide services under OAR 436-015-0070."

Options:

- Replace primary care physician or authorized nurse practitioner with come-along providers in the last sentence of 436-015-0060(1). *See* draft text below.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

436-015-0060 Commencement/Termination of ~~Members~~Panel Providers
Draft text:
(1) Prospective new ~~members~~panel providers of an MCO ~~shall~~must submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership ~~pursuant~~according to the membership requirements of the MCO. The MCO ~~shall~~must verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee ~~shall~~must be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by ~~primary care physicians or authorized nurse practitioners who provide services under OAR 436-015-0070~~come-along providers.

(Issue 1269)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #17

Rule: OAR 436-015-0105 (new)

Issue: Would introducing time frames for MCOs to respond to medical service requests or require that MCOs respond within a "reasonable time" reduce treatment delays?

Background:
The division has heard from providers and attorneys that treatment for enrolled workers may sometimes be delayed because an MCO did not respond to a pre-certification request in a reasonable timeframe.

Establishing standards for responsiveness to medical service requests may promote responsiveness to such requests.

An MCO's treatment standards may require some medical services, such as imaging or other diagnostics, to be pre-authorized by the MCO. Division 015 does not include a time frame for responding to medical service requests, and care may be delayed if the MCO does not approve or deny a request.

Options:

- State time frames or reasonableness standards for MCOs to respond to medical service requests.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 1283)

Oregon Administrative Rule Revision
Chapter 436, Division 015

Issue #18

Rule: OAR 436-015

Issue: Should managed care organizations (MCOs) be subject to the same time frames for elective surgery certification as insurers under 436-010-0250?

Background: MCOs are not subject to elective surgery processing requirements under OAR 436-010-0250. The division has heard complaints that MCOs may put surgery certification requests into "deferred status." This delays services to the worker, and if the provider proceeds with the surgery, may deprive the provider of payment for the surgery.

Timeline summary for elective surgery under OAR 436-010-0250:

- The provider gives notice of surgery to insurer within **7 days** before surgery.
- The insurer must approve surgery or send the provider Form 3228 and may request a second opinion exam within **7 days***.
- The second opinion exam must be completed within **28 days**.
- The insurer must send the provider the second opinion report within **7 days**.
- If the provider disagrees with the insurer's decision or the second opinion and the provider can't resolve the disagreement with the insurer, the provider should notify the insurer in writing or sign Form 3228.
- The insurer must request Administrative Review within **21 days***.

***** If the insurer does not respond to your surgery notification within seven days or does not request administrative review within 21 days after you sign Form 3228, the insurer may not challenge the appropriateness of the proposed surgery. However, failure to respond timely does not prevent the insurer from contending that the proposed surgery is not related to the compensable condition/injury.

Options:

- Establish time frames and procedures in division 015 that are similar to or equivalent to those in 436-010-0250.
- Make MCOs subject to the time frames and procedures in 436-010-0250.
- Other?
- No change.

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

(Issue 1270 & 1278)

Housekeeping

Reason for change: To clarify and to correct citation to statute.

436-015-0007 Entities Allowed to Manage Care
(1) Only an MCO may provide managed care services as described in ORS 656.260(4)(d)~~,~~ ~~656.260(20)~~ and (21)(a), ~~and under these rules,~~ except as allowed under 436-015-0009.

(2) An insurer or someone acting on behalf of an insurer may not manage the care of ~~non-MCO enrolled~~ workers by limiting the choice of medical providers, ~~except as allowed under ORS chapter 656,~~ or by requiring medical providers to abide by specific treatment standards, treatment guidelines, ~~and~~or treatment protocols.

Reason for change: To simplify the structure of the rule. The subsections to sections (3) and (4) become subsections of new section (3).

436-015-0009 Formed/Owned/Operated
Amended and renumbered to 436-015-0009(3)
~~(2)~~**(3)** A non-qualifying employer or any member of its staff**, or their immediate family,** may not: * * *
~~(3) A non-qualifying employer or any member of its staff, or their immediate family, may not:~~ * * *
~~(4) A non-qualifying employer or any member of its staff may not:~~

Reason for change: To combine language from 0030(4)(e)~~,~~ and (7)(a)~~, and 0035(3)~~ to improve organization of the rules.

436-015-0030(6) Formerly (4)
MCO Plan – Choice of Provider.
The plan must provide:

(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO. Formerly (4)(e), (7)(a)

Reason for change: To simplify and to remove unnecessary language.

436-015-0030(8)(b)(C) A standardized medical record ~~keeping~~ system ~~designed to facilitate quality assurance~~.

Reason for change: It should be easier to find provisions about "MCO insurer contracts" if they are listed in a separate rule titled MCO insurer contracts.

Rule: OAR 436-015-0035 Move sections (1), (4), and (5) to new rule 0037, titled "MCO insurer contracts." Delete the second sentence of 0035(4), because subsection (a) states that the contract must specify who is governed by the contract. The second sentence of (4), therefore, seems superfluous.

Draft rule text: Please refer to full draft. (Issue 1288)

Reason for deletion: Insurers must comply with OAR 436-009 and 010, and it is not necessary to state the requirement in these rules.

~~**436-015-0095 Insurer's Rights and Duties**~~
~~Insurers shall also comply with OAR 436-010 and 436-009 when carrying out their duties under these rules.~~

Reason for change: ORS 656.260 was renumbered by Senate Bill 533 (2013), and the citation to 656.260(14) should now be to (15).

436-015-0110(6) The time frame for resolution of the dispute by the MCO may not exceed 60 days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260~~(14)~~(15), the MCO must * * *

Reason for change: The language from 015-0110(11) is redundant and already stated in the proposed 0120(2) and (3).

OAR 436-015-0110(11) 436-015-0110~~(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.~~

Reason for change: The correct name for the "Department of Consumer and Business Services Fund" is now the "Consumer and Business Services Fund."

436-015-0120(1)(b) [(3)(b) after renumbering]: (b) Civil penalty as provided under ORS 656.745(2) and (3). All penalties collected under this section ~~shall~~must be paid into the ~~Department of~~ Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director ~~shall~~will consider * * *

Reason for change: Move (9) and (10) to 436-015-0120, as these sections are better placed in the rule on "Sanctions and Civil Penalties." Delete (11) because ~~it's~~ it is redundant to information ~~already stated~~ in 0120~~(10)~~(3).

~~(9) Complaints pertaining to violations of these rules must be directed to the division.~~

~~(10) The division may investigate the alleged rule violation. The investigation may include, but will not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330.~~

~~(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.~~

Managed Care Organizations
Oregon Administrative Rules
Chapter 436, Division 015

DRAFT Proposed

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NOTE: Revisions are marked as follows*:

Deleted text has a "strike-through" style, as in ~~Deleted~~

Added text is underlined, as in Added

Historical rules: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-015-0001 Administration of These Rules

(1) Any orders issued by the Workers' Compensation Division (division) in carrying out the director's authority to enforce ORS chapter 656 and these rules ~~adopted pursuant thereto,~~ are considered orders of the director. Moved from 0006

(2) Authority For Rules.

These rules are promulgated under the director's general rule-making authority of ORS 656.726 (4) and specific authority under ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794.

(3) Purpose.

The purpose of these rules is to establish and provide policies, procedures, and requirements to administer, evaluate, and enforce statutes relating to the delivery of medical services by managed care organizations (MCOs) to workers within the workers' compensation system. Formerly 436-015-0002

(4) Applicability of Rules.

(a) These rules apply on and after the effective date to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794, and govern all MCOs and insurers contracting with an MCO. Formerly 0003(1)

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute. Formerly 0003(2)

(5) Determining timeliness of documents required by these rules.

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or emailed, it must be received by the division by 11:59 p.m. Pacific Time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(d) The date and time of receipt for electronic filings is determined under ORS 84.043.

(e) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in

ORS 187.010 and 187.020. New – same wording as 436-001-0027.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02, as Admin. Order 02-053, eff. 4/1/02
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

~~**436-015-0002 Purpose**~~

~~The purpose of these rules is to establish and provide policies, procedures, and requirements for the administration, evaluation, and enforcement of the statutes relating to the delivery of medical services by managed care organizations (MCOs) to injured workers within the workers' compensation system.~~

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
Repealed xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

~~**436-015-0003 Applicability of Rules**~~

~~(1) These rules apply on and after the effective date to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.260, 656.268, 656.325, 656.327, and 656.794, and govern all MCOs and insurers contracting with an MCO.~~

~~(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, waive any procedural rules as justice so requires.~~

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99
Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Repealed xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 ~~and OAR 436-010-0005~~ are hereby incorporated by reference and made a part of these rules.

~~(1)~~**(2) "Administrative review"** means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001. Copied from Div010

(3) "Come-along provider" means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO. Copied from Div010

(4) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical

portion of workers' compensation coverage, for some or all of the employer's workers, which provides workers with health care benefits even if a workers' compensation claim is denied. Copied from Div010

(5) "Group of medical service providers" means individuals duly licensed to practice one or more of the healing arts who join together to provide ~~managed~~ medical services through a managed care organization, whether or not such providers have an ownership interest in the managed care organization. Formerly (1)

~~(2)~~**(6) "GSA"** means a geographic service area. Formerly (2)

~~(3)~~**(7) "Health care provider"** means an entity or group of entities, organized to provide health care services or organized to provide administrative support services to entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider. Formerly (3)

~~(4)~~**(8) "Insurer"** means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407. Copied from Div010

(9) "Managed care organization" ~~**or (**~~**"MCO")** means an organization formed to provide medical services and certified under these rules. Formerly (4)

~~(5)~~**(10) "Medical provider"** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services. Copied from Div010

(11) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and where necessary, physical restorative services. Copied from Div010

(12) "Medical service provider" means a person duly licensed to practice one or more of the healing arts. Copied from Div010

(13) "Non-qualifying employer" means either: Formerly (5)

(a) An insurer as defined under ORS 656.005(14), with respect to managed care services to be provided to any subject worker; or~~,~~ Formerly (5)(a)
(b) An employer as defined under ORS 656.005(13), other than a health care provider, with respect to managed care services to such employer's employees. Formerly (5)(b)

~~(6)~~**(14)** **"Primary care physician"** means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner. Formerly (6)

(15) "Show cause hearing" means an informal meeting with the director or designee where the MCO is provided an opportunity to explain and present evidence regarding any proposed orders by the director to suspend or revoke the MCO's certification. New

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 (ch. 423, OL 2007)
Hist: Amended 6/12/08 as WCD Admin. Order 08-053, eff. 7/1/08
Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

~~436-015-0006 Administration of Rules~~

~~Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.~~

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
Repealed xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0007 Entities Allowed to Manage Care

(1) Only an MCO may provide managed care services as described in ORS 656.260(4)(d)~~, 656.260(20)~~ and (21)(a), ~~and under these rules,~~ except as allowed under OAR 436-015-0009.

(2) An insurer or someone acting on behalf of an insurer may not manage the care of ~~non-MCO enrolled~~ workers by limiting the choice of medical providers, ~~except as allowed under ORS chapter 656,~~ or by requiring medical providers to abide by specific treatment standards, treatment guidelines, ~~and~~or treatment protocols.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Adopted 12/15/08 as WCD Admin. Order 08-064, eff. 1/1/09
Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0008 ~~Administrative~~ Request for Review before the Director

~~(1) Any party may request that the director provide voluntary mediation after a request for administrative review or hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the director's satisfaction, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, administrative review shall continue.~~

~~(2)~~(1) ~~**Administrative review before the director:**~~ The process for administrative review ~~of such matters shall be~~ before the director is as follows:
Formerly (2)

(a) Any party that disagrees with an action ~~taken by~~of an MCO ~~pursuant to these rules~~ must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision~~.~~ unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.
Formerly (2)(a)

(b) ~~The~~ Within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process, the aggrieved party ~~shall~~must file a written request for administrative review with the ~~administrator of the Workers' Compensation D~~division ~~within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process.~~ . The request must specify the grounds upon which the action is contested. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO final decision.

If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party ~~may~~must request administrative review within 60 days of the failure of the MCO to issue a decision. ~~The request must specify the grounds upon which the action is contested.~~Formerly (2)(b)

(c) The director ~~shall~~will create a documentary record sufficient for judicial review. The director may require and allow the parties to submit ~~such~~ input and information appropriate to complete the review. Formerly (2)(c)

(d) The director ~~shall~~will review the ~~relevant information~~record and issue an order. The order ~~shall~~must specify that it will become final ~~and not subject to further review~~ within 30 days of the mailing date of the order unless a written request for hearing is filed with the administrator ~~within 30 days of the mailing date of the order.~~of the ~~Workers' Compensation D~~division. Formerly (2)(d)

~~(3)~~**(2) Dispute resolution by agreement.**

Any party may request that the director provide voluntary mediation after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the director's satisfaction, the agreement must be in writing and approved by the director. If the dispute does not resolve through mediation, administrative review will continue. Formerly (1)

(3) Physician review (e.g., appropriateness).

If the director determines an evaluation by a physician is indicated to resolve the dispute, the director~~, in accordance with OAR 436-010-0330,~~ may appoint an appropriate medical service provider or panel of providers under ORS 656.325(1) to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. The worker may refuse an invasive test without sanction. Formerly (3)

(a) A single physician selected to conduct an evaluation must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed. Formerly (3)(a)

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, as the medical service provider whose treatment or service is being reviewed. Formerly (3)(b)

(c) When an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. No party may directly contact the physician or panel except as it relates to the examination date, time, location, and attendance. If the parties ~~wish that~~want the physician or panel to address special questions, the parties must submit these questions to the director for screening. The director will determine the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical evaluation, and the director will not submit questions regarding such matters to the evaluating physician(s). The evaluation may include: Formerly (3)(c)

(A) A review of all medical records and diagnostic tests submitted~~,~~; Formerly (3)(c)(A)

(B) An examination of the worker~~,~~; and Formerly (3)(c)(B)

(C) Any necessary and reasonable medical tests. Formerly (3)(c)(C)

(4) Hearings.

Hearings before an administrative law judge: Any party who disagrees with an order under these rules may ~~request a hearing by filing~~ file a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing. In the review of orders issued ~~pursuant to~~under ORS 656.260(~~14~~15) and (16), no new medical evidence or issues ~~shall~~will be admitted at hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be remanded to the MCO for further evidence taking, correction, or other necessary action if the administrative law judge or director determines the record has been improperly, incompletely, or otherwise insufficiently developed. Formerly (4)

(5) Contested case hearings of sanctions and civil penalties:

Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director ~~pursuant to~~under ORS 656.745, or to a civil penalty or cease and desist order issued under ORS 656.260(~~20~~21), may request a hearing by the Hearings Division of the Workers' Compensation Board as follows: Formerly (5)

(a) The party ~~shall~~must file a written request for a hearing with the administrator of the ~~Workers' Compensation D~~division within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested. Formerly (5)(a)

(b) The division ~~shall~~will forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board. Formerly (5)(b)

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, ~~shall~~will conduct the hearing ~~in accordance with~~ under ORS 656.740 and ORS chapter 183. Formerly (5)(c)

(6) MCO certification suspension or revocation.

Hearings on the suspension or revocation of an MCO's certification: Formerly (6)

(a) At a show cause hearing on a notice of intent to suspend issued ~~pursuant to~~under

OAR 436-015-0080(2), the MCO must ~~show cause~~ present evidence regarding why it should be permitted to continue to provide services under these rules. Formerly (6)(a)

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings ~~pursuant to~~under OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director ~~shall~~will issue an order withdrawing the notice. Formerly (6)(a)(A)

(B) If the MCO disagrees with the order, ~~it~~ the MCO may ~~request a hearing by filing~~file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. Formerly (6)(a)(B)

(C) OAR 436-001 applies to the hearing. Formerly (6)(a)(C)

(b) A revocation issued ~~pursuant to~~under OAR 436-015-0080(5) ~~shall become~~becomes effective ~~within~~ 10 days after service of such notice upon the MCO unless, within such period of time, the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for a show cause hearing with the administrator of the ~~Workers' Compensation D~~division. Formerly (6)(b)

(A) If the MCO appeals, the administrator ~~shall~~will set a date for a show cause hearing and ~~shall~~will give the MCO at least ten days notice of the time and place of the hearing. At hearing, the MCO ~~shall~~must show cause why it should be permitted to continue to provide services under these rules. Formerly (6)(b)(A)

(B) Within ~~thirty~~30 days after the hearing, the director ~~shall~~will issue an order affirming or withdrawing the revocation. Formerly (6)(b)(B)

(C) If the MCO disagrees with the order, ~~it~~the MCO may ~~request a hearing by filing~~file a request for hearing as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. Formerly (6)(b)(C)

(D) OAR 436-001 applies to the hearing.

(c) An emergency revocation issued ~~pursuant to~~under OAR 436-015-0080(7) is effective immediately. The MCO ~~must~~may file a request for hearing with the administrator as provided in OAR 436-001-0019 within 60 days of the mailing date of the order. OAR 436-001 applies to the hearing. Formerly (6)(c)

Stat. Auth.: ORS 183.310 thru 550; ORS 656.260, 656.325, 656.704,; and 656.726(4)
Stats. Implemented: ORS 656.260, 656.325, and 656.704
Hist: Amended 11/17/11 as Admin. Order 11-057, eff. 1/1/12
Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0009 Formed~~/~~, Owned~~/~~, or Operated

(1) The director will not certify an MCO formed, owned, or operated by a non-qualifying employer.

(2) For purposes of this rule, "staff" means any individual who is an employee of a non-qualifying employer or of any parent or subsidiary entity of a non-qualifying employer. Formerly (5)

(3) A non-qualifying employer or any member of its staff, or their immediate family, may not: Formerly (2)

(a) Directly participate in the formation, certification, or incorporation of the MCO; Formerly (2)(a)

(b) Nominate, assume a position as, or act in the role of, a director, officer, agent, or employee of the MCO; ~~or~~Formerly (2)(b)

(c) Arrange for, lend, guarantee, or otherwise provide financing for any ~~of the~~ organizational costs of the MCO~~.~~; Formerly (2)(c)

~~(3) A non-qualifying employer or any member of its staff, or their immediate family, may not:~~

~~(a)~~**(d)** Arrange for, lend, guarantee, or otherwise provide financial support to the MCO (financial support does not include contracted fees for services rendered by an MCO); ~~or~~Formerly (3)(a)

~~(b)~~**(e)** Have any ownership or similar financial interest in or right to payment from the MCO~~.~~; Formerly (3)(b)

~~(4) A non-qualifying employer or any member of its staff may not:~~

~~(a)~~**(f)** Make or exercise any control over business, operational, or policy decisions of the MCO; Formerly (4)(a)

~~(b)~~**(g)** Possess or control the ownership of voting securities of the MCO~~;~~. ~~t~~The director will presume possession or control exists if any person, directly or indirectly, holds the power to vote or holds proxies of any other person representing ten percent or more of the voting securities of the MCO; Formerly (4)(b)

~~(c)~~**(h)** Provide MCO services other than as allowed by section (~~6~~4) of this rule; Formerly (4)(c)

~~(d)~~**(i)** Enter into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or Formerly (4)(d)

~~(e)~~**(j)** Direct or interfere with the MCO's delivery of medical and health care services. Formerly (4)(e)

~~(5) For purposes of this rule, "staff" is any individual who is a regular employee of a non-qualified employer or of any parent or subsidiary entity of a non-qualified employer.~~

~~(6)~~**(4)** Notwithstanding ~~sections (2),~~section (3~~), and (4~~) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be ~~in accordance with~~according to protocols and standards established by the certified MCO plan. ~~For purposes of this rule, the~~The insurer may not provide or participate in the provision of managed care services related to dispute resolution, service utilization review, or physician peer review. Formerly (6)

~~(7) An MCO may not contract exclusively with a single insurer. However, an MCO has up to one year from the effective date of its first contract to obtain contracts with more than one insurer. If the MCO has not obtained additional contracts within this time period, the MCO must provide the director with a report documenting the MCO's efforts to obtain additional contracts.~~

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/12/08 as WCD Admin. Order 08-053, eff. 7/1/08
Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0010 Notice of Intent to Form an MCO

(1) Any health care provider or group of medical service providers initiating an MCO under ORS 656.260, must submit a "Notice of Intent to Form" to the director, by certified mail, in a format prescribed by the director. (Form ~~440-~~2737 may be used for this purpose).

(2) The notice of intent must include the following:

(~~1~~a) The ~~I~~identity of ~~the~~ each person ~~or persons~~ who participates in discussions intended to result in the formation of an MCO. If the person is a member of a closely held corporation, the notice ~~should~~must include the identity of the shareholders;

(~~2~~b) The name, address, and telephone number of a contact person; and

(~~3~~c) A summary of the information that will be shared in discussions preceding the application for MCO certification.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/12/08 as WCD Admin. Order 08-053, eff. 7/1/08
Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0030 Applying for Certification

(1) General.
The MCO must establish one place of business in Oregon where it administers the plan and keeps membership and other records as required by OAR 436-015-0050. Formerly (12)

(2) An applicant for MCO certification must submit the following to the director ~~the following:~~: Formerly (1)

(a) One copy of the application; Formerly (1)(a)

(b) A non-refundable fee of $1,500 payable to the Department of Consumer and Business Services which will be deposited in the Consumer and Business Services Fund; Formerly (1)(b)

(c) Affidavits of each person identified in section (~~2~~3) of this rule, certifying that the individuals have no interest in ~~an insurance company in accordance with~~a non-qualifying employer under ~~the provisions of~~ OAR 436-015-0009; Formerly (1)(c)

(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services ~~in accordance with~~under the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and Formerly (1)(d)

(e) A complete organizational chart. Formerly (1)(e)

~~(2)~~(3) MCO Application.
The application must include: Formerly (2)

(a) The name of the MCO; Formerly (2)(a)

~~(b) A proposed plan for the MCO, in which the applicant identifies the manner in which the MCO will meet the requirements of ORS 656.260 and these rules;~~

~~(c)~~**(b)** The name~~(s)~~ of ~~the~~each person~~(s)~~ who will be a director~~(s)~~ of the MCO; Formerly (2)(c)

~~(d)~~**(c)** The name of the person who will be the president of the MCO; Formerly (2)(d)

(d) The title and name of the person who will be the day-to-day administrator of the MCO; Formerly (2)(e)

(e) The title and name of the person who will be the ~~day-to-day administrator of the MCO; and~~

~~(f) The title and name of the person who will be the~~ administrator of the financial affairs of the MCO~~.~~; and Formerly (2)(f)

~~(3)~~**(f)** A proposed plan for the MCO, in which the applicant identifies how the MCO will meet the requirements of ORS 656.260 and these rules. Formerly (2)(b)

(4) MCO Plan - General.

The plan must:

(a) ~~i~~Identify the initial GSA(s) in which the MCO intends to operate. (For details regarding GSAs, see ~~*http://wcd.oregon.gov/Bulletins/bul_248.pdf*~~).*http://wcd.oregon.gov/rdrs/mru/mco/orgsa.html*). Formerly (3)

~~(4) The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:~~

~~(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;~~

~~(b) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner within 24 hours of the MCO's knowledge of the need or a request for treatment;~~

~~(c) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner in the MCO within 5 working days, after treatment by a physician outside the MCO;~~

~~(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include the worker's right to receive emergency or urgent care, and the hours of regular MCO operation if assistance is needed to select an attending physician or answer other questions;~~

~~(e) Receive necessary treatment from any category of medical service provider as defined in subsection (7)(a) of this rule and have a choice of at least three medical service providers within each category. The worker also must be able to choose from at least three physical therapists and three psychologists. For categories in which the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards;~~

~~(f) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;~~

~~(g) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographical service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if they agree to the MCO's terms and conditions;~~

~~(h) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker;~~

~~(i) Receive specialized medical services the MCO is not otherwise able to provide; and~~

~~(j) Receive treatment that is consistent with MCO treatment standards and protocols.~~

~~(5) The plan must provide a procedure that allows workers to receive compensable medical treatment from a primary care physician, chiropractic physician, or authorized nurse practitioner who is not a member of the MCO and has received authorization under OAR 436-015-0070.~~

~~(6) The plan must include:~~

~~(a) A copy of the standard provider agreement that is used by the MCO when a provider is credentialed as a panel provider. If there are variations from the standard provider agreement, those must be identified when the plan is submitted for director approval.~~

~~(b) A list of the names, addresses, and specialties of the individuals who will provide services under the managed care plan. This list must indicate which medical service providers will act as attending physicians in each GSA.~~

~~(7) The plan must provide:~~

~~(a) An adequate number of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician, as listed in ORS 676.110. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO.~~

~~(b) A process that allows workers to select a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010. If the MCO has fewer than three authorized nurse practitioners from which workers can choose within a GSA, the MCO must allow workers to seek treatment outside the MCO from authorized nurse practitioners, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners are not themselves bound by the MCO's treatment and utilization standards; however, workers are subject to those standards.~~

~~(c) A program that specifies the criteria for selection and de-selection of physicians and the process for peer review. The processes for terminating a physician and peer review must provide adequate notice and hearing rights for any physician.~~

~~(8) The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent~~

~~inappropriate or excessive treatment including:~~

~~(a) A program of peer review and utilization review to prevent inappropriate or excessive treatment including the following:~~

~~(A) A pre-admission review program of elective admissions to the hospital and of elective surgeries;~~

~~(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;~~

~~(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, time loss of claimant, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile must not be released to anyone outside the MCO without the physician's specific written consent, except that the physician's profile must be released to the director without the necessity of obtaining such consent;~~

~~(D) Concurrent review programs, that periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary;~~

~~(E) Retrospective review programs, that examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate;~~

~~(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.~~

~~(b) A quality assurance program that includes:~~

~~(A) A system for monitoring and resolving problems and complaints, including problems and complaints of workers and medical service providers;~~

~~(B) Physician peer review, which must be conducted by a group designated by the MCO or the director, and which must include members of the same healing art in which the physician practices;~~

~~(C) A standardized medical record keeping system designed to facilitate quality assurance.~~

~~(c) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, and quality assurance.~~

~~(9) The plan must include:~~

~~(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers in accordance with OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing the waiver of the time period to appeal a decision to the MCO upon a showing of good cause; and~~

~~(b) A description of how the MCO will ensure the worker continues to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process.~~

(10) The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must include:

(a) A description of the medical expertise or specialties of the clinicians involved;

(b) A description regarding what the protocols and guidelines are based on;

(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines;

(d) A description of the criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines;

(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and

(f) A description of a process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.

(11) The plan must provide other programs that meet the requirements of ORS 656.260(4), including:

(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers; and

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must include:

(A) Identification of how the MCO will promote such services;

(B) A method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer;

(C) A method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001;

(D) A provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and

(E) A provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO.

(12) The MCO must establish one place of business in Oregon where it administers the plan and keeps membership records and other records as required by OAR 436-015-0050.

(13) The plan must include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization in accordance with OAR 436-015-0040 and OAR 436-009.

~~(14) The MCO must designate an in-state communication liaison for the department and the insurers at the MCO's established in-state location. The responsibilities of the liaison include:~~

~~(a) Coordinating and channeling all outgoing correspondence and medical bills;~~

~~(b) Unless otherwise provided by the MCO contract, providing centralized receipt and distribution of all reimbursements back to the MCO members and primary care physicians; and~~

~~(c) Serving as a member on the quality assurance committee.~~

~~(15) The plan must describe~~**(b)** Describe the reimbursement procedures for all services provided. Formerly (15)

~~(16) The plan must include~~**(c)** Include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service. Formerly (16)

~~(17) The plan must describe~~**(d)** Describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers~~.~~ and ~~The plan must also describe~~ how workers can access those providers.

(e)~~The plan must p~~Provide a procedure for regular, periodic updating of ~~the~~all MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days. Formerly (17)

~~(18)~~**(f)** Include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization under OAR 436-015-0040 and OAR 436-009. Formerly (13)

(5) MCO Plan – Worker Rights.

The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to: Formerly (4)

(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan; Formerly (4)(a)

(b) Receive initial treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within 24 hours of the MCO's knowledge of the need or a request for treatment; Formerly (4)(b)

(c) Receive treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within five working days after the worker received treatment outside the MCO; Formerly (4)(c)

(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include: Formerly (4)(d)

(A) The worker's right to receive emergency or urgent care, and Formerly (4)(d)

(B) The MCO's regular hours of operation if the worker needs assistance selecting an attending physician or has other questions. Formerly (4)(d)

(e) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance; Formerly (4)(f)

(f) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographic service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if they agree to the MCO's terms and conditions; Formerly (4)(g)

(g) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker; Formerly (4)(h)

(h) Receive specialized medical services the MCO is not able to provide; and Formerly (4)(i)

(i) Receive treatment that is consistent with MCO treatment standards and protocols. Formerly (4)(j)

(6) MCO Plan – Choice of Provider.

The plan must provide: Formerly (4)

(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet

this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO. Formerly (4)(e), (7)(a)

For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards. Formerly 0035(3)

(b) A process that allows workers to select an authorized nurse practitioner. If the MCO has fewer than three authorized nurse practitioners within a GSA, the MCO must allow workers to seek treatment outside the MCO from authorized nurse practitioners, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners cannot be required to comply with the terms and conditions regarding services performed by the MCO. These authorized nurse practitioners are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards. Formerly (7)(b)

(c) A procedure that allows workers to receive compensable medical treatment from a come-along provider authorized under OAR 436-015-0070. Formerly (5)

(7) MCO Plan – Provider Agreement.

The plan must include: Formerly (6)

(a) A copy of the standard provider agreement used by the MCO when a provider is credentialed as a panel provider. Variations from the standard provider agreement must be identified when the plan is submitted for director approval; and Formerly (6)(a)

(b) An initial list of the names, addresses, and specialties of the individuals who will provide services within the MCO. This list must indicate which medical service providers will act as attending physicians in each GSA. Formerly (6)(b)

(8) MCO Plan – Monitoring and Reviewing.

The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including: Formerly (8)

(a) A program of peer review and utilization review ~~to prevent inappropriate or excessive treatment~~ including the following: Formerly (8)(a)

(A) Pre-admission review of elective admissions to the hospital and elective surgeries; Formerly (8)(a)(A)

(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly; Formerly (8)(a)(B)

(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, workers' time loss, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile must not be released to anyone outside the MCO without the physician's specific written consent, except that the physician's profile must be released to the director without the necessity of obtaining such consent; Formerly (8)(a)(C)

(D) Concurrent review programs that periodically review the care after treatment has begun, to determine if continued care is medically necessary; Formerly (8)(a)(D)

(E) Retrospective review programs that examine care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and Formerly (8)(a)(E)

(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended. Formerly (8)(a)(F)

(b) A quality assurance program that includes: Formerly (8)(b)

(A) A system for monitoring and resolving problems or complaints, including those identified by workers or medical service providers; Formerly (8)(b)(A)

(B) Physician peer review, which must be conducted by a group designated by the MCO or the director. The group must include members of the same healing art as the peer reviewed physician; and Formerly (8)(b)(B)

(C) A standardized medical record system. Formerly (8)(b)(C)

(c) A program that specifies the criteria for selection and termination of panel providers and the process for peer review. The processes for terminating a panel provider and peer review must provide adequate notice and hearing rights. Formerly (7)(c)

(d) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, or quality assurance. Formerly (8)(c)

(9) MCO Plan – Dispute Resolution.

The plan must include: Formerly (9)

(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers under OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing waiver of the 30 day period to appeal a decision to the MCO upon a showing of good cause; and Formerly (9)(a)

(b) A description of how the MCO will ensure workers continue to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process. Formerly (9)(b)

(10) MCO Plan – Treatment Standards, Protocols, and Guidelines.

The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must describe: Formerly (10)

(a) The medical expertise or specialties of the clinicians involved; Formerly (10)(a)

(b) What the protocols and guidelines are based on; Formerly (10)(b)

(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines; Formerly (10)(c)

(d) The criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines; Formerly (10)(d)

(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and Formerly (10)(e)

(f) A process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning. Formerly (10)(f)

(11) MCO Plan – Return to Work and Workplace Safety.

The plan must provide other programs that meet the requirements of ORS 656.260(4), including: Formerly (11)

(a) A program involving cooperative efforts by the workers, the employer, the insurer,

and the MCO to promote early return to work for enrolled workers; and Formerly (11)(a)

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must: Formerly (11)(b)

(A) Identify how the MCO will promote such services; Formerly (11)(b)(A)

(B) Describe the method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer; Formerly (11)(b)(B)

(C) Describe the method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001; Formerly (11)(b)(C)

(D) Include a provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and Formerly (11)(b)(D)

(E) Include a provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO. Formerly (11)(b)(E)

(12) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA(s) of the MCO. If the certification is denied**,** the director will provide the applicant with the reason for the denial. Formerly (18)

~~(19)~~**(13)** The director will not certify an MCO if the plan does not meet the requirements of these rules. Formerly (19)

(14) Communication Liaison.

The MCO must designate an in-state communication liaison ~~for~~to the director and the insurers at the MCO's established in-state location. The liaison must serve as a member on the quality assurance committee. Formerly (14)

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 (ch. 423, OL 2007)
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0035 Coverage Responsibility of an MCO

(1) ~~An MCO shall provide comprehensive medical services in accordance with its certification to all enrolled injured workers covered by the insurer/MCO contract.~~ Moved to 0037(1)

~~(2)~~ The director ~~shall~~will designate an MCO's initial ~~GSA and approve any expansions to the MCO's service area. Injured workers shall not be governed by an MCO until the director has approved the~~ geographic~~al~~ service area~~.~~ (GSA). GSAs ~~shall be~~are established by postal zip code~~.~~ (See www.oregonwcd.org). The MCO may only provide contract services ~~to~~in those GSAs approved by the director. Workers are not subject to an MCO contract unless the director has approved the GSA. Formerly (2)

~~(3)~~**(2)** Any expansion of an MCO's ~~GSA~~service area must be approved by the director. The request for expansion must identify the ~~postal zip code areas of the proposed expansion and~~ new GSA and include evidence that the MCO has an adequate provider panel ~~in the new areas~~ which meets the minimum requirements ~~as set forth in~~under OAR 436-015-0030. ~~An MCO may be authorized by the~~The director ~~to expand~~may approve the MCO's new GSA without the minimum categories of medical service providers when the MCO establishes that there are not an adequate number of providers in a given category able or willing to become members of the MCO.

For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories~~,~~. Treatment provided to workers must be consistent with the MCO's treatment and utilization standards. Such providers, unlike ~~qualified primary care physicians and chiropractic physicians~~come-along providers, cannot be required to comply with the terms and conditions regarding services performed by members of the MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards. Formerly (3)

~~(4) An MCO may contract only with an insurer as defined in OAR 436-010-0005. When an MCO contracts with an insurer to provide services, the contract shall specify those employers governed by the contract. The MCO/insurer contract must include the following terms and conditions:~~ Moved to 0037(3)

~~(a) The contract must specify who is governed by the contract;~~ Moved to 0037(3)(a)

~~(b) The insured's place of employment must be within the authorized geographical service area;~~ Moved to 0037(3)(b)

~~(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location shall be governed by the same MCO(s). When insurers contract with multiple MCOs each worker shall have initial choice at time of injury to select which MCO will manage their care except when the employer provides a coordinated health care insurance program as defined in OAR 436-010-0005.~~ Moved to

0037(4)(c)

~~(d) Workers enrolled in an MCO shall receive medical services in the manner prescribed by the terms and conditions of the contract; and~~ Moved to 0037(3)(d)

~~(e) To ensure continuity of care, the contract shall specify the manner in which injured workers will receive medical services on open claims including but not be limited to the following:~~ Moved to 0037(3)(e)

~~(A) Upon enrollment, allowing the worker to continue to treat with a non-qualified medical service provider for at least seven days after the mailing date of the notice of enrollment; and~~ Moved to 0037(3)(e)(A)

~~(B) Upon termination or expiration of the MCO/insurer contract, allows the workers to continue treatment in accordance with ORS 656.245(4)(a).~~ Moved to 0037(3)(e)(B)

~~(5) Notwithstanding the requirements of this rule, failure of the MCO to provide such medical services does not relieve the insurers of their responsibility to ensure benefits are provided injured workers under ORS chapter 656.~~ Moved to 0037(4)

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0037 MCO/Insurer Contracts

(1) An MCO must provide comprehensive medical services to all enrolled workers covered by the MCO/insurer contract according to the MCO's certification. Formerly 0035(1)

(2) An MCO may not contract exclusively with a single insurer. However, an MCO has up to one year from the effective date of its first contract to obtain contracts with more than one insurer. If the MCO has not obtained additional contracts within this time period, the MCO must provide the director with a report documenting the MCO's efforts to obtain additional contracts. Formerly 0009(7)

(3) An MCO may contract only with insurers. The contract must include the following terms and conditions: Formerly 0035(4)

(a) Who is governed by the contract; Formerly 0035(4)(a)

(b) The covered place of employment must be within the authorized geographic service area; Formerly 0035(4)(b)

(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location must be governed by the same MCO(s). When insurers contract with multiple MCOs each worker must have initial choice at the time of injury to select which MCO will manage their care except when the employer provides a coordinated health care program; Formerly 0035(4)(c)

(d) Workers enrolled in an MCO must receive medical services as prescribed by the terms and conditions of the contract; and Formerly 0035(4)(d)

(e) A continuity of care provision specifying how workers will receive medical services on open claims, including the following: Formerly 0035(4)(e)

(A) Upon enrollment, allowing workers to continue to treat with the current medical service providers for at least seven days after the mailing date of the notice of enrollment; and Formerly 0035(4)(e)(A)

(B) Upon termination or expiration of the MCO/insurer contract, allowing workers to continue treatment under ORS 656.245(4)(a). Formerly 0035(4)(e)(B)

(4) Notwithstanding the requirements of this rule, failure of the MCO to provide medical services does not relieve the insurers of their responsibility to ensure benefits are provided to workers under ORS chapter 656. Formerly 0035(5)

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Adopted xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0040 Reporting Requirements ~~For~~ for an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO ~~shall~~must provide the director with a copy of the entire text of any MCO/insurer contract ~~agreement~~, signed by the insurer and the MCO, within 30 days of execution of such contracts. ~~Amendments~~The MCO must submit any amendments, addendums, ~~and~~or cancellations~~, together with the entire text of the underlying contracts, shall be submitted~~ to the director within 30 days of execution.

(2) ~~Notwithstanding section (1), when~~When an MCO/insurer contract ~~agreement~~ contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination~~, or~~. If the MCO fails to provide the director with a copy of the signed contract extension, workers will no longer be subject to the contract after it expires or terminates ~~without renewal pursuant to ORS 656.245(4)(a).~~.

(3) ~~Any amendment~~The MCO must submit any amendments to the ~~approved MCO~~certified plan ~~must be submitted~~ to the director for approval. The MCO ~~shall~~must not take any action based on the proposed amendment until the ~~amended plan is approved~~director approves the amendment.

(4) Within 45 days of the end of each calendar quarter, each MCO ~~shall~~must provide the following information to the director, current on the last day of the quarter, ~~in a form and format~~ as prescribed by ~~the director: specify~~Bulletin 247:

(a) The quarter being reported~~,~~; Formerly (4)

(b) MCO certification number~~, membership~~; and Formerly (4)

(c) Membership listings by category of medical service provider (in coded form), including ~~provider~~: Formerly (4)

(A) Provider names~~, specialty~~; Formerly (4)
(B) Specialty (in coded form~~),~~); Formerly (4)
(C) Tax ID number~~,~~; Formerly (4)
(D) National Provider Identifier (NPI) number~~, business~~; and Formerly (4)
(E) Business address and phone number. ~~(All fields are required unless specifically excepted by bulletin.)~~ When a medical service provider has multiple offices, only one office location in each geographic~~al~~ service area needs to be reported. ~~In addition, the updated membership listing shall include the names and addresses of all health care providers participating in the MCO.~~Formerly (4)

(5) By April 30 of each year, each MCO must provide the director with the following information for the previous calendar year:

(a) A summary of any sanctions or punitive actions taken by the MCO against its members; and

(b) A summary of actions taken by the MCO's peer review committee~~; and~~.

~~(c) An affidavit that the approved MCO plan is consistent with the MCO's business practices, and that any amendments to the plan have been approved by the director.~~

(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of ~~primary care physicians, chiropractic physicians and nurse practitioners who are not members of the MCO to provide compensable medical treatment under ORS 656.245(5) and 656.260(4)(g)(A).~~come-along providers. The MCO's report must include the following:

(a) Provider type (primary care physician, chiropractic physician, or authorized nurse practitioner) reported by geographic~~al~~ service area (GSA).

(b) The number of workers affected, reported by provider type.

(c) Date of denial or termination.

(d) One or more of the following reason(s) for each denial or termination:

(A) Provider failed to meet the MCO's credentialing standards within the last two years;

(B) Provider has been previously terminated from serving as an attending physician within the last two years;

(C) Treatment is not ~~in accordance with~~according to the MCO's service utilization process;

(D) Provider failed to comply with the MCO's terms and conditions after being granted come~~ ~~along privileges; or

(E) Other reasons authorized by statute or rule.

(7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.

(8) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 (ch. 423, OL 2007)
Hist: Amended 6/12/08 as WCD Admin. Order 08-053, eff. 7/1/08
Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0050 ~~Notice of~~ Record Keeping and Place of Business ~~in State; Records MCO Must Keep in Oregon~~

(1) Every MCO ~~shall~~must give the ~~division~~director notice of one ~~in-state~~Oregon location and mailing address where the MCO keeps records of the following:

(a) Up-to-date~~d~~ membership listings of all MCO members;

(b) ~~Records of any sanctions~~Sanctions or punitive actions taken by the MCO against its members;

(c) ~~Records of a~~Actions taken by the MCO's peer review committee;

(d) ~~Records of u~~Utilization reviews performed ~~in accordance with the requirements of utilization and treatment standards pursuant to ORS 656.260 showing~~identifying cases reviewed, ~~the~~ issues involved, and ~~the~~ action taken;

(e) A profile analysis of each provider in the MCO ~~listed by the International Classifications of Disease 9 Clinical Manifestations (ICD 9 CM) diagnosis;~~;

(f) ~~A record of those e~~Enrolled ~~injured~~ workers receiving treatment by ~~non-panel primary care physicians or authorized nurse practitioners authorized to treat pursuant to OAR 436-015-0070~~come-along providers; and

(g) All other records as necessary to ensure compliance with the certification requirements ~~in accordance with~~under OAR 436-015-0030.

(2) Records ~~retained as~~ required by section (1) of this rule must be ~~main~~retained at the authorized ~~in state~~Oregon location for three full calendar years.

(3) If the MCO/insurer contract is canceled for any reason, all MCO records~~, as identified in section (1),~~ relating to treatment provided to workers within the MCO must be forwarded to the insurer upon request. The records included in subsections (1)(b), (c), (d), and (e) of this rule are confidential ~~in accordance with~~under ORS 656.260~~(6) through (10).~~.

(4) ~~Individual~~Each MCO provider~~s~~ must maintain claimant medical records as provided by OAR 436-010-0240.

(5) Nothing in this ~~section~~rule is intended to ~~otherwise~~ limit the number of locations the MCO may maintain to carry out the provisions of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04
Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0060 Commencement~~/~~ and Termination of ~~Members~~Panel Providers

(1) Prospective new ~~members~~panel providers of an MCO ~~shall~~must submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership ~~pursuant~~according to the membership requirements of the MCO. The MCO ~~shall~~must verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee ~~shall~~must be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by ~~primary care physicians or authorized nurse practitioners who provide services under OAR 436-015-0070~~come-along providers.

(2) Individual ~~members~~panel providers may elect to terminate their participation in the MCO or be subject to cancellation by the MCO ~~pursuant~~according to the membership requirements of the MCO plan. Upon termination of a ~~member~~panel provider, the MCO ~~shall:~~must:

(a) Make alternate arrangements to provide continuing medical services for any affected ~~injured~~ workers under the plan~~.~~; and

(b) Replace any terminated ~~member~~panel provider when necessary to maintain an adequate number of each category of medical service provider.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0065 Monitoring~~/~~ and Auditing

(1) The director will monitor and conduct periodic audits of an MCO as necessary to ensure compliance with the MCO certification and performance requirements. Formerly 0100(1)

(2) All records of an MCO and their individual panel providers must be disclosed upon the director's request. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes. Formerly 0100(2)

Stat. Auth.: ORS 656.260, 656.726(4); Stats. Implemented: ORS 656.260
Hist: Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99
Amended and renumbered xx/xx/xx from 436-015-0100, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0070 ~~Primary Care Physicians, Chiropractic Physicians, and Authorized Nurse Practitioners Who Are Not MCO Members~~Come-along Providers

(1) The MCO must authorize a nurse practitioner or physician who is not ~~a member of the~~an MCO panel provider to provide medical services to an enrolled worker if:

(a) The nurse practitioner is an authorized nurse practitioner under ORS 656.245~~ and OAR 436-010-0005~~, the chiropractic physician has certified to the director that he or she has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);

(b) The authorized nurse practitioner or physician agrees to comply with~~ all terms and conditions regarding services governed by the MCO. For purposes of this section, the phrase "all terms and conditions regarding services governed by the MCO" means~~ MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services ~~in accordance with OAR 436-015-0090. However, the MCO's terms and conditions may not place limits on the length of services unless such limits are stated in ORS chapter 656; and~~under OAR 436-015-0090; and

(c) The authorized nurse practitioner or physician agrees to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require.

(2) The physician or authorized nurse practitioner who is not ~~a member of the~~an MCO panel provider will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if ~~an injured~~a worker has selected a physician or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.

(3) The MCO may not limit the length of treatment authority of a come-along provider unless such limits are stated in ORS chapter 656. Formerly (1)(b)

~~(3)~~**(4)** Notwithstanding section (1), for those workers receiving their medical services from a facility which maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians or authorized nurse practitioners who are not MCO ~~members~~panel providers, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician or authorized nurse practitioner to treat the compensable injury. Formerly (3)

~~(4)~~**(5)** Any questions or disputes relating to the worker's selection of a physician or authorized nurse practitioner who is not an MCO ~~member~~panel provider must be resolved ~~pursuant to~~under OAR 436-015-0110. Formerly (4)

~~(5)~~**(6)** Any disputes relating to a ~~worker's non-MCO primary care or chiropractic physician's, non-MCO authorized nurse practitioner's,~~come-along provider's or other non-MCO ~~physician's~~provider's compliance with MCO standards and protocols must be resolved ~~pursuant to~~under OAR 436-015-0110. Formerly (5)

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 12/1/05 as Admin. Order 05-072, eff. 1/1/06
Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0075 Worker Exam~~ination~~s

When the MCO schedules a worker ~~examination~~exam that includes a psychological evaluation, the appointment letter must:

(1) Inform the worker that a psychological evaluation is part of the ~~examination,~~exam; and

(2) State the reason for the psychological ~~examination.~~exam.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Adopted 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0080 Suspension; Revocation

(1) ~~Pursuant to~~Under ORS 656.260, the ~~certification of a managed care organization issued by the~~ director may ~~be suspended~~suspend or ~~revoked~~ revoke an MCO's certification if:

(a) The director finds a serious danger to the public health or safety;

(b) The MCO is not providing services ~~not in accordance with~~according to the terms of the certified MCO plan;

(c) There is a change in legal entity of the MCO which does not conform to the requirements of these rules;

(d) The MCO fails to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, or orders of the director~~.~~;

(e) The MCO or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or 656.745;

(f) Any false or misleading information is submitted by the MCO or any member of the organization;

(g) The MCO continues to ~~utilize~~ use the services of a health care practitioner whose license has been suspended or revoked by the licensing board; or

(h) The director determines that the MCO was or is formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider as defined in these rules.

(2) The director ~~shall~~will provide the MCO written notice of ~~an~~ intent to suspend the MCO's certification.

(a) The notice ~~shall~~will:

(A) Describe generally the acts of the MCO and the circumstances that would be grounds for suspension; and

(B) Advise the MCO of their right to ~~participate in~~ a show cause hearing and the date, time, and place of the hearing.

(b) The director will serve the notice ~~shall be served~~ upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served at least 30 days ~~prior to~~ before the scheduled date of the hearing.

(3) The show cause hearing on the suspension ~~shall~~must be conducted as provided in OAR 436-015-0008(~~6~~7).

(4) An order of suspension ~~shall~~will suspend the MCO's authority to enter into new contracts with insurers for a specified period of time up to a maximum of one year. During the suspension, the MCO may continue to provide services ~~in accordance with~~under the contracts in effect at the time of the suspension.

(a) ~~A suspension~~The director may ~~be~~ set aside the suspension ~~prior to~~ before the end of the suspension period if the director is satisfied of the MCO's current compliance, ability, and commitment to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan.

(b) ~~Prior to~~ Before the end of the suspension period the ~~division shall~~director will determine if the MCO is in compliance with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan. If the MCO is in compliance the suspension will terminate on its designated date. If the MCO is not in compliance the suspension may be extended beyond one year without further hearing, or revocation proceedings may be initiated.

(5) The process for revocation of ~~a~~an MCO ~~shall be~~is as follows:

(a) The director ~~shall~~will provide the MCO with notice of an order of revocation~~. The order shall~~ which:

(A) Describes generally the acts of the MCO and the circumstances that are grounds for revocation; and

(B) Advises the MCO that the revocation ~~shall~~will become effective within 10 days after service of such notice upon the MCO, unless within ~~such period of time~~10 days the MCO corrects the grounds for the revocation to the satisfaction of the director or the MCO files an appeal as provided in OAR 436-015-0008(~~6~~7).

(b) The director will serve the order ~~shall be served~~ upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served.

(c) A show cause hearing on the revocation ~~shall~~will be conducted as provided in OAR 436-015-0008(~~6~~7).

(d) If the director affirms the revocation ~~is affirmed~~, the revocation is effective 10 days after service of the order upon the MCO unless the MCO appeals the order.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for three years or longer, ~~it~~the MCO may petition the director to restore its authority by making application as provided in these rules.

(7) Notwithstanding section (5) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show ~~-~~cause hearing. Such order ~~shall~~will be final, unless the MCO requests a hearing. ~~The~~OAR 436-015-0008(7) outlines the process for review ~~shall be as provided in OAR 436-015-0008(6).~~.

(8) Insurer contractual obligations to allow ~~a managed care organization~~ an MCO to provide medical services for ~~injured~~ workers are null and void upon revocation of the MCO certification by the director.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0090 Charges and Fees

(1) Billings for medical services under an MCO ~~shall~~must be submitted in the form and format as prescribed in OAR 436-009. The payment of medical services may be less than, but ~~shall~~must not exceed, the maximum amounts allowed ~~pursuant to~~under OAR 436-009.

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by ~~primary care physicians and chiropractic physicians who qualify under ORS~~

~~656.260(4)(g) or authorized nurse practitioners who qualify under ORS 656.245 (5) shall~~come-along providers must not be less than fees paid to MCO panel providers for similar medical services. ~~Fees paid~~

(3) Payments to medical providers who are not under contract with the MCO~~, shall be~~ are not subject to ~~the provisions of OAR 436-009.~~an MCO discount. Formerly (2)

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.245 and 260
Hist: Amended 5/27/10, as Admin. Order 10-054, eff. 7/1/10
Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

~~436-015-0095 Insurer's Rights and Duties~~

~~Insurers shall also comply with OAR 436-010 and 436-009 when carrying out their duties under these rules.~~

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02
Repealed xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

~~436-015-0100 Monitoring/Auditing~~

~~(1) The division shall monitor and conduct periodic audits of an MCO as necessary to ensure the compliance with the MCO certification and performance requirements.~~

~~(2) All records of an MCO and their individual members shall be disclosed upon request of the director. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.~~

~~Stat. Auth.: ORS 656.260, 656.726(4); Stats. Implemented: ORS 656.260~~
~~Hist: Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99~~
Amended and renumbered to 436-015-0065, xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0110 Dispute Resolution~~/Complaints of Rule Violation~~

(1) Disputes which arise between any party and an MCO must first be processed through the dispute resolution process of the MCO.

(2) The MCO must promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary must include at least the following:

(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;

(b) The types of issues the MCO will consider in its dispute resolution process;

(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and

(d) A statement that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) The MCO must notify the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute under this rule; or

(b) Issues any decision under this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice must include the following paragraph, in bold text:

> **NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. ~~If~~Absent a showing of good cause, if you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.**

(5) If an MCO receives a complaint or dispute that is not included in the MCO dispute resolution process, the MCO must, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director under OAR 436-015-0008. The notice must include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter that we handle. To pursue this issue, you must request administrative review of the issue by the director of the Department of Consumer and Business Services (DCBS). Send written requests for review to: DCBS, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days of the mailing date of this notice, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.

(6) The time frame for resolution of the dispute by the MCO may not exceed 60 days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260(14), the MCO must notify all parties to the dispute in writing~~, including the worker's attorney where written notification has been provided by the attorney~~ with an explanation of the reasons for the decision. If the worker's attorney has notified the insurer in writing of representation, the MCO must also send a copy of the explanation of the reasons for the decision to the attorney. This notice must inform the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008. The notice must include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.

(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO must notify the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008 including the appeal rights provided in (6) ~~above.~~of this rule.

(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further the dispute resolution process. Any of the parties also may request in writing that the director assist in resolution if the dispute cannot be resolved by

the MCO.

~~(9) Complaints pertaining to violations of these rules must be directed to the division.~~

~~(10) The division may investigate the alleged rule violation. The investigation may include, but will not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330.~~

~~(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.~~

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 2/16/12, as Admin. Order 12-052, eff. 4/1/12
Amended 3/11/13 as Admin. Order 13-053, eff. 4/1/13
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx

436-015-0120 Sanctions and Civil Penalties

(1) Complaints pertaining to violations of these rules must be sent to the director. Formerly 0110(9)

(2) The director may investigate an alleged rule violation. The investigation may include, but is not limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate panel of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330. Formerly 0110(10)

~~(1)~~**(3)** If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against an~~y~~ MCO: Formerly (1)

(a) Reprimand by the director; Formerly (1)(a)

(b) Civil penalty as provided under ORS 656.745(2) and (3). All penalties collected under this section ~~shall~~must be paid into the ~~Department of~~ Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director ~~shall~~will consider: Formerly (1)(b)

(A) The degree of harm inflicted on the worker, insurer, or medical provider; Formerly (1)(b)(A)

(B) ~~Whether there have been p~~Previous violations; and Formerly (1)(b)(B)

(C) ~~Whether there is e~~Evidence of willful violation. Formerly (1)(b)(C)

(c) Suspension or revocation of the MCO's certification ~~pursuant to~~under OAR 436-015-0080. Formerly (1)(c)

~~(2)~~**(4)** If the director determines that an insurer has entered into a contract with an MCO which violates OAR 436-015 or the MCO's certified plan, the insurer ~~shall~~will be subject to civil penalties as provided in ORS 656.745. Formerly (2)

~~(3)~~**(5)** If an insurer or someone who is not a certified MCO acting on the insurer's behalf engages in managed care activities prohibited under these rules, the director may impose a sanction or civil penalty. Formerly (3)

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260 and 656.745
Hist: Amended 11/1/07 as Admin. Order 07-058, eff. 1/1/08
Amended 12/15/08, as Admin. Order 08-064, eff. 1/1/09
Amended xx/xx/xx, as Admin. Order xx-xxx, eff. xx/xx/xx