Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules:

- **OAR 436-009, "Oregon Medical Fee and Payment Rules,"**
- **OAR 436-010, "Medical Services,"**
- **OAR 436-015, "Managed Care Organizations," and**
- **OAR 436-035, "Disability Rating Standards" (addressing only OAR 436-035-0260(3), Visual Field Loss)**

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	**November 18, 2025, 1-4 p.m.** 350 Winter St. NE, Salem, Oregon – Labor & Industries Building, Room F (basement) and via Microsoft Teams: https://teams.microsoft.com/l/meetup-join/19%3ameeting_MDQ1MTc0YjMtMzViYS00MjQwLWIxODUtMzc1OTE0Y2RjN2Ew%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: 294 305 717 925 6 Passcode: ht9y8xW9 +1 503-446-4951,,842623980# Phone conference ID: 842 623 980#
Facilitators:	Marie Rogers, Juerg Kunz, Mary MacKie—Workers' Compensation Division
1:00 to 1:10	Welcome and introductions; meeting objectives
1:10 to 2:30	Discussion of issues – see attachment.
2:30 to 2:40	Break
2:40 to 3:45	Discussion of issues on agenda continued, and request for new issues
3:45 to 4:00	Summing up – next steps – thank you!

Attached: Issues document

Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
November 18, 2025, Stakeholder Rules Advisory Committee Meeting

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Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2026)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2026. However, the Workers' Compensation (WCD) does not publish its permanent fee schedule updates until April 1, 2026 (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, 2026.

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, 2026, 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 can update appendices B – E, effective Jan. 1, 2026, and assign maximum payment amounts using the 2025 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 adopts 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 2025.

Options:

- Adopt new CPT® codes and standards (OAR 436-009-0004) through a temporary rule, effective January 1, 2026.
- Update appendices B – E with payment amounts for new codes using the 2025 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business: No fiscal impacts are anticipated.

How will adoption of this rule affect racial equity in Oregon? No racial equity impacts are anticipated.

Recommendations:

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Permanent rules, effective April 1, 2026)

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 – E will be outdated when the permanent rules become effective on April 1, 2026.

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).
- 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 – 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 – E using more current CMS spreadsheets and updated WCD conversion factors/multipliers.

- Other?

Fiscal Impacts, including cost of compliance for small business:
No fiscal impacts are anticipated.

How will adoption of this rule affect racial equity in Oregon?
No racial equity impacts are anticipated.

Recommendations:

Issue # 3 (2142)

Rule: OAR 436-009-0004 and Appendix B

Issue: Last year's rules advisory committee recommended that WCD develop a fee schedule amount for CPT® code 0232T (Platelet Rich Plasma Injection).

Background:

- Prior to April 1, 2025, platelet rich plasma (PRP) injections were not a compensable medical services.
- Based on the recommendation by WCD's Medical Advisory Committee, PRP injections became compensable on April 1, 2025.
- Outside the workers' compensation arena, PRP injections are generally not paid by health insurance, i.e., most PRP injections are paid out of pocket by patients.
- Because CMS has not assigned a relative value unit (RVU) to CPT® code 0232T, and the department did not have any billing data for this CPT code, WCD was unable to develop a fee schedule amount for PRP injections.
- In the meantime, WCD has received some billing and payment data through medical EDI. See attachment (at the end of the agenda PDF).

Options:

- Create fee schedule amount for CPT® code 0232T of $500, $550, other?
- 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 (2131)

Rule: OAR 436-009-0025

Issue: WCD sees more and more disputes involving reimbursement requests from workers who paid for a medical service or paid a co-pay/co-insurance/deductible on either interim claims, i.e., before claim acceptance/denial, or on denied claims that were later accepted. There is no specific rule addressing a situation where a worker paid for medical services prior to a claim being accepted and subsequently requests reimbursement from the insurer.

Background:

- When a medical provider treats a worker with an accepted workers' compensation claim, the provider must bill the insurer and is not allowed to collect any payments from the worker.
- However, prior to the claim being accepted[1], a worker may have paid a provider for medical services.
- Once a claim gets accepted, a worker may ask for reimbursement from the insurer for medical expenses, copayments and deductibles paid by the injured worker.
- There are three basic scenarios that may need to be addressed by rule:
    - The insurer received bills and chart notes from the provider and paid the provider prior to receiving the worker's reimbursement request;
    - The insurer received bills and chart notes from the provider but hasn't paid the provider yet when the insurer receives the worker's reimbursement request; or
    - The insurer has not received any bills or chart notes from provider when the insurer receives the worker's reimbursement request.

Options:

- Create a new section in OAR 436-009-0025:
  (x) Reimbursement for medical services paid for by the worker prior to claim acceptance.
  When the insurer receives a reimbursement request from a worker for medical services, if the insurer:
  (a) Paid the provider prior to receiving the worker's reimbursement request, then the worker must request a refund from the provider, and the provider must refund the worker within 60 days of receiving the request;
  (b) Has not paid the provider, but has bills or chart notes from provider, then the insurer must reimburse the worker for compensable medical services and pay any balance up to the fee schedule to the provider;
  (c) Has not paid the provider and does not have bills or chart notes from provider, the insurer must inform the worker in writing that they need chart notes from the provider

[1] This could be during the normal course of filing a claim while waiting for the insurer to accept the claim, or it could be prior to a claim denial being overturned.

before they can proceed with reimbursing the worker. [Should the rule state whose responsibility it is to get chart notes, i.e. the worker's or the insurer's?]

- 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 # 5 (2150)

Rule: OAR 436-009-0030, -0110, and 436-010-0270

Issue: Some insurers and service companies are located in different time zone and may make return phone calls to providers as early as 5:00 am Pacific time.

Background:

- Above listed rules require insurers or their representatives to respond to certain questions by providers within two days, excluding Saturdays, Sundays, and legal holidays.
- This issue was brought to WCD's attention by a provider who opines that insurers should return phone calls during Oregon business hours, not during business hours that are based on Central or Eastern U.S. time zones.

Options:

- Amend OAR 436-009-0005, 436-009-0030, 436-009-0110, and 436-010-0270 as follows:
    - OAR 436-009-0005: Create a new section (36): "**Regular Oregon business hours"** means from 8:00 am to 5:00 pm pacific time zone.
    - OAR 436-009-0030(3)(c)(C): "An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within two days **during regular Oregon business hours**, excluding Saturdays, Sundays, and legal holidays;"
    - OAR 436-009-0110(7)(j): "The insurer or its representative must respond to an interpreter's inquiry about payment within two days **during Oregon regular business hours**, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer."
    - OAR 436-010-0270(4)(a): "The insurer or its representative must respond to a medical provider's inquiry about claim status, accepted conditions, or MCO enrollment within two days **during regular Oregon business hours**, excluding Saturdays, Sundays, and legal holidays listed in ORS 187.010 and 187.020. The insurer or its representative may not refer the medical provider to another entity to obtain an answer. For the purpose of this rule, "regular Oregon business hours" means from 8:00 am to 5:00 pm pacific time zone.

- 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 (2105)

Rule: OAR 436-009-0060 Oregon Specific Codes

Issue: There is no billing code for treat and release.

Background:

- A stakeholder requests that WCD create two new Oregon Specific Codes (OSCs). The stakeholder noted:

  > "Due to the unique niche of our services, we do not have a OSC or HCPCS that accurately represents what we do. We are an Oregon non-profit organization and my department, Mobile Health, serves the community by responding to on-the-job injuries on-site to assess, treat and transport, if necessary. We are not an ambulance service but are licensed EMTs and Paramedics. We work under the control of a dually-licensed physician. Our calls fall into 3 categories, 1) on-site treat and release, 2) transport from job site to an appropriate level of care, 3) provide medical service on-site at an hourly rate (such as a blood draw for an exposure where we can get both source and exposed together). We are 24/7/365 and charge an extra fee for after hours and holidays. Treat and release situations are typically billed to the employer since a claim is not opened but occasionally, a treat and release will seek a higher level of care at a later date if new symptoms arise or their injury is not improving. If they end up coming into our clinic for a higher level of care, we would then bill our service to workers comp as well. An injury that we know will open a claim is sent to workers comp."
- The stakeholder requests OSCs for the following services:
  - Basic Life Support (BLS) non-emergent response and treatment. No transport. (non-ambulance)
  - BLS non-emergent response. Treatment and transport. (non-ambulance)
- If two new OSCs are created:
  - Should they have a fee schedule amount?
  - If so, how would the department assign an appropriate fee?
  - If there is no fee schedule amount it would be payable at 80% of billed.

Options:

- Create two new OSCs for:
  - BLS non-emergent response and treatment. No transport. (non-ambulance);
  - BLS non-emergent response. Treatment and transport. (non-ambulance).

- Assign a fee schedule amount to the new codes.

- 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 (2117)

Rule: OAR 436-009-0060 Oregon Specific Codes

Issue: The billing code (W0001) for a worker requested medical exam (WRME) includes the charges for the exam, time spent reviewing the record, and the report. However, the code does not include charges for authoring an addendum to a report.

Background:

- OAR 436-009-0060(2) provides the following descriptor for W0001: "WRME (worker requested medical exam): Exam, report, or time spent reviewing the records associated with the scheduled exam."
- Under OAR 436-060-0147:
    - The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the WRME physician at the exam to the physician at least 14 days before the scheduled date of the exam.
    - Upon completion of the exam, the WRME physician must address the original independent medical examination (IME) questions and the questions from the worker or the worker's attorney and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.
- Since the worker or the worker's attorney must submit questions to the physician 14 days prior to the exam, there should generally not be a need for an addendum report.
- However, there may be times when the WRME physician is asked to respond to an addendum report from the IME physician. The division believes that in such a case, the WRME physician should be reimbursed for authoring an addendum report.

Options:

- Add "addendum to a report when authored in response to an IME addendum report" to the descriptor of billing code W0001.
- 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 (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), may be outdated.

Background:

- On January 1, 2012, WCD started using CMS' DMEPOS fee schedule as the basis for the new workers' compensation 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, certain 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.
- The rental rates for some DME codes published in OAR 436-009-0080(7) may now be lower than 10% of the purchase price.
- 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 would become 10% of the purchase price published in Appendix E.
- WCD intends to compare the rental rates listed in OAR 436-009-0080(7) to the proposed 2026 DMEPOS fee schedule and remove any codes from OAR 436-009-0080(7) that are below 10% of the fee schedule amount

Options:

- Remove codes whose rental fees published in OAR 436-009-0080(7) are below 10% of the fee schedule amount 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 # 9 (2112)

Rule: OAR 436-009-0110 Interpreters

Issue: A stakeholder noted that OAR 436-009-0110(2)(b) as worded violates Title VI of the Civil Rights Act.

Background:

- OAR 436-009-0110(2)(b) provides, in relevant part, that, "if the insurer denies the claim, interpreters may bill the worker."
- According to the stakeholder, "[i]t is illegal to pass the cost of interpreting services onto the worker."
- Title VI of the Civil Rights Act provides that no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.
- The obligations under Title VI regulations apply broadly to any program or activity that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.
- In the workers' compensation setting, workers may choose their own interpreters, rather than use an interpreter arranged for by the provider. OAR 436-009-0110(2)(b) is intended for interpreters chosen by the worker, not the provider. In such a case, neither any program nor any activity is involved that receives any federal funding.

Options:

- Amend OAR 436-009-0110(2)(b) as follows:

  "Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if **the interpreter is chosen by the worker and** the insurer denies the claim, **the** interpreter~~s~~ may bill the worker."

  Or

  "Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). ~~However, if the insurer denies the claim, interpreters may bill the worker.~~"

- 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 (2145)

Rule: OAR 436-010 and 436-015

Issue: There is no standardized process for submitting requests for pre-authorization of medical services.

Background:

- This issue was raised by a stakeholder on behalf of the Oregon Trial Lawyers Association (OTLA). OTLA opines that a standardized process is needed for submitting requests for pre-authorization of medical services in order to streamline the process for providers and provide enforceable deadlines for insurer responses.
- ORS 656.245(1)(a) provides that for every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires.
- In the Oregon workers' compensation system, unless the claim is enrolled in an MCO, providers are generally not required to request pre-authorization. However there are providers who insist on receiving some form of pre-authorization from insurers before they are willing to provide medical services to a workers' compensation patient. In such cases an insurer may have to pre-authorize a medical service in order to cause the medical service to be provided.
- There is a provision in OAR 436-010-0270(4) that requires insurers to respond to a provider's pre-authorization request for diagnostic imaging studies: "Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized."
- The stakeholder noted that "[w]orkers and their medical providers often face difficulty and delay in getting responses from insurers so that treatment can proceed or denials can be appealed. This was discussed during the MLAC Access to Care Subcommittee over the summer. It is a common issue cited by providers in terms of added administrative burden."
- The MLAC access to care subcommittee recommended that OTLA move forward with requesting WCD rulemaking to consider a standard procedure for submitting requests for preauthorization with a deadline for response, after which the worker could treat the lack of response as a denial and file an appeal.
- All three certified MCOs require pre-certification of many medical services, and each MCO has their own pre-certification form.
- The stakeholder proposed that WCD "[c]reate a standardized form that providers are encouraged to use for any type of medical service whether or not an MCO is involved. The form would be deemed received after being faxed or emailed, and the insurer would have a set time for response, after which the worker could treat the failure to respond as a denial and file an appeal."

- If WCD created a form for preauthorization of medical services, would MCOs have to accept this form rather than mandate use of their own form?

Options:

- Create a new form that providers must use if they wish to request preauthorization of medical services.

- Amend OAR 436-010-0270 as follows:
  (3)**(a)** Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request **on Form XXX** for preauthorization of ~~diagnostic imaging studies, other than plain film X-rays~~ **medical services**. The response must include whether the service is pre-authorized or not pre-authorized. Preauthorization is not a guarantee of payment.
  (b) If the insurer fails to respond within 14 days of receiving Form XXX:
  (A) The medical service is considered denied; and
  (B) The insurer is barred from challenging the medical appropriateness.

- Delete OAR 436-010-0230(12).
  (Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not preauthorized within 14 days of receipt of the request.)

- 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 (2146)

Rule: OAR 436-010-0270(1)

Issue: When a worker becomes medically stationary, OAR 436-010-0270(1) requires the insurer to "immediately" send a notice to the worker, whereas OAR 436-060-0015(8) requires a notice to be sent within seven days.

Background:

- OAR 436-010-0270(1)(c) provides that in disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).
- Further, subsection (1)(d) of rule 0270 states that when the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.
- OAR 436-060-0015(8) provides that an insurer must mail or deliver a written notice to a worker and the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.
- This issue was raised by a stakeholder[2] who noted that insurers may send out multiple notices to injured workers informing them of their medically stationary status. This increases costs for insurers, results in duplicative documents. The stakeholder pointed out that representatives of injured workers have consistently reported that workers receive too much paperwork during the course of their claim.
- The stakeholder is proposing that aligning the time period to send the medically stationary notice under OAR 436-010-0270(1)(c) with OAR 436-060-0015(8). If adopted, an insurer would have to the send the medically stationary notice within 7 days of the worker being declared medically stationary under both rules. This would simplify the timeline and avoid duplicative mailings or delivery of the same or similar notices.
- WCD has noticed that oftentimes ancillary care providers and specialist physicians are not made aware of the worker's medically stationary status and, therefore, are not aware that medical services for a worker are limited to those listed in ORS 656.245(1)(c).

Options:

- Amend OAR 436-010-0270(1)(c) as follows:
  In disabling and nondisabling claims, ~~immediately following~~ **within seven days of** notice or knowledge that the worker is medically stationary, the insurer must notify the worker

[2] This issue was raised previously by a stakeholder, however, at that time, WCD did not make a rule change.

and ~~the attending physician or authorized nurse practitioner~~ **all medical service providers** in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245-(1)(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 # 12 (2137)

Rule: OAR 436-010-0280

Issue: MCOs are allowed to grant full length attending physician (AP) status to physician associates (PAs), i.e., permit them to be AP for the life of the claim. Similarly, MCOs may allow authorized nurse practitioners (ANPs) to treat workers for the life of the claim. However, under OAR 436-010-0280(1) MCOs may not allow PAs and ANPs to make findings of impairment.

Background:

- ORS 656.245(2)(b) provides that a medical service provider who is not a member of a managed care organization is subject to the following provisions:

  (C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

  (D)(iii) When an injured worker treating with a nurse practitioner or physician assistant authorized to provide compensable services under this section becomes medically stationary within the 180-day period in which the nurse practitioner or physician assistant is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability.
- OAR 436-010-0280(1) provides, in relevant part, that when a worker becomes medically stationary and there is a reasonable expectation of permanent disability, and the worker is under the care of an authorized nurse practitioner, physician associate, or a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam.
- ORS 656.245(2)(b)(C) and (D)(iii) apply to providers who are not members of an MCO. However, OAR 436-010-0280(1) as currently worded applies to all ANPs, PAs, and naturopathic physicians, regardless of whether they are members of an MCO.

Options:

- Amend OAR 436-010-0280(1) as follows: "When a worker becomes medically stationary and there is a reasonable expectation of permanent disability, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. **Unless otherwise provided by an MCO,** ~~If~~ **if** the worker is under the care of an authorized nurse practitioner, physician associate, or a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam."

- 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 (2148)

Rule: OAR 436-015-0037(3)

Issue: A stakeholder stated that workers report that it becomes increasing difficult to schedule an appointment with an MCO panel provider within the timeframe required by OAR 436-015-0037(3)(e)(A).

Background:

- OAR 436-015-0037(3)(e)(A) allows a worker, upon being enrolled in an MCO, to continue to treat with the current medical service providers for at least 14 days after the mailing date of the notice of enrollment.
- This issue was raised by a stakeholder who noted:

  > Injured workers have only 14 days from the date of mailing a letter informing them they are subject to an MCO to find providers within the MCO. These letters are mailed, often from out of state, and workers don't receive them until days later. Then they only have 10 days or less to find a new doctor. As you can imagine, calling any medical clinic and being seen in that timeframe is impossible. If the worker can't be seen within 14 days of the letter, they will lose their time loss. The rule should be changed to reflect the reality of how hard it is to find a doctor within that timeframe. 30 or even 45 days seem more reasonable.

Options:

- Amend OAR 436-009-0037(3)(e)(A) to allow workers, upon being enrolled in an MCO, to continue to treat with the current medical service providers for at least 30 (or 45?) days after the mailing date of the notice of enrollment, rather than the current 14 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 # 14 (2158)

Rule: OAR 436-015-0110 and 436-015-0008

Issue: The timeframes for MCO dispute resolution and administrative review by the director may delay necessary treatment substantially.

Background:

- OAR 436-015-0110(6) provides that the time frame for resolution of the dispute by the MCO may be up to 60 days from the date the MCO receives the dispute to the date it issues its final decision.
- An aggrieved party may then request administrative review by the director within 60 days of the date the MCO issues a final decision. OAR 436-015-0008(1)(b).
- Reducing the timeframes listed in OAR 436-015-0008(1)(b) and OAR 436-015-0110(6) from 60 to 30 days could reduce treatment delay by up to 60 days.

Options:

- Amend OAR 436-015-0008(1)(b) and -0110(6) as follows:
    - OAR 436-015-0008(1)(b):
      Within ~~60~~ **30** days of the date the MCO issues a final decision under the MCO's dispute resolution process, the aggrieved party must file a written request for administrative review with the division. The request must specify the grounds upon which the action is contested.
      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 must request administrative review within ~~60~~ **30** days of the failure of the MCO to issue a decision.
      When the aggrieved party is a represented worker, and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the ~~60~~**30**-day time frame begins when the MCO issues its final decision to the attorney.
    - OAR 436-015-0110(6):
      The time frame for resolution of the dispute by the MCO may not exceed ~~60~~ **30** 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(15), the MCO must notify all parties to the dispute in writing 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.

- 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:

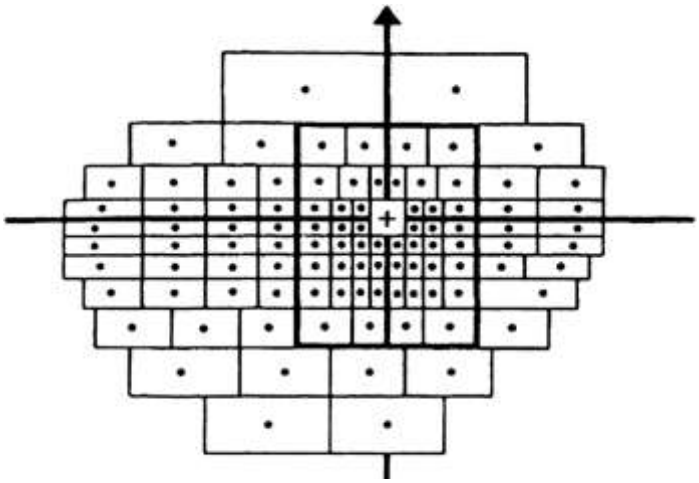
Issue #15

Rule: OAR 436-035-0260(3)

Issue:
OAR 436-035-0260(3) specifies that a Goldmann perimeter must be used to measure visual field loss. Because this device is now outdated, there are a limited number of ophthalmologists available to conduct closing and arbiter exams requiring visual field testing.

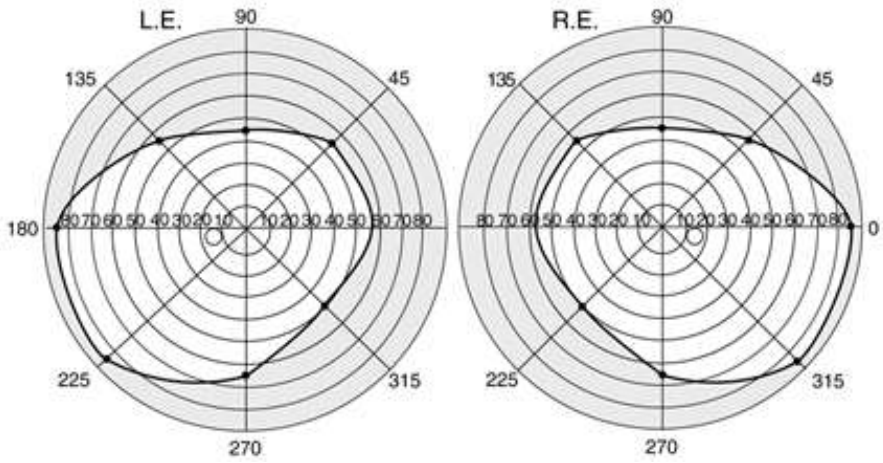
Background:
For permanent partial disability (PPD), a worker's level of impairment must be determined based on objective medical findings. ORS 656.726(4)(f)(B), OAR 436-035-0013(1). Findings vary based on body part and are outlined in OAR 436-035. One component of visual loss impairment is visual field loss, or the loss of peripheral vision to a certain extent due to a compensable injury. The impairment ratings for visual field loss are based on "measurements of each eye separately using the Goldmann perimeter with a III/4e stimulus." OAR 436-035-0260(3). The rule provides two methods for scoring the results of these measurements in order to determine the percentage of loss.

The first method uses the Esterman Grid, which is a set of 100 test points used to systematically map the visual field and identify areas of loss. The operator draws a line around the outermost points that the worker can see to determine the extent of their visual field. The rule provides that the number of points counted outside or on this line is the percentage of loss. OAR 436-035-0260(3)(a). The Esterman Grid is shown below:



Source: Esterman B: Grid for scoring visual fields. Archives of Ophthalmology, 1968.

The second method uses a perimetric chart, which is a map of the visual field split into eight sections. The operator measures the worker's peripheral view in each direction of gaze to trace the outer boundary of their vision. The rule requires that the measurements are added together and provides a chart to convert the total degrees retained into a percentage of loss. OAR 436-035-0260(3)(b). A perimetric chart is shown below:



Source: Workers Compensation Division (WCD) Form 2312

OAR 436-035-0260(3) was added to the division's disability rating standards in 1992 and has not been updated since then. The rule specifically requires use of the Goldmann perimeter, a manual device that is now outdated. The manufacturer of the device discontinued its production in 2007 and repair parts for existing machines are unavailable. There is currently only one clinic in the state with a Goldmann perimeter and available arbiter ophthalmologists. Due to the limited number of ophthalmologists able to comply with the rule, the division faces challenges in scheduling arbiter exams and recruiting new arbiter ophthalmologists. Additionally, this may pose challenges for insurers to schedule closing exams, possibly requiring some workers to travel across the state to reach this one clinic.

The Goldmann perimeter uses a method referred to as kinetic perimetry, where the operator manually moves a test stimulus inside of a bowl. Since the Goldmann perimeter was discontinued, the field has moved towards automated devices that use a different technique called static perimetry. With this technique, the test stimulus is placed in a few locations while its size and intensity are changed. The Humphrey Field Analyzer and the Octopus, which each come in a variety of models, are now more commonly used by ophthalmologists to measure the visual field. These devices are typically used in their automatic mode, which is limited to assessing central portions of the visual field, out to about 30 degrees. However, certain models of these devices are capable of performing kinetic perimetry. This type of testing is able to provide reliable measurements of the full peripheral visual field and is preferred when rating impairment for visual field loss.

In order to allow more devices to be used to conduct closing and arbiter exams requiring visual field testing, the division is considering updating OAR 436-035-0260(3) to remove required use of a Goldmann perimeter, instead requiring the use of kinetic perimetry on a device that is capable of producing the findings required for completion of either of the two reporting methods allowed under the rule. The division invites stakeholder input on the following options:

Options:

1) Amend OAR 436-035-0260 as follows:

OAR 436-035-0260 Visual Loss

(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using kinetic perimetry ~~the Goldmann perimeter with~~ and a III/4e stimulus on a device that is capable of producing the findings required for completion of either one of the two reporting methods below. The results may be scored in either one of the two following methods:

(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or

(b) Using a~~A~~ perimetric chart, ~~may be used which~~ indicate~~s~~ the extent of retained vision for each of the eight standard 45° meridians out to 90°. The directions and normal extent of each meridian are as follows:

Minimal normal extent of peripheral visual field

Direction	**Degrees**
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
TOTAL	500

(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.

(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.

(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

2) Other?

Fiscal impacts, including cost of compliance for small business:
No significant impacts are expected, though there could be some cost reduction. Currently, insurers may need to reimburse workers who require a visual field loss exam for travel to reach the one available clinic. Costs could be reduced by allowing additional clinics for these exams in more locations throughout the state. The division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule could affect racial equity in this state:
The 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 Americans 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, changes to exam scheduling may impact 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.

Re: Issue #3 (Platelet Rich Plasma Injection)

Billings for PRP Injections (CPT code 0232T) With DOS 4/1/25 - 10/13/25

DOS	Charge	Paid
7/8/2025	$400.00	$0.00
7/8/2025	$400.00	$0.00
7/8/2025	$400.00	$0.00
7/8/2025	$400.00	$0.00
5/6/2025	$500.00	$0.00
8/12/2025	$500.00	$0.00
6/3/2025	$500.00	$0.00
8/4/2025	$500.00	$400.00
6/24/2025	$500.00	$400.00
8/4/2025	$500.00	$400.00
5/13/2025	$500.00	$400.00
4/29/2025	$500.00	$500.00
4/29/2025	$500.00	$500.00
4/29/2025	$500.00	$500.00
6/17/2025	$550.00	$413.60
6/27/2025	$550.00	$440.00
6/19/2025	$800.00	$640.00
7/14/2025	$850.00	$0.00
8/6/2025	$850.00	$680.00
4/7/2025	$895.00	$0.00
5/12/2025	$895.00	$0.00
5/7/2025	$995.00	$0.00
5/7/2025	$995.00	$796.00
5/8/2025	$1,200.00	$960.00

Summery:

Total Charged	Count	24
	Min	$400.00
	Median	$500.00
	Mean	$632.50
	Max	$1,200.00
Total Paid	Count	13
	Min	$400.00
	Median	$500.00
	Mean	$540.74
	Max	$960.00