Response to Potential Rule Changes: #10, #13, #14
Majoris Health Systems
November 24, 2025

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.

Majoris is opposed to any change to the rules that would require a standardized form for the Managed Care Organization utilization review process. This issue is centered on providers requiring a preauthorization response from insurers. The MCO process is a separate process and should not be combined by way of a universal, mandated form.

The MCO precertification process is for the purpose of reviewing medical necessity for the diagnosed condition. It does not include any comment on compensability. That is reserved for the insurer.

MCO forms are developed to efficiently obtain the information needed to make an informed medical decision. The data points needed vary depending on the type of care. Majoris has different forms depending on the treatment category and we developed an electronic form that filters to the specific fields needed based on the drop downs selected. Trying to create a standardized form that covers the range of information the MCO needs for the various treatment categories and the information and framing the insurer needs to make their compensability review would be unwieldy and highly inefficient.

Separate processes and forms also provide clarity to the provider on which entity type they are interacting with (MCO vs insurer).

Lastly, because the MCO is only commenting on medical necessity, providers may choose to also verify authorization with the insurer from a compensability standpoint. Utilizing the same form for both stages of inquiry as well as for non-enrolled claims would introduce significant confusion.

Separate forms are appropriate when the purpose of the form is distinct, as in this case. Moreover, providers need clarity on which entity they are interacting with. Separate processes also support that.

Issue #13

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

Majoris is opposed to any change to the rules.

The issue is inaccurately framed. OAR 436-015-0037(3)(e)(A) does not require a worker establish with a new provider within 14 days if they are treating with a non-network provider at time of enrollment. It provides opportunity for the worker to treat with a non-network provider for an additional 14 days after enrollment.

Nothing in the OAR dictates an impact to authorized time loss at the end of the 14 days. Time loss continues for as long as it was authorized for or until it is updated by an attending physician.

Enrollment timing is not tied to the date of the last appointment. A worker may have just been seen, or about to be seen, by their current attending physician. Which means, the timeframe on when they next need to be seen can range from immediately to 30+ days out. The 14 days of authorized non-network treatment allows those with immediate needs to have a final visit with their current provider, which then typically extends the need for a follow-up visit or updated work release an additional 30 days. For those recently seen prior to enrollment, their need for care will be less immediate. With the next follow-up visit or updated work release likely needed within the next 24-30 days.

Additional transition solutions within the existing framework include:

- If a worker is within the global period of a surgery or in the middle of a course of PT, they are allowed to complete that global period/PT course.
- If the timing of their existing follow-up visit falls outside of the 14-day window they can request an earlier appointment with their current attending or ask them for a recommendation or referral to an in-network option.
- If a worker contacts the MCO because they are struggling to find an in-network option and their time loss is set to run out, the MCO can help them find an in-network urgent care for a next appointment while working with them to identify a new long-term attending physician option.

The 14 days is meant to serve as a bridge so workers nearing an already scheduled appointment or the end of authorized time loss have opportunity to treat with their non-network attending an additional time while working to transition into the MCO network. Majoris data shows the median number of days from enrollment to first office visit is 13.2 days. The average is 22.9 days. Factoring in that not all workers require an immediate office visit, this demonstrates the current timeline is sufficient to support appropriate transition into network. Moreover, there are already additional avenues to pursue non-network care for the outliers where the MCO is not able to provide a network option.

Extending the period of out-of-network care can delay the worker's transition into the network and contribute to care delays, as non-network providers are often unfamiliar with the responsibilities and processes required when treating injured workers.

In response to the concern raised regarding the timing of mailed notices. Majoris issued enrollment notices are mailed locally. We do acknowledge that mailing adds additional time and appreciate another stakeholder's suggestion that electronic notices by e-mail be allowed as an alternative when an e-mail address is available.

Issue #14

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. WCD recommends shortening the appeal timeframe to 30 days (from 60) and the time for an MCO to issue a final decision to 30 days (currently 60).

Majoris is opposed to any change to the rules.

It is important appeals related to MCO decisions are medically informed and comprehensive.

For injured workers, follow-up visits are commonly scheduled every 30 days with an attending physician and often further out with consulting specialists. Reducing the appeal timeframe to 30 days would prevent many workers from consulting with the prescribing physician prior to the appeal deadline.

For the MCO, the appeal process is statutorily mandated and designed to ensure medical disputes are evaluated by medical professionals using the full scope of available clinical information. Achieving this requires balancing timeliness and quality. Reducing the timeframe to 30 days would limit the MCO's ability to conduct a comprehensive review.

A shortened timeframe undermines two key components of the appeal review:

- Ability to gather new information. This includes recent office visit notes, new consultation records or diagnostics. The MCO may also reach out to one or more providers for consultation, review literature submitted or referenced with the appeal, or request additional information from the appellant. These efforts help the Committee develop a fully informed decision, providing all parties a robust explanation on the decision. It also provides an opportunity to update the original decision based on new information, negating the need for an appeal review at all.
- Ability to ensure all desired specialties are represented at the Medical Review Committee meeting. Most committee members are actively practicing, and coordinating schedules without reasonable lead time can conflict with their active practice demands.

While 30 days is sufficient to achieve the standard of medically informed review for most cases, it is not sufficient for all cases. A tightened timeframe increases risk of rushed decisions, resulting in less complete decisions by the MCO and increasing likelihood of appeals to the Medical Resolution Team. This could elongate the overall appeal period for more workers, since appeals beyond the MCO require additional steps and are not subject to a set timeframe for a final decision by MRT.