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 436-030, "Claim Closure and Reconsideration." (single issue)**

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	**November 3, 2026, 1-4pm** 350 Winter St NE, Salem, Labor & Industries Building Room F (basement) Or **Microsoft Teams meeting:** **Join:** https://teams.microsoft.com/meet/259099945964855?p=5FwWjUY2KnY4oznnvc Meeting ID: 259 099 945 964 855 Passcode: wv6eE7pA **Dial in by phone** +1 503-446-4951,,540249677# United States, Portland Phone conference ID: 540 249 677# **November 10, 2026, 1-4pm (if more time needed after 11/3)** 350 Winter St NE, Salem, Labor & Industries Building Room F (basement) Or **Microsoft Teams meeting:** **Join:** https://teams.microsoft.com/meet/26973978919344?p=Nq0hN35arTH152u98e Meeting ID: 269 739 789 193 44 Passcode: CK9hr79P Dial in by phone +1 503-446-4951,,266109810# United States, Portland Phone conference ID: 266 109 810#
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 2:45	Break
2:45 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 3 and, if needed, November 10, 2026, Rules Advisory Committee Meeting

Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2027)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2027. However, the Workers' Compensation (WCD) does not publish its permanent fee schedule updates until April 1, 2027 (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, 2027.

Background:

- 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, 2027, 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, 2027, and assign maximum payment amounts using the 2026 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 code from any appendix and providers may continue to use all codes valid in 2026.

Options:

- Adopt new CPT® codes and standards (OAR 436-009-0004) through a temporary rule, effective January 1, 2027.
- Update appendices B – E with payment amounts for new codes using the 2026 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Level 3 - Restricted

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, 2027)

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, 2027.

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 considering 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:

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

Recommendations:

Issue # 3 (Standing)

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 rental rates 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 # 4 (2189)

Rule: OAR 436-009-0040 and Appendix B

Issue: A stakeholder is requesting a five percent increase of the physician fee schedule.

Background:

- The stakeholder:
  - Opines that applying the increase uniformly across the entire physician fee schedule rather than code-by-code avoids distorting relative value relationships between specialties and will keep implementation administratively simple;
  - Notes that the Oregon Workers' Compensation Maximum Allowable Payment conversion factors have not seen a significant across-the-board increase in the last two years, even as wage, utility, insurance, and regulatory costs have compounded over that same period;
  - Points out that Oregon's tiered minimum wage climbed roughly 5.3–6.2% over the past two years across all three geographic tiers, Portland metro, standard counties, and non-urban counties, and that clinical and administrative staff wages (MAs, front-office, billing) generally track at or above minimum wage benchmarks;
  - States that commercial lease renewals in the Portland metro and other Oregon markets have followed multi-year rent escalation clauses (commonly 3–5% annually), meaning a typical practice has absorbed 6–10% in cumulative rent growth over the same two-year period;
  - Observes that utilities, insurance, taxes, and license costs have risen similarly; and
  - Believes that fee schedule rates that lag behind operating costs create incentive for providers to limit workers' compensation caseloads, which can delay injured workers' access to timely treatment.
- DCBS projects that a 5 percent increase of the physician fee schedule would have a system wide fiscal impact of $9,659,349.

Options:

- Increase the physician fee schedule uniformly by five 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:

Issue # 5 (2191)

Rule: OAR 436-009-0040

Issue: CPT® codes for psychiatry services are part of the medicine group even though some services are seemingly analogous to E/M services.

Background:

- A stakeholder requested that CPT® codes for certain psychiatry services be paid using the conversion factor of the E/M office visit category.
- The specific codes are:
  - 90791 (Psychiatric diagnostic evaluation)
  - 90792 (Psychiatric diagnostic evaluation with medical services)
  - 90832 (Psychotherapy 30 minutes with patient)
  - 90833 (Psychotherapy 30 minutes with patient with an E/M service)
  - 90834 (Psychotherapy 45 minutes with patient)
  - 90836 (Psychotherapy 45 minutes with patient with an E/M service)
  - 90837 (Psychotherapy 30 minutes with patient)
  - 90838 (Psychotherapy 60 minutes with patient with an E/M service)
- DCBS projects that moving above codes from the Medicine category to the E/M office visits category will have a fiscal impact of $404,173.
- The stakeholder hopes that raising the fees for psychiatry services will encourage more therapists to accept WC patients, and improve access and quality of available therapists.
- The stakeholder noted that a recent study published in The American Journal of Managed Care, has demonstrated how an increase in mental health provider compensation is beneficial to overall Health Resource Utilization. Therefore, overall workers' compensation costs could decrease dramatically if there is a pay increase for Psychiatrists, Psychologists and other mental health providers.

Options:

- Add CPT® codes 90791, 90792, 90832, 90833, 90834, 90836, 90837, and 90838 to the E/M office visits category.

- 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 (2178)

Rule: OAR 436-009-0010 and -0060

Issue: A stakeholder states that they are seeing more and more excessive charges from providers submitting return-to-work status forms.

Background:

- A provider may bill for completing a work release form as long as the provider performs an exam/tests. OAR 436-009-0010(11)(a).
- Currently, there is no Oregon Specific Code (OSC) to bill for completing a work release form and providers generally use CPT® code 99080. This code is payable at 80 percent of billed, i.e., the fee schedule does not establish a fixed maximum payment amount.
- The stakeholder noted that some providers charge between $300 and $600 for filling out a return-to-work form, even if there is no documentation of new diagnostic testing, significant clinical findings, treatment modifications, or changes in work or medical status that would necessitate repeated form completion.

Options:

- Create an Oregon Specific Code, e.g., RTW01 and assign a fixed fee schedule amount of, e.g., $75.00.

- 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 (2192)

Rule: OAR 436-009-0010

Issue: An insurer observed that insurers and employers are impacted by increasing administrative work to review and audit bills that are submitted closer to 12 months rather than within the 60 days required by OAR 436-009-0010(2)(a).

Background:

- OAR 436-009-0010(2)(a) requires a medical provider to bill within:
  (A) 60 days of the date of service;
  (B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or
  (C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.
- Subsection (2)(c) of this rule compels a medical provider to establish good cause when submitting a bill later than outlined in subsection (a). However, the rule does not list any consequences when a provider does not establish good cause.
- OAR 436-009-0010(2) further provides that an insurer may not reduce payment due to late billing when a provider submits a bill within 12 months of the date of service.
- The insurer has observed that the percentage of bills submitted within 60 days has decreased over the last few years while the percentage of bills submitted past 180 days has increased.
- According to the insurer, 2.7 percent of bills were submitted later than six months.
- The insurer states that providers who bill close to the 12-month mark increase the administrative burden on the insurer to review and audit the bill for payment. The insurer specifically points out that:
  - Because there are fewer claim documents to filter through at 6 months compared to 12 months, the required records can be located more efficiently, decreasing bill review time;
  - Delayed bill submission limits the ability to identify and educate providers on billing issues in a timely manner. As a result, incorrect billing practices may continue for an extended period, increasing administrative workload for both the insurer and providers through denials, reconsiderations, refunds, and billing inquiries;
  - Delayed bill submission can make it challenging to verify details regarding when, where, and whether services were rendered. The longer the time between the service date and the inquiry, the greater the risk that provider responses may be incomplete or less reliable, potentially impacting billing accuracy and resolution efforts; and
  - Delayed payment in interpreter billing – when a medical provider does not submit the bill/records for their service timely it is harder to validate the interpreter service.

Options:

- Amend OAR 436-009-0010(2) as follows:
  (2) Billing Timelines (For payment timelines see OAR 436-009-0030)

(a) Medical providers must bill within:
(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

~~**(b)** If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.~~

~~**(c)** When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause.~~

(~~d~~b) When a provider submits a bill within ~~12 months~~ **180 days** of the date of service, the insurer may not reduce payment due to late billing.

(ec) When a provider submits a bill more than ~~12 months~~ **180 days** after the date of service, the bill is not payable, except when a provision of ~~subsection~~ **paragraphs** (2)(a)**(B) or (C)** is the reason the billing was submitted after ~~12 months~~ **180 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 # 8 (2188)

Rule: OAR 436-015-0110

Issue: Workers may lose access to the appeal process when MCOs encourage providers to withdraw precertification requests.

Background:

- OAR 436-015-0110(4) provides that whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue, the notice must include mandatory 30-day appeal language to the MCO in a particular form and format.
- WCD has seen instances where an MCO, e.g., finds that "[t]here is no evidence that [a prior medical service] resulted in any functional or objective improvement. There is no reason to expect that further [same medical service] would result in a different outcome." The MCO then asks the provider: "With this in mind, please consider withdrawing your request for [this medical service] or, using objective data, provide the rationale to support this request."
- Further, WCD has seen instances where a provider inadvertently withdraws the medical service request.
- Although it is clear from the correspondence of the MCO to the provider that the MCO will not approve the request as submitted, because the MCO does not "officially" deny a service and instead asking the provider to withdraw the request, the worker loses their right to appeal the "decision" to the MCO.

Options:

- Amend OAR 436-015-0110 as follows:

  436-015-0110 <u>Precertification and</u> Dispute Resolution

- **<u>(1) When the MCO receives a precertification request for medical services, the MCO may not ask the provider to reconsider the request and must make a decision addressing appropriateness of the medical services requested.</u>**
-
- 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 (2197)

Rule: OAR 436-010-0270 Insurer's rights and Duties

Issue: A stakeholder opines that MCOs now regularly assist insurers in processing claims, helping insurers process, assess, and determine entitlement to non-medical benefits, such as temporary disability and permanent disability. The stakeholder contends that this often occurs when an insurer asks an MCO to use its provider agreement to coerce a response from a provider, such as agreement with an IME.

Background:

- Under ORS 656.262 and 656.780(3), claims processing is the responsibility of the insurer. On the other hand, determining medical appropriateness is the responsibility of an MCO under ORS 656.260.
- The stakeholder proposes a rule that prohibits insurers from contacting MCOs regarding non-medical benefits. Specifically, a "new rule prohibiting an insurer/employer to contact the MCO regarding any benefits under Chapter 656, except for medical services under ORS 656.245(1)(a) and (1)(c)." The stakeholder proposes the amendments to OAR 436-010-0270(5) listed in the first bullet under "Options."
- ORS 656.245(1)(a) provides: "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, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury."
- ORS 656.245(1)(c) lists the medical services the worker is entitled to after becoming medically stationary.
- The stakeholder is further requesting a "rule requiring investigation by the director for allegation of insurer misconduct and sanctions for violations."

Options:

- Amend OAR 436-010-0270 as follows:
  (5) Insurer's Duties under MCO Contracts.
  ***
  (d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:
  ***

(G) State that the insurer will not communicate with the MCO regarding the processing, assessment, or determination of any workers' compensation benefits, except medical services available under ORS 656.245(1)(a) and (1)(c).

***

(o) The insurer shall not communicate with the MCO regarding the processing, assessment, or determination of any benefits available under Chapter 656, except for medical services available under ORS 656.245(1)(a) and (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 # 10 (2194)

Rule: OAR 436-009-0005, 436-010-0005, 436-015-0005, and 436-015-0007

Issue: The definition of "medical service" does not specify that "medical service" does not include work restrictions or restrictions on activities.

Background:

- OAR 436-009-0005(28), 436-010-0005(25), and 436-015-0005(12) define "medical service" as any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services.
- A stakeholder is requesting that the definition of "medical service" be amended with the following sentence: "'Medical service' does not include work restrictions or restrictions on activities. "
- The stakeholder further proposes adding a new section to OAR 436-015-0007: (3) An MCO may not be involved in the processing, assessment, or determination of any benefits under Chapter 656, except medical services under ORS 656.245(1)(a) and (1)(c).
- ORS 656.260 provides, in relevant part:
  ***
  (4) The director shall certify a health care provider or group of medical service providers to provide managed care under a plan if the director finds that the plan:
  ***
  (e) Provides a program involving cooperative efforts by the workers, the employer and the managed care organizations to promote workplace health and safety consultative and other services and early return to work for injured workers.
- OAR 436-015-0030 provides, in relevant part:
  ***
  (11) MCO Plan – Return to Work and Workplace Safety.
  The plan must provide other programs that meet the requirements of ORS 656.260(4), including:
  (a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers;
- One could argue that in order to implement OAR 436-015-0030(11)(a), the MCO may need accurate information from the attending physician regarding work restrictions or restrictions on activities.
- The stakeholder proposes the amendments to OAR 436-015-0005 and 436-015-0007 listed in the first and second bullet under "Options."

Options:

- Amend OAR 436-015-0005 as follows:
  ***

(12) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services. **"Medical service" does not include work restrictions or restrictions on activities.**

- Add a new section (3) to OAR 436-015-0007:
  (3) An MCO may not be involved in the processing, assessment, or determination of any benefits under Chapter 656, except medical services under ORS 656.245(1)(a) and (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 # 11 (2195)

Rule: OAR 436-015-0009 and 436-015-0040

Issue: MCOs are not required to disclose communication between an MCO and an insurer or medical provider concerning a workers' claim.

Background:

- A stakeholder contends: "Insurers and self-insured employers rely on MCOs for claim processing. They have MCOs obtain information from medical providers and then use that data to decide whether a worker should receive non-medical benefits such as lost wages and permanent disability payments. Insurers have MCOs use the terms of the MCO's provider agreement to coerce physicians and others to concur with statements about those other benefits--benefits that are not related to medical care. There are telephone conversations between the "enforcer" doctor of the MCO and the treating physician, the contents of which are never disclosed. This needs to change. Communications between MCO personnel and treating physicians should be discoverable."
- The stakeholder is requesting a "rule requiring that all written communication between an MCO and an insurer or a provider be copied simultaneously to the worker and the workers' attorney, if represented."
- The stakeholder further requests a "rule requiring all verbal communication between an MCO and an insurer or a provider to be recorded and disclosed upon request by the worker or the worker's attorney."
- The stakeholder proposes the amendments to OAR 436-015-0009(4) and 436-015-0040 listed in the first and second bullet under "Options."

Options:

- Amend OAR 436-015-0009 as follows:

  (3) A non-qualifying employer or any of its staff, or their immediate family, may not:
  (a) Directly participate in the formation, certification, or incorporation of the MCO;
  (b) Nominate, assume a position as, or act in the role of, a director, officer, agent, or employee of the MCO;
  (c) Arrange for, lend, guarantee, or otherwise provide financing for any organizational costs of the MCO;
  (d) Arrange for, lend, guarantee, or otherwise provide financial support to the MCO (financial support does not include contracted fees for services rendered by an MCO);
  (e) Have any ownership or similar financial interest in or right to payment from the MCO;
  (f) Make or exercise any control over business, operational, or policy decisions of the MCO;
  (g) Possess or control the ownership of voting securities of the MCO. The director will presume possession or control exists if any person, directly or indirectly, holds

the power to vote or holds proxies of any other person representing 10 percent or more of the voting securities of the MCO;
(h) Provide MCO services other than as allowed by section (4) of this rule;
(i) Enter into any contract with the MCO that limits the ability of the MCO to accept business from any other source; or
(j) Direct or interfere with the MCO's delivery of medical and health care services.

(4) ~~Notwithstanding section (3) of this rule, an MCO may contract with an insurer to provide certain managed care services. However, such insurer-provided services must be according to protocols and standards established by the certified MCO plan. The insurer may not provide or participate in the provision of managed care services related to dispute resolution, service utilization review, or physician peer review.~~ **An MCO must maintain records of communication with an insurer in accordance with OAR 436-015-0040(8) and (9).**

- Amend OAR 436-015-0040 as follows:
  ***
  (7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.
  (8) All written communication between an MCO and an insurer or medical provider concerning a workers' claim must also be sent to the worker and the worker's attorney, if represented, at the time of the communication.
  (9) All verbal communication between an MCO and an insurer or medical provider concerning a worker's claim must be recorded and disclosed to the worker upon the worker's or worker's attorney's request within 7 days of the request.
  (8<u>10</u>) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

- 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 (2196)

Rule: OAR 436-015-0007

Issue: Administrative rules may not emphasize enough that insurers are not allowed to participate in the selection or choice of medical providers or specialists for workers enrolled in MCOs.

Background:

- A stakeholder points out that under ORS 656.260(21), only MCOs may participate in directing care, and insurers and self-insured employers are prohibited from directing a worker's care.
- The stakeholder believes that recently, insurers have been directing care "through" MCOs, by requesting that the MCO recommend certain providers or certain specialists, trying to prevent workers from seeing a certain type of specialists or participating in programs, or by limiting workers' treatment to certain providers or specialties without a review of requested medical services.
- Therefore, the stakeholder proposes a rule that helps prevent insurers from directing or restricting care through the use of their MCOs. See first bullet under "Options."

Options:

- **436-015-0007 Entities Allowed to Manage Care**

  ***

  (2) An insurer or someone acting on behalf of an insurer may not manage the care of workers by limiting the choice of medical providers, or by requiring medical providers to abide by specific treatment standards, treatment guidelines, or treatment protocols~~,~~ **including recommending or participating in the selection or choice of medical providers for workers enrolled in an MCO.**

- 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:

ADDED OCTOBER 26, 2026

Issue # 13

Rule: OAR 436-030-0034, Administrative Claim Closure

Issue:
There have been concerns raised about the ambiguity of the administrative claim closure process, specifically regarding closure under OAR 436-030-0034(1) and (2). The division has also noted that many administrative closures must be rescinded because the letters sent to workers regarding these closures ("bug letters") do not strictly comply with rule.

Background:

- ORS 656.268(1)(c) requires administrative claim closure when a worker "fails to seek medical treatment for a period of 30 days" without approval from their attending physician and for reasons within their control.
- OAR 436-030-0034 outlines the administrative claim closure process. As written, the rule does not clarify when closure is required under section (1) versus (2) of the rule. The division's policy is that closure under OAR 436-030-0034(1) is for when a worker has an authorized attending physician overseeing their care, and closure under OAR 436-030-0034(2) is for when a worker does not have an authorized attending physician overseeing their care.
    - A claim must be closed under OAR 436-030-0034(1) when a worker fails to see their authorized attending physician or participate in medical treatment approved by their authorized attending physician for more than 30 days for reasons within the worker's control, unless they were instructed or approved by their authorized attending physician not to seek medical treatment for a longer period of time.
    - A claim must be closed under OAR 436-030-0034(2) when a worker does not have an authorized attending physician overseeing their care, as required by OAR 436-010-0210(1). In other words, the worker does not have an attending physician who is authorized under ORS 656.005(12)(b) and (c), ORS 656.245, and OAR 436-010. For example, a worker may be treating with a naturopathic physician past the time limit they are able to serve as an attending physician.
- Insurers must send notifications regarding administrative closure informing affected workers about the reason for impending closure and the steps they must take to avoid closure. These are referred to as "bug letters." These letters must strictly comply with the requirements currently outlined in OAR 436-030-0034(1)(a). The division has noted that many administrative closures must be rescinded because the bug letters do not strictly comply with rule. Therefore, the division is proposing amendments to OAR 436-030-0034(1) and (2) to provide clear direction for insurers to properly close these types of

claims and clear direction to workers on the steps they need to take to avoid their claim being closed. The proposed amendments:

- Provide separate instructions for closing a claim under each section, rather than directing the insurer to follow the steps in section (1) to complete a closure under section (2); and
- Include required notice language for each type of closure, which has been simplified to improve readability for workers.

- The division invites stakeholder feedback on amending these rules to clarify and improve the transparency of the administrative claim closure process.

Options:

- Amend OAR 436-030-0034(1) and (2), and OAR 436-030-0005 as follows:

OAR 436-030-0034 Administrative Claim Closure

(1) The worker must see their attending physician authorized under ORS 656.005(12)(b) and (c), ORS 656.245, and OAR 436-010 or participate in medical treatment approved by their authorized attending physician at least every 30 days, unless the authorized attending physician has approved the worker to not seek medical treatment for a longer period of time.

(a) The insurer must close a claim under this section when:

(A) The worker has an authorized attending physician;

(B) -T~~t~~he worker is not medically stationary; and

(C) For more than 30 days, ~~the worker fails to seek treatment for more than 30 days~~ without the instruction or approval of the authorized attending physician and for reasons within the worker's control, the worker fails to seek medical treatment with the authorized attending physician and medical treatment approved by the authorized attending physician, if any..

(b) In order to close a claim under this section, the insurer must:

(A~~a~~) Wait for the 30-day lack of medical treatment period to expire or any additional time period recommended by the authorized attending physician before sending the worker written notification by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented~~, informing the worker of the following:~~. The notification must include the following notice in bold:

Notice to Worker:
You have not had medical treatment with your authorized attending physician or medical treatment approved by your authorized attending physician, if any, for more than 30 days.
You must seek medical treatment promptly.
Your claim will be closed if you do not seek medical treatment promptly. You may also lose part or all of your disability award.
Your claim will be closed unless, within 14 days from the date this letter was sent by certified mail, you show that:

- **You have gone to an existing appointment with your authorized attending physician;**
- **You have scheduled a new appointment with your authorized attending physician; or**
- **You could not seek medical treatment for reasons you could not control.**

~~**(A)** The worker's responsibility to seek medical treatment in a timely manner;~~
~~**(B)** The consequences for failing to seek treatment in a timely manner which include, but are not limited to, claim closure and possible loss or reduction of a disability award; and~~
~~**(C)** The claim will be closed unless the worker establishes within 14 days from the date the letter was sent certified mail that:~~
~~**(i)** Treatment has resumed by attending an existing appointment or scheduling a new appointment; or~~
~~**(ii)** The reasons for not treating were outside the worker's control.~~

(B~~b~~) Wait the 14-day period given in the notification letter to allow the worker to provide evidence that the lack of medical treatment was either ~~authorized~~ approved by the authorized attending physician or beyond the worker's control.

(C~~c~~) Determine whether claim closure is appropriate based on the information received.

(D~~d~~) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited to, any irreversible findings.

(E~~e~~) Use 30 days from the last medical treatment provided or approved by the authorized attending physician or any additional time period ~~authorized~~ approved by the authorized attending physician as the date the claim qualifies for closure on the Notice of Closure.

(2) The worker must have an attending physician authorized under ORS 656.005(12)(b) and (c), ORS 656.245, and OAR 436-010 overseeing their care. Regardless of whether the worker is medically stationary, the insurer must close a claim under this section when the~~a~~ worker ~~has~~ does not ~~sought treatment for~~ have an authorized attending physician for more than 30 days. ~~with a health care provider authorized under ORS 656.005 and ORS 656.245 (e.g., a worker enrolled in a managed care organization (MCO) who treats with a provider outside the MCO is not treating with an authorized health care provider).~~ In order ~~T~~to close a claim under this section, the insurer must: ~~follow the requirements in section (1) of this rule and inform the worker that the reason for the impending closure is because the worker failed to treat with an authorized health care provider.~~

(a) Wait for the worker to go without having an authorized attending physician for more than 30 days before sending the worker written notification by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented. The notification must include the following notice in bold:

Notice to Worker:

You have not had an authorized attending physician for more than 30 days. You must seek medical treatment with an authorized attending physician promptly.
Your claim will be closed if you do not seek medical treatment with an authorized attending physician promptly. You may also lose part or all of your disability award.
Your claim will be closed unless, within 14 days from the date this letter was sent by certified mail, you show that:

- **You have gone to an existing appointment with an authorized attending physician;**
- **You have scheduled a new appointment with an authorized attending physician; or**
- **You could not seek medical treatment with an authorized attending physician for reasons you could not control.**

(b) Wait the 14-day period given in the notification letter to allow the worker to provide evidence that the lack of medical treatment with an authorized attending physician was beyond the worker's control.
(c) Determine whether claim closure is appropriate based on the information received.
(d) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited to, any irreversible findings.
(e) Use 30 days from the last medical treatment provided or approved by an authorized attending physician as the date the claim qualifies for closure on the Notice of Closure.

OAR 436-030-0005 Definitions
(1) "Authorized attending physician" means an attending physician authorized under ORS 656.005(12)(b) and (c), ORS 656.245, and OAR 436-010.

- No change
- Other?