Agenda	**Rulemaking Advisory Committee** **Workers' Compensation Division Rules,** • **OAR 436-009, Oregon Medical Fee and Payment** • **OAR 436-010, Medical Services** • **OAR 436-015, Managed Care Organizations**

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	November 30, 2023, 1:30 – 4:30 p.m. Room 260 (2nd floor), Labor & Industries building, 350 Winter St. NE, Salem, Oregon Join via Microsoft Teams: https://teams.microsoft.com/l/meetup-join/19%3ameeting_MjJlMzc5NmMtMTEzOC00NjhlLWFlNzMtNzMwMWZiN2VlZWMx%40thread.v2/0?context=%7b%22Tid%22%3a%22aa3f6932-fa7c-47b4-a0ce-a598cad161cf%22%2c%22Oid%22%3a%22419bb41f-34a1-4d77-8afc-abd87db857e0%22%7d Meeting ID: 232 240 062 811 Passcode: 9mHSPr **Or call in (audio only)** +1 503-446-4951,,608532618#
Facilitators:	Marie Loiseau and Juerg Kunz, Workers' Compensation Division
1:30 to 1:40	Welcome and introductions; meeting objectives
1:40 to 3:00	Discussion of issues – see attachment.
3:00 to 3:15	Break
3:15 to 4:15	Discussion of issues on agenda continued, and request for new issues
4:15 to 4:30	Summing up – next steps – thank you!

Attached: Issues Document

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Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
November 30, 2023, SRAC Meeting

Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2024)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2024. However, the Workers' Compensation (WCD) does not publish its permanent fee schedule updates until April 1, 2024 (projected effective date). This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if providers use new codes from January 1 through March 31, 2024.

Background:

- In order to allow time for public input, WCD publishes a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), effective April 1 of each year.
- Adopting the new CPT® and HCPCS codes, effective January 1, 2024, would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid, new codes.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD could update appendices B – E, effective Jan. 1, 2024, and assign maximum payment amounts using the 2023 conversion factors/multipliers. One should bear in mind that due to time and staffing restraints, it may not be possible to update all appendices.
- Various organizations will publish updates to standards that WCD adopted in OAR 436-009-0004.
- WCD began issuing temporary rules in January 2016 to allow providers to bill insurers using new codes for dates of service from January 1 through March 31 of each year.
- As in years past, the temporary rules would not delete any codes from any appendix and providers may continue to use all codes valid in 2023.

Options:

- Adopt new CPT® codes and standards (OAR 436-009-0004) through a temporary rule, effective January 1, 2024.
- Update appendices B – E with payment amounts for new codes using the 2023 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Permanent rules, effective April 1, 2024)

Issues:

- ORS 656.248(7) requires that WCD update the fee schedules annually.
- The references listed in OAR 436-009-0004 and the fee schedules published in appendices B through E will be outdated when the permanent rules become effective on April 1, 2024.

Background:

- The above listed appendices are based on conversion factors and multipliers developed by DCBS, and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare & Medicaid Services (CMS). In particular:
    1) Current Appendix B is based on the CMS file *RVU23A*, effective January 2023. We expect that CMS will publish the file containing the 2024 RVUs in November 2023.
    2) Current Appendix C and D are based on spreadsheets published by CMS in CMS-1772-FC. We expect that CMS will publish CMS-1786-FC, containing the 2024 ASC fee schedule amounts for surgical procedures and ancillary services, in November 2023.
    3) Current Appendix E is based on the CMS file *DME23-A*, effective January 2023. We hope that CMS will publish the file containing the 2024 DMEPOS fee schedule in November 2023.
- Every year, there are some CPT® and HCPCS codes that are deleted and some new codes are introduced. Adopting new billing codes and updating Appendices B through E allows us to stay current with valid CPT® and HCPCS codes.
- Every year, DCBS develops updated conversion factors and multipliers taking into account stakeholder input, utilization of medical services, and the new values and fee schedule amounts developed by CMS.
- Various organizations publish updates to standards that WCD adopted in OAR 436-009-0004.

Options:

- Adopt updated standards listed in OAR 436-009-0004 and update Appendices B through E using more current CMS spreadsheets and updated WCD conversion factors/multipliers.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 3 (1991)

Rule: OAR 436-009-0040 and Appendix B

Issues:

- A stakeholder requested that WCD discuss the fee schedule level of the physical medicine and rehabilitation (PM&R) category of the physician fee schedule.
- Another stakeholder requested a fee increase for the following billing codes: 12001 (simple repair of up to 2.5 cm superficial wound), 15853 (removal of sutures or staples not requiring anesthesia), 99203, 99204, 99205 (office visits new patients), 99213, 99214, 99215 (office visits established patients), 99442, 99443 (telephone evaluation and management 11 – 20 minutes, 21 – 30 minutes resp. of medical discussion), N0001 (brief narrative), and N0002 (complex narrative).

Background:

- The PM&R category contains CPT® codes 97010 through 97799.
- PM&R services are mainly provided by physical and occupational therapists, and chiropractic physicians.
- The PM&R category is the largest payment category of the physician fee schedule. Payments for PM&R services provided in 2022, were $64,573,046, representing around 37 percent of the total payments for services covered under the physician fee schedule.
- Over the past 10 years, from 2013 to 2023, WCD raised the overall fee schedule for the PM&R category by two percent. All other categories saw larger increases during that period:
    - Minor Surgery, Radiology, Lab and Pathology, Medicine, and Anesthesiology: Five percent;
    - Evaluation and management (E/M) other than office visits: 10 percent;
    - Major surgery: 20 percent;
    - Chiropractic manipulation codes: 21 percent; and
    - E/M office visits: 40 percent.
- Since 1997, the Oregon workers' compensation physician fee schedule is based on CMS' resource-based relative value scale (RBRVS). The RBRVS assigns, where possible, a relative value unit (RVU) to each code[1]. The RVU consists of three values:
    1. One for the work performed by the provider, which includes time and experience;
    2. One for the practice expense, i.e. the provider's overhead; and
    3. One for the malpractice expense.
    - In essence, the RBRVS determines the value of a service compared to another service. In order to assign a fee schedule amount for a service, one has to multiply the RVU for that service by a conversion factor.
    - WCD groups CPT codes into nine categories and assigns a conversion factor to each category.

[1] CMS is unable to assign an RVU to some codes that are relatively unspecific; e.g. surgical CPT code 21899 (Unlisted procedure, neck or thorax).

  - There are only a few codes, such as chiropractic manipulation treatment codes (98940 – 98943), where WCD publishes fee schedule amounts independent of CMS' RVUs.
- The All-Payers All-Claims (APAC) data allows WCD to compare the maximum allowable payment (MAP) under the workers' compensation (WC) fee schedule to the median allowed amount of commercial insurers who report to the Oregon APAC database. The latest APAC data available is from 2021. When comparing the WC MAP to commercial insurers' allowable payments for 2021, we find:
  - PM&R category: The average WC MAP is 8% above the median amount of commercial insurers.
  - CPT® Code 12001: This code is part of the minor surgery category. The WC MAP is 26% above the median amount of commercial insurers. The minor surgery category as a whole is 48% above the median amount of commercial insurers. WCD has not raised the average WC MAP of the minor surgery category since 2021.
  - CPT® Code 15853: This is a new code that was added to the minor surgery category in 2023.
  - CPT® Codes 99203 – 99205: The WC MAP ranges from 9% below (99204) to 4% above (99205) the median amount of commercial insurers.
  - CPT® Codes 99213 – 99215: The WC MAP ranges from 8% (99214) to 25% (99215) above the median amount of commercial insurers. The office visit category as a whole is 3% above the median amount of commercial insurers. WCD raised the average WC MAP of the E/M office visit category by 18% in 2023.
  - CPT® Codes 99442 and 99443: The WC MAP for 99442 is 57% above and for 99443 14% below the median amount of commercial insurers. WCD has not raised the average WC MAP of the E/M other than office visits category since 2021.
  - Oregon specific codes N0001, and N0002. Since these are Oregon specific codes, no comparison to the APAC data is possible. From 2013 to 2023, WCD raised the MAP for N0001 and N0002 by 5%.

Options:

- Increase the maximum payment amounts of the physical therapy and rehabilitation category.
- Decouple specific codes from CMS' RBRVS system and publish fee schedule amounts for selected codes without using CMS' RVUs.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 4 (1992)

Rule: OAR 436-009-0023 and Appendices C and D

Issue: Since WCD's introduction of CMS' ambulatory surgery center (ASC) payment system in April 2012, WCD has not raised the ambulatory surgery center fee schedules (Appendices C and D).

Background:

- Prior to April 1, 2012, WCD published one ASC fee schedule, covering the facility cost of an ASC, based on Medicare's 2006 ASC groupers. Since April 1, 2012, WCD uses CMS' new ASC payment system and part of CMS' hospital outpatient prospective payment system for the ASC fee schedules.
- Appendix C covers fees for ASC facility services, such as operating and recovery rooms, all services and procedures provided with surgical procedures furnished by nurses, technical personnel, laboratory testing, supplies, etc. Appendix D, also introduced on April 1, 2012, covers ancillary services, such as x-rays, provided by ASCs.
- WCD applies a multiplier to CMS' ASC fee schedules. Since 2012, WCD has adjusted the multiplier to keep the ASC fee schedule cost neutral, meaning, if utilization stays the same from year to year, the total costs for ASC services also stay the same.
- In 2022, total payments to ASCs were $18,152,783, representing 14 percent of the total facility[2] payments.

Options:

- Increase the ASC fee schedule by ?? percent.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

[2] Facility services consist of hospital outpatient, hospital inpatient, ASC, skilled nursing, and home health services

Issue # 5 (1949)

Rule: OAR 436-009-0080(7) Durable Medical Equipment (DME) Rental Rates

Issue: Some of the rental rates for DME, published in OAR 436-009-0080(7) are outdated.

Background:

- On January 1, 2012, WCD started using CMS' DMEPOS fee schedule as the basis for the new workers' comp DMEPOS fee schedule.
- Many items covered by the DMEPOS fee schedule are being rented, not purchased. The monthly rental rate is 10% of the fee schedule amount (purchase price), published in appendix E.
- Analysis of WCD's billing and payment data showed that for some items, the calculated rental rate was significantly below the going rental rate, and providers pointed out that they would not be able to provide these items at the calculated rental rate. Therefore, 18 DME codes were carved out, and WCD publishes a rental rate in OAR 439-009-0080(7) for these DME codes independent from the purchase price.
- While CMS' and WCD's DMEPOS fee schedules are updated annually, no changes to the rental rates published in OAR 436-009-0080(7) have occurred.
- A recent analysis has brought to light that, due to increases in the DMEPOS fee schedule, the rental rates for some DME codes published in OAR 436-009-0080(7) are now lower than 10% of the purchase price.
- Although WCD has not received any complaints from DME providers, it is reasonable to remove those codes whose rental rates are below 10% of the purchase price from OAR 436-009-0080(7), i.e., their rental rates will be 10% of the purchase price published in Appendix E.
- As of 2023, there are three codes whose rental fees published in OAR 436-009-0080(7) are below 10% of the fee schedule amount: E0194, E0434, and E0971.

Options:

- Remove codes E0194, E0434, and E0971 from OAR 436-009-0080(7).
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 6 (1990)

Rule: OAR 436-009-0060 (Oregon Specific Codes)

Issue: An arbiter physician noted that there was no code for a very complicated report, which could take 2+ hours, and thought such a code should be paid in the $600 range. The physician further suggested that a new code be created for the most complicated exams, payable at least in the $750 to $800 range.

Background:

- WCD publishes Oregon Specific Codes (OSCs) and fee schedule amounts for arbiter services in OAR 436-009-0060(2) and Appendix B.
- There are five billing codes for an arbiter file review:
  - AR021 for a file review of a limited record, payable at $150;
  - AR022 for a file review of an average record, payable at $250;
  - AR023 for a file review of a large record, payable at $397.57;
  - AR024 for a file review of an extensive record, payable at $767.38; and
  - AR025 for a file review of an extensive record with unique factors, payable at $1023.93.
- For arbiter exams, there are only three basic and one extra codes available:
  - AR001 for a basic medical exam with no complicating factors, payable at $384.06;
  - AR002 for a moderately complex exam that may have complicating factors, payable at $511.58; and
  - AR003 for a very complex exam that may have several complicating factors; payable at $639.86.
  - AR004 is used for a limited exam that may involve a newly accepted condition, or a partial exam, payable at $192.03.
- Similar to exams, there are only three basic codes available for arbiter reports:
  - AR011 for a report that answers standard questions, payable at $150;
  - AR012 for a report that answers standard questions and complicating factors, payable at $250; and
  - AR013 for a report that answers standard questions and multiple complicating factors, payable at $400.
- If we introduced a new code for a most complicated exam, it might be more logical to assign code AR004 to that exam, and use a new code (AR005) for an exam currently described by code AR004.

Options:

- Create a new OSC for a most complicated exam, payable at, e.g., $775.
  - Use current code AR004 for the most complicated exam; and
  - Use a new code (AR005) for a limited exam currently coded as AR004.

- Create a new OSC for a most complicated report that may take over two hours to complete, payable at, e.g., $650.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 7 (2018)

Rule: OAR 436-009-0060 (Oregon Specific Codes)

Issue: The Appellate Review Unit (ARU) is experiencing significant challenges finding psychiatrists to perform psychiatric arbiter exams and psychologists to perform the extensive testing needed in neuropsychological arbiter exams.

Background:

- There are very few providers willing to participate in these types of exams based on our current fee schedule and many are booked out far beyond the time period ARU needs to complete the reconsideration process within. Also, whereas psychiatric exams and neuropsychological exams were very infrequent in the past, we have seen a significant increase in cases requiring these exam types.
- ARU's statutory short time frames, in combination with a limited pool of providers willing to participate and with available time within the period needed, are making these exams very challenging to obtain.
- These exams types, unlike physical exams that usually are an hour or less, can take several hours to complete.
- ARU proposes to create a new Oregon specific code (OSC) for psychiatric arbiter exams and the psychological provider component of the neuropsychological arbiter exams, payable as billed.
- ARU would instruct psychiatrists and psychologists to use existing OSCs with a fixed fee schedule amount for performing a file review and authoring a report in addition to a newly created exam code.
- By creating an "as billed" code ARU anticipates broadening the examiner base and retaining more examiners for these exam types. ARU believes a broader examiner base in this area benefits the system through diversity and offers more opportunities for deselection by the parties. OAR 436-030-0165(2) states, in part: "If the director determines there are enough appropriate physicians available to create a list of possible arbiters and it is practicable, each party will be given the opportunity to agree on a physician and to remove one physician from the list through the process described below." Due to the limited number of providers willing to perform psychiatric and the psychological provider component of the neuropsychological exams, deselection is not currently an option and ARU would like to be able to recruit and build a larger pool of providers to possibly provide that opportunity for these exam types.
- ARU anticipates a limited financial impact as, though the number of these exam types has increased, they remain a small fraction of the overall arbiter exams performed.
- Additionally, a broader arbiter pool could potentially reduce travel/accommodation costs. Currently we have workers from all over the state traveling to Southern Oregon for neuropsychologists, because that's often the only region we can find a provider with availability.
- OAR 436-009-0010(8) provides that "[f]or services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a

provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008.

Options:

- Create a new OSC for an arbiter exam performed by a psychiatrist or psychologist, payable as billed.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 8 (2000)

Rule: OAR 436-009-0110 (Interpreters)

Issue: A stakeholder noted that since rates last increased for interpreter services, inflation significantly lowered the value of the maximum hourly rate currently payable by insurers.

Background:

- The stakeholder stated that the Bureau of Labor Statistics' website displays a CPI calculator that computes a 13.6% inflation from 2021 to 2023.
- The stakeholder proposes a 9.2% increase in the certified and non-certified interpreter hourly rates.
- WCD last increased the maximum interpreter hourly rates on April 1, 2022, by an average of 8.4%.

Options:

- Make the following changes to the interpreter fee schedule:

For:	The maximum payment is:
Interpreter services provided by a noncertified interpreter of an hour or less	$~~65.00~~**71.00**
Interpreter service of an hour or less provided by health care interpreters certified by the Oregon Health Authority[1]	$~~76.00~~**83.00**
American sign language interpreter services of an hour or less	$~~76.00~~**83.00**
Interpreter services provided by a noncertified interpreter of more than one hour	$~~16.25~~**17.75** per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Interpreter service of more than one hour provided by health care interpreters certified by the Oregon Health Authority[1]	$~~19.00~~**20.75** per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language interpreter services of more than one hour	$~~19.00~~**20.75** per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	The private vehicle mileage rate published in Bulletin 112
An examination required by the director or insurer that the patient fails to attend or when the provider cancels or	$~~65.00~~**71.00** no-show fee plus payment for mileage if 15 or more miles round trip

reschedules	
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage
[1] A list of certified health care interpreters can be found online under the Health Care Interpreter Registry at http://www.oregon.gov/oha/oei/Pages/HCI-Program.aspx .	

- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 9 (1969)

Rule: OAR 436-010-0240 (Medical Records and Reporting Requirements for Medical Providers)

Issue: There is no timeframe for how soon after receiving a request for medical records from workers or their representatives a medical provider must provide the requested records.

Background:

- A stakeholder noted: "Is there a reason why 436-010-0240(4)(c) does not require medical providers to provide the same information to the patient's representatives as it does to the insurer or its representatives? We have been getting more and more push back when we are trying to get records for the representation of our clients. *** It seems both sides should have the same mandatory right, including the 14-day turnaround, to get the patient's records. This is similarly weighted in favor of the insurer in 436-010-0270. While I appreciate the insurer's deadlines, we quite often have our own deadlines and end up fighting to obtain records for much longer periods."
- OAR 436-010-0240(4)(c) provides that a medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476..
- Further, subsection (4)(d) provides that the medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services.
- Subsection (4)(e) states in relevant part: "Patients or their representatives are entitled to copies of all medical and payment records, *** . Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers."

Options:

- Add a timeframe, e.g., 14 days, to OAR 436-010-0240(4)(e); or add "workers or their representatives" to subsection (4)(c).
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 10 (1952)

Rule: OAR 436-010-0270 (Insurer's Rights and Duties)

Issue: Currently insurers are not required to communicate to providers, or workers or their representatives whether the insurer will authorize or deny treatment after an MCO approves it as medically appropriate.

Background:

- This issue was raised by a workers' attorney. The attorney stated: "I regularly see MCOs approve surgery and the insurer remain silent on the issue. If no MCO were involved, the insurer would be subject to the elective surgery rules, which give a sensible timeline for responding to the authorization request. This creates confusion for workers who are not aware of what needs to happen to move things forward. I would propose a rule that requires insurers to acknowledge the MCO approval and authorize or deny services within a specified time frame."
- In MCO enrolled claims, a variety of medical services require pre-certification by the MCO. The MCO reviews the pre-certification request for appropriateness of the medical service. Any party, including an insurer, that disagrees with the MCO's pre-certification decision may appeal the decision to the MCO within 30 days.
- Since the MCO's pre-certification decision is in regards to the appropriateness of a medical services, it is not a guarantee of payment, as the insurer may deny the service, e.g., on the grounds that the service is not related to the compensable injury. In such a case, the insurer is not required to either appeal the MCO decision or notify the parties that the insurer denies the service as not causally related.
- Without communication by the insurer whether the insurer will authorize or deny treatment after an MCO approves it as medically appropriate, a provider may not be willing to provide the service, which can delay treatment for the worker, or the provider risks not getting paid, despite MCO approval.

Options:

- Create a rule that requires insurers, within a specified time frame, to communicate to providers, or workers or their representatives whether the insurer will authorize or deny treatment after an MCO approves it as medically appropriate.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 11 (1974)

Rules:

- **OAR 436-010-0220(5) (Managed Care Organization (MCO) Enrolled Workers)**
- **OAR 436-015-0030(6) (MCO Plan – Choice of Provider)**

Issue: OAR 436-010-0220(5) and 436-015-0030(6) provide that an MCO may have to provide a list of three providers willing to treat a worker within a reasonable period of time. However, there is no fixed timeframe for how soon an MCO must provide such a list.

Background:

- OAR 436-015-0030(6)(a) requires an MCO to have an adequate number, but not less than three, of medical service providers from certain provider categories. For categories where the MCO has fewer than three providers within a geographic service area (GSA) or the MCO is unable to provide a list of three providers willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories.
- OAR 436-010-0220(5)(b) provides: "Notwithstanding subsection (a) of this section, if a worker is unable to find three providers that are willing to treat the worker in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's geographic service area (GSA), the worker may contact the MCO for a list of three providers who are willing to treat the worker. If the MCO, within a reasonable period of time, is unable to provide a list of three providers who are willing to treat the worker, the worker may choose a non-panel provider in that category."
- WCD has seen an increase in the number of workers who are unable to find an MCO provider willing to treat them within a reasonable time.
- WCD has also heard from workers that they had to wait extended periods of time before they received a list of three willing providers from the MCO.
- A stakeholder also submitted this issue. The stakeholder wanted to see the following outcome:
    - Require the MCO to provide a list of three providers within seven days of the request, or allow the worker to treat with a non-MCO panel provider (notice of release).
    - Listed providers must be willing to see the worker within 14 days.
    - If no list or release notice is provided within seven days, the worker may seek treatment outside the MCO and is no longer subject to the MCO.

Options:

- Require the MCO to provide a list of three providers or allow the worker to treat with a non-MCO panel provider within a certain period of time, e.g., seven days.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 12 (2001)

Rule: OAR 436-015 (Managed Care Organizations)

Issue: A stakeholder opines that MCOs overtly control benefits other than medical care.

Background:

- Under ORS 656.260(4), an MCO is tasked to provide managed care, consisting of medical and health care services.
- According to this stakeholder, "MCOs were intended [to] govern medical care only. Now MCOs overtly control other benefits (temporary disability, vocational services, permanent disability, compensability) at the request of insurers. This exceeds the authority of MCOs. The rules need to expressly limit MCO involvement in a claim to determining whether requested medical treatment is excessive, inappropriate, or ineffectual, period. MCOs should be prohibited from interfering with, or influencing eligibility for other benefits, either directly or indirectly. The rules need to [be] clarified to make this limit enforceable by the director and the worker."
- The stakeholder referred to one MCO's provider manual, which provides: "In instances when time loss is authorized, [this MCO] requires attending physicians to authorize no more than thirty (30) days at a time." The stakeholder contends that such a provision is in essence controlling temporary disability, not controlling doctor visits or medical treatment.
- This stakeholder is specifically requesting:
    - "Add provision limiting purpose of MCOs to medical treatment and clarifying that MCOs are not to be involved in other benefits.
    - "Definition of 'medical service' to clarify that medical service excludes imposition of work restrictions or temporary disability authorizations.
    - "Clarify that MCO actions that interfere with or influence non-medical treatment benefits directly or indirectly are actions of the insurer and the worker may request administrative [review] by the director with attendant penalties/fees."
- The stakeholder is also requesting that a definition of "medical treatment" be added to division 015.
- "Medical treatment" is defined in OAR 436-010-0005(28). Since OAR 436-015-0005 provides that the definitions of ORS chapter 656 and OAR 436-010-0005 are incorporated by reference, the definition of "medical treatment" in the division 010 rule also applies to OAR 436-015.

Options:

- Amend rule to address stakeholder concerns.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Issue # 13

Rules: OAR 436-009-0025(1), 436-010-0290(2), 436-015-0110(5), (6), and (7)

Issue: Many prescribed notices in the above referenced rules are worded above a Grade 10 level.

Background: In March 2022, the Workers' Compensation Division invited interested parties to an advisory committee that identified and discussed opportunities to simplify and streamline notices distributed to workers and employers. Committee members advised that revisions of the content and format of notice language that is prescribed by rule could make the notices easier to understand.

Currently, OAR chapter 436 prescribes language for 30 different notices. Many of these notices include information on the worker's rights, processes for appeals, and contact information for questions or assistance. When a rule requires that notices to workers or employers include specific wording, it is critically important that the text helps readers understand their rights and responsibilities. Failure to meet a deadline, for example, can result in suspension or termination of a worker's benefits, or loss of appeal rights.

The division has drafted revised wording for review by the rulemaking advisory committee. The intent is to simplify and clarify the prescribed wording without changing the meaning.

Current wording and revised wording are presented below. These paragraphs are available with marked edits in the appendix.

OAR 436-009-0025(1)(e)(D)

Current, Grade 15:	**Draft, revised, Grade 8 (as of 6/23/23):**
To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit wcd.oregon.gov or call 503-947-7606.	Bulletin 112 lists reimbursement amounts for travel, food, and lodging. The bulletin is posted here: https://wcd.oregon.gov/Bulletins/bul_112.pdf. Questions? Call 503-947-7606.

OAR 436-009-0025(1)(e)(F)

Current, Grade 11:

If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. *Or* you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records.

Draft, revised, Grade 6 (as of 6/23/23):

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the director of the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:

- **Submit your request within 90 days of the mailing date of this explanation**
- **Sign and date this explanation in the space provided**
- **Explain why you think the payment is incorrect**
- **Attach required supporting documentation of your expense**
- **Send the documents to:**

  DCBS Workers' Compensation Division
  Medical Resolution Team
  350 Winter Street NE
  PO Box 14480
  Salem OR 97309-0405

  Or

  Fax your request to the director at 503-947-7629

- **Send a copy of your request to the insurer**

Keep a copy of this document for your records.

OAR 436-010-0290(2)(c)

Current, Grade 16	**Draft, revised, Grade 6 (as of 6/23/23)**
NOTICE TO WORKER, WORKER'S ATTORNEY, AND ATTENDING PHYSICIAN: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services in writing within 90 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 90 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.	**Notice to worker, worker's attorney, and attending physician:** **If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:** • **Notify the director of the Department of Consumer and Business Services (DCBS) in writing** • **Send your written request 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 90 days, you will lose all rights to appeal the decision.** **For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.**

OAR 436-015-0110(4)

Current, Grade 10	**Draft, revised, Grade 6 (as of 6/23/23)**
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 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.	**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 your written request for review to:** **{MCO name}** **{MCO address}** **If you have questions, contact {MCO contact person and phone number}.** **If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision, unless you show good cause. If you appeal within the 30-day timeframe, we will review the disputed decision and notify you of our decision within 60 days of your request. After that, if you still disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you do not seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.**

OAR 436-015-0110(5)

Current, Grade 13

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.

Draft, revised, Grade 6 (as of 6/23/23)

Notice to the worker and all other parties:

We do not review the type of issue you have raised. To pursue this issue you must request administrative review of the issue within 60 days of the mailing date of this notice.

If you do not notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.

Send your written request for review to:

DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405.

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

OAR 436-015-0110(6)

Current, Grade 15	**Revised, draft, Grade 6 (as of 6/23/23)**
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.	**Notice to the worker and all other parties:** **If you want to appeal this decision, you must do so within 60 days from the mailing date of this notice.** **If you do not notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.** **Send your written request for review to:** **DCBS Workers' Compensation Division** **Medical Resolution Team** **350 Winter Street NE** **PO Box 14480** **Salem OR 97309-0405.** **For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.**

Alternatives:

- Revise notices (with additional edits, as needed, based on advice)
- Do not revise notices
- Other

Fiscal Impacts, including cost of compliance for small business:
Insurers and self-insured employers may incur some near-term costs to revise letters and associated computer programs and templates. The agency does not have data that would allow projection of overall costs, but invites input from claims processors.

How will adoption of this rule affect racial equity in Oregon?
The Workers' Compensation Division does not collect data about race or ethnicity related to workplace injuries and illness in Oregon, but the United States Bureau of Labor Statistics publishes lists of occupations and numbers of Americans employed broken down by race. Black/African American and Hispanic/Latino workers are represented in some of the more

dangerous occupations in higher numbers than their respective shares of the U.S. workforce. To the extent Oregon workers in these racial groups suffer more on-the-job injuries and illnesses, streamlining of communications may benefit these racial groups more than others. The agency does not have sufficient data needed to estimate specific effects on racial equity in Oregon, but invites public input.

Recommendation:

Appendix A

Revised mandatory notice wording with marked edits

OAR 436-009-0025(1)(e)(D)

Bulletin 112 lists reimbursement amounts for travel, food, and lodging. The bulletin is posted here: https://wcd.oregon.gov/Bulletins/bul_112.pdf. Questions? Call 503-947-7606.

OAR 436-009-0025(1)(e)(F)

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the director of the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:

- **Submit your request within 90 days of the mailing date of this explanation**
- **Sign and date this explanation in the space provided**
- **Explain why you think the payment is incorrect**
- **Attach required supporting documentation of your expense**
- **Send the documents to:**

  DCBS Workers' Compensation Division
  Medical Resolution Team
  350 Winter Street NE
  PO Box 14480
  Salem OR 97309-0405

  Or

  Fax your request to the director at 503-947-7629

- **Send a copy of your request to the insurer**

Keep a copy of this document for your records.

OAR 436-010-0290(2)(c)

Notice to worker, worker's attorney, and attending physician:

If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:

- **Notify the director of the Department of Consumer and Business Services (DCBS) in writing**
- **Send your written request 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 90 days, you will lose all rights to appeal the decision.

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

OAR 436-015-0110(4)

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 your written request for review to:**

  {MCO name}
  {MCO address}

If you have questions, contact {MCO contact person and phone number}.

If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision, unless you show good cause. If you appeal within the 30-day timeframe, we will review the disputed decision and notify you of our decision within 60 days of your request. After that, if you still disagree with our decision, you may appeal to the director of the

Department of Consumer and Business Services (DCBS) for further review. If you do not seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.

OAR 436-015-0110(5)

Notice to the worker and all other parties:

We do not review the type of issue you have raised. To pursue this issue you must request administrative review of the issue within 60 days of the mailing date of this notice.

If you do not notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.

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Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405.

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

OAR 436-015-0110(6

Notice to the worker and all other parties:

If you want to appeal this decision, you must do so within 60 days from the mailing date of this notice.

If you do not notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.

Send your written request for review to:

DCBS Workers' Compensation Division
Medical Resolution Team

350 Winter Street NE
PO Box 14480
Salem OR 97309-0405.

For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.