Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, 015, and 030
November 3, 2026 Rules Advisory Committee Meeting
Meeting Minutes

Location of meeting: 350 Winter St. NE, Salem, OR; Virtual Teams meeting

Stakeholders attending:

Ted Heus	OTLA
Ivo Trummer	SAIF Corporation
Scott Winkels	Oregon Business & Industry
Dr. Ron Bowman	MD
Dr. Eric Hubbs	DC
Ann Klein	Majoris Health Systems
Lisa Johnson	Majoris Health Systems
Kris Gorriaran	Majoris Health Systems
Lon Holston	MAC
Dr. Paul McMahon	MD, Endeavor Psychiatry
Misty Bergenstock	Endeavor Psychiatry
Dr. Dan Miller	DC
Kevin Barrett	SAIF Corporation
DeAnna Tapia	Professional Interpreters
Kaylee Bond	CorVel
Joy Chand	Takacs Clinic
Thomas Hernandez	Professional Interpreters
Amanda Waibel	Reinisch Wilson
Thais Lomax	Sedgwick
Sydney Montanaro	OTLA
Jovanna Patrick	OTLA
Kevin Anderson	SBH Legal
Tricia Jones	Clackamas
Ashley Livingston	SAIF Corporation
Ramona St. George	Majoris Health Systems
Matt Corpe	SAIF Corporation
Cozetta Knutson	SAIF Corporation
Anna Wagner	SAIF Corporation
Kaylee Stolsig	SAIF Corporation
Liberty Corman	MTSL Group
Harry Noone	SAIF Corporation
James Washburn	Kaiser Permanente
Amanda Mercier	SAIF Corporation
Maggie Gerlicher	AGC Oregon
Adam Fowler	My Matrixx

Level 3 - Restricted

Jennifer Davis	HealtheSystems
Monica Rice	Sedgwick
Lauren Grace	Oregon Law Center
Bryan Null	SAIF Corporation
Ryan Hearn	MLAC
Jenny Walsh	Providence MCO
Dr. Maureen Sacon	DO
Kirsten Adams	AGC Oregon
Jacqueline Hall	Cadence RX
Skylar Hall	SAIF Corporation
Kevin Barrett	SAIF Corporation
Hasina Wittenberg	Government Relations Strategies
Connie Whelchel	IMA Corp
Andrea Martinez	Enlyte
Dan Schmelling	SAIF Corporation
Lydia Reid	SAIF Corporation
Matthew Jacobsen	Oregon Occupational Medicine
Janet Hartsfield	SAIF Corporation
Joshua McNeal	CorVel
Susan Quinones	City of Portland
Serena Sison	Concentra
Keith Semple	OTLA
Brigitte Hamilton	SAIF Corporation
Angie Renhard	SAIF Corporation
Freddy Ky	SAIF Corporation
Stephanie Meyer	SAIF Corporation
Jeanette Decker	Providence MCO

Department staff members attending:

Matt West
Caitlin Breitbach
Rob Andersen
Juerg Kunz
Mary MacKie
Barbra Anderson
Marie Rogers
Troy Painter
Steve Passantino

Yesenia Gonzalez
Kirsten Schrock
Jennifer Ferris
Stanley Fields
Theresa Van Winkle
Stephanie Doster
Troy Painter
Katie Van Cleave
Zoe Tacadena
Jill Schlosser

Minutes: Marie Rogers welcomed the committee members, asked the members to provide advice about any fiscal impacts of possible rule changes, and also to advise about effects on racial equity in Oregon.

NOTE: Additional summary minutes are included below each issue.

Note: The committee addressed issue #13 first.

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~~e~~) 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?

Minutes:

- Mary MacKie described the issue – see above – and asked the committee for advice.
- Ivo Trummer noted that SAIF has no issues with the proposed changes, but asks for 90 days to implement. They currently have one form and will need to create an additional form.

- Dan Miller questioned the definition of "seek" medical treatment. He asked what would result if a worker tried but failed to find medical treatment. He noted that, in Woodburn, there are about 30 providers and only two accept workers' compensation matters. He noted that the worker needs to understand when they've done enough—or not—to "seek" medical treatment as required.
- Jovanna Patrick had concerns about the proposed language. First, she noted that the proposed language in section (1) adds a requirement not in statute. She noted that the statute merely provides a method for the insurer to contact the worker if they've gone more than 30 days (to request they make an appointment), but the proposed rule adds an affirmative statement for the worker to see their attending physician. She noted that this issue has been before MLAC and noted that MLAC ultimately decided not to impose a requirement that a worker see their attending physician every thirty days. She noted that this proposed language reverses things and puts the requirement on the worker. And, she had concerns about requiring an attending physician as finding one can be problematic for workers. She did not want a claim to be closed simply because a worker could not find an attending physician (despite looking for one). She asked that more review into this, including case law regarding reconsideration and appeals, be done before these proposed rules move forward.
- Ted Heus echoed Jovanna's concerns and noted that, it appears the changes were intended to be procedural (e.g. add clarity to the existing rules around how to close these claims). However, he noted that the first sentences within the proposed language trigger substantive changes as they put new obligations on workers. He asked the division to take a closer look at that language to ensure any changes are not substantive if we intend them to be merely procedural.
- Jovanna added that there is ambiguity within the notice language. She said she talks to workers often and they are not sure what does or does not count as medical treatment with respect to this requirement. There is also confusion around when the clock starts. And, she added, what if the worker has a future appointment (something that is not addressed in the proposed language)? The workers, she believes, need additional clarity and believes these changes would confuse workers.

Level 3 - Restricted

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:

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

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- No discussion.

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:

<u>Minutes</u>:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- No discussion.

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:

<u>Minutes</u>:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- No discussion.

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:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- DeAnna Tapia asked when we last increased the fee schedule in this way.
- Dan Miller noted that he remembered a 3.7% increase across the board maybe twelve years previously.
- Juerg noted that the division does not typically increase the entire schedule, but rather increases only certain fees.
- Ivo Trummer cited medical escalation of 8-11% recently, so SAIF does not support an increase of 5%. SAIF does support, however, taking a look at potentially indexing the fee schedule in future years for consistency, transparency, and predictability. They approve of a methodical approach to increases in the future.
- Juerg noted that the division is looking into doing such a thing—a consistent and transparent annual increase—starting next year.
- Dan noted that looking at CPI may be the most appropriate for a consistent increase of that kind. And, a 5% increase is likely less than we would see if hinging our increase on the CPI.
- Joy Chand requested a minimum of a 5% increase. She noted that wages have increased, utilities, etc. She noted there is additional work that is not accounted for, too. She noted that there are a lot of providers not willing to see workers' compensation patients, and these increasing costs may be a reason.
- Kirsten Adams echoed SAIF's sentiments. She understands the need for the increase but would prefer doing something methodical and transparent and consistent so that it is fair for everyone.
- Ryan Hearn noted that he understands keeping workers' compensation reimbursements competitive is needed to maintain provider access. However, he noted that increases across the board compound quickly; so, he would like more conversations before moving forward with this increase.
- Lon Holston noted that there is an immediate need to increase these fees; he questioned how many providers might leave the system if nothing is done right now. He agreed it is fine to do something methodical in future years, but urged the division to implement the 5% increase now.
- Keith Semple (via Microsoft Teams chat): "I would echo what Lon said. This is an immediate crisis of provider flight, so much that we had a series of MLAC subcommittee meetings. The overhead added by WC was cited over and over as a deterrent to participation. I disagree with Mr. Hearn [sic] that provider education was the thrust of the conclusions. OTLA proposed an increase at those meetings, and we continue to support an increase. This would be a good start."
- Scott Winkels agreed with SAIF and did not support the increase. He believes more conversations need to be had first.
- Dan noted that the E&Ms often go up, often more than 5%, and there is often no opposition. This, even though E&Ms make up the majority of costs in the system. He

Level 3 - Restricted

asked why this 5% increase is so burdensome when there is typically no issue with the other increases?

- Ryan Hearn noted that some commenters cited the increasing costs as a reason providers stay out of the workers' compensation space. Ryan noted that MLAC has discussed the issues with workers' access to care subcommittee and has emphasized the importance of educating providers regarding workers' compensation. Ryan suggested that the lack of education, rather than the costs, were keeping providers out of workers' compensation.
- Lauren Grace noted that she often works with workers trying to find providers in the workers' compensation space. She emphasized how difficult it is for workers to find providers. And, she noted that inflation has hit everyone, and noted that it is important that the division do what it can to not allow inflation to drive even more providers out of the workers' compensation market.
- Ryan Heard also added that MLAC recently allowed NPs to be attending physicians, which may help the access to care issue.
- Paul McMahon noted that the E&M codes are not just for the physicians, but for the support staff in the providers' offices. These fees help pay for and employ everyone who helps these offices run smoothly.
- Sydney Montanaro, a claimant's attorney, noted that she sees so many workers who cannot find providers. She warned of the risk of losing more providers if nothing is done. She noted that it is hard to provide care in this space, and if they are not compensated properly, she worries we risk losing even more providers.
- Maureen Sacon, a physician in private practice, noted that she recently had a fight about a workers' compensation bill. The attorney, she noted, got an additional $1000 for the time spent arguing about the bill, but she did not get any additional funds. She noted that the administrative costs of doing business in workers' compensation is great and often her office is not compensated justly for it.
- Ann Klein cited Ryan Hearn's comment about MLAC discussing education for providers. She believed this could be an effective way to improve things for everyone—whether the division raises rates or not, Ann believes that improving education for providers would be worthwhile.
- Joy Chand noted that, even if educating providers, the prices for things are not going down. The costs, she noted, will keep going up.

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:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Ivo Trummer asked that the division provide some clarification, as SAIF's data reflected a fiscal impact of about $815,000 for SAIF alone.
- Ryan Hearn would also like to see more data regarding the impacts.

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:

<u>Minutes</u>:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Kaylee Bond of CorVel noted that most of the charges that they are seeing are reasonable. But, if there are outliers of $600, they need to pay 80% of that charge. She noted that that is a significant expense for the claim management without adding to the worker's care. She doesn't believe they should be allowed to bill excessively for it. She noted that they calculated an average of about $120. She noted that mostly that is in addition to the E&M code that the provider is receiving payment for.

Level 3 - Restricted

- Ivo Trummer noted that SAIF supports a fixed amount and agrees with most of what Kaylee Bond stated; however, SAIF is seeing $50 as a reasonable fee.
- Dan Miller noted that providers are not always also collecting the E&M because they're looking back at a file rather than seeing the worker. Dan does not have a problem with a fixed number.
- Kirsten Adams noted that it makes sense to do something to prohibit excess billing. She believed $75 or $50 seems to make sense.
- Tricia Jones (via Microsoft Teams chat): "I received a bill today from an Occupational Clinic billing $605 for a work status form to be completed."
- Tom Hernandez (via Microsoft Teams chat): "Interpreters face a similar issue with regard to reasonable service charges for delay of payment. ProLanguage Interpreters requests an OSC for "reasonable service charges": D00__"

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:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Tom Hernandez noted that a year may seem long. However, as a small business, there are often limited resources and it can take longer than 180 days to get things sorted out. He noted instances in which there is an invalid claim number or some other issue, which can cause significant delays.
- Ivo Trummer noted that a year is a long time and receiving bills after so long can cause a significant administrative headache. Trying to align everything within the file can take a long time.

- DeAnna Tapia noted that she understands both sides. However, as the biller for her small business, she noted that it does sometimes take longer than 180 days to bill. She noted that she needs to get information from the interpreter, then bill a month later, can then later learn that it is a workers' compensation matter—all of that takes time. Sometimes providers are not helpful or bill in a group manner that causes delays. Sometimes there are delays because one can't bill without the chart notes. She emphasized that six months could be a tight timeline.
- Dan Miller asked for clarification re: "submitted bill." He asked, for example, if that included when a provider submitted an erroneous bill. He also asked for clarification regarding the penalty. What does it mean, he asked, for the bill to be "reduced?"
- DeAnna Tapia noted that she has worked with several insurers who are understanding if DeAnna submits a statement explaining why the bill is late. However, she's worked with an out-of-state insurer who, despite receiving such a statement of explanation, still reduced the bill to zero. She confirmed for Dan Miller that to "reduce" a bill can mean "not get paid at all."
- Tom Hernandez emphasized that, for small businesses with fewer resources, getting the bills submitted before six months can be hard. He noted that there is a difference between having two employees and hundreds, as some of the insurers do.
- Misty Bergenstock sought fiscal clarification from the insurers. She noted that the issue states about 2.7% of bills are received after a year. She asked if the insurer was presumably not paying the 2.7% (because received after a year), was that amount equal to the administrative burden caused by the delay?
- Ivo Trummer noted that it is not a money-saving issue. He noted that when SAIF receives a late bill, it takes a lot of time to match everything up in the file. It is an issue regarding time, not money.
- Misty Bergenstock added that, as someone from a small business, they are often not paid by insurers if the bill is older than a year. She noted that it is time consuming and she doesn't believe there are providers out there intending to take longer than a year to bill.
- Thais Lomax noted that trying to match documents in the file when they are received after a year is an administrative burden. Often, if the bill comes a year or more after the date of service, the file is likely processed and closed. New bills have likely come in and aligning everything takes a lot of work.
- Kirsten Adams acknowledged that this is an important conversation to have; she wondered if there are particular areas where 180 days is particularly difficult and if there were opportunities to streamline in those spaces.
- Ivo Trummer noted that SAIF does not require a claim number when submitting billing.
- DeAnna Tapia noted that she believes SAIF does require a claim number.
- Ivo Trummer said he would take another look at SAIF's requirements
- Thais Lomax noted that no claim number is required but the insurers need to have other adequate information to identify the claim. If not, it will likely be kicked back.
- Ann Klein cited some of the comments made regarding struggles to bill in 180 days; she noted that the clock does not start until medical providers receive notice or knowledge of the responsible workers compensation insurer. So, any back and forth taking place when

Level 3 - Restricted

trying to figure out the responsible payor doesn't start that clock. She noted that there is a tension to have flexibility for the exceptions (e.g. small businesses waiting on providers) while also wanting the system to be streamlined and the best it can be. She added that 180 days is three times the target; we want the flexibility for the named exceptions but we still need to be aiming for that target.

- Paul McMahon would like to see more data regarding the reason for late submissions as well as the administrative burden faced by those receiving late bills.

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:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Scott Winkels asked if there had been any conversations between the division and MCOs regarding this practice.
- Juerg noted that there were conversations about this years previously, and the practice stopped. Now, the practice is happening once again.
- Scott then noted that there is a statute allowing MCOs to engage in case management. He suggested the proposed rule would limit MCOs' ability to do that. He asked if DOJ had weighed in on this proposed language.
- Juerg noted that DOJ had not provided feedback on the proposed rule.
- Ann Klein noted that when Majoris receives a precertification request that is based on the medical records at hand, the physician reviewer can look at that and apply the treatment guidelines to it. If it appears there is not enough information to substantiate going outside of the treatment guidelines, Majoris takes a claims management step and asks for additional information or reconsideration based on the information provided. The attending physician has three choices: (1) stand firm on initial statements and diagnosis; (2) provide additional information to deviate from treatment guidelines; (3) adjust treatment plan based on new information. She noted she had a recent example involving an MRI indicating a tear. They could ask the provider if, given that new information, the provider supported deviating from the treatment plan. So, Majoris is opposed to the proposed language as it removes Majoris' ability to have those conversations. Since January 2025, Majoris has contacted providers in cases like this 4095 times. Of those cases, about a third of physicians approved going outside the treatment plan based on new information, about a third had their initial submission approved, and about a third disapproved (needing appeal rights). As the proposed language is written, all of those cases would have been denied. This then causes delays. Majoris does appreciate the concern regarding inadvertent withdrawals and ensuring the provider understands they can say no, that they stand with their initial submission. If there is a way Majoris can be clearer in its communications, Majoris is open to that feedback. As proposed, though, Majoris believes this will cause more barriers and delays to care and add expense to the system as a whole. Additionally, Ann noted that Majoris plans to submit a redacted letter that demonstrates what these communications look like. Finally, Ann noted that Majoris is comfortable with setting a timeframe in rule (e.g. if there is no response in 14 days, the MCO should understand that to mean that the provider is sticking with their initial submission).
- Dan Miller asked what the difference was between this and an EOB? What difference does it make if there is an MCO or not?

- Juerg clarified that, in these instances, there is no appeal language presented to workers. Instead, there is a withdrawal in the background. When there is no MCO and the payment is denied, the worker receives notice of appeal rights.
- Ann Klein noted that, if the provider changes treatment plans, the worker always has the opportunity to advocate for their care. The attending physician, she added, is ultimately responsible for developing the treatment plan.
- Maureen Sacon noted that she doesn't get requests to withdrawal treatment from other insurers, she only gets them from MCOs. In her experience, it relates to official disability guidelines, so even if there is objective improvement with physical therapy, if it falls outside of the objective of the official disability guidelines, she will get a letter with a box to check indicating withdrawal. She added that doing so is not paid work, but work nonetheless. She noted that if a third of the time Majoris is changing the decision, that means a third of the time the providers are working for free.
- Jovanna Patrick noted that we need to focus on the pressure that providers feel and how busy they are when they are trying to treat injured workers. "Case management" under the statute does not allow MCOs to tell doctors what the law is, and what they can or cannot provide treatment for. The division is the entity that should be deciding whether treatment is reasonable, necessary, and related. But, if it doesn't fit into the MCO guidelines, even if the division has not adopted the MCO guidelines, the MCO feels it is appropriate to tell the doctors what they can or cannot do. The providers can decide if they think something is reasonable and necessary and a denial can be issued including appeal rights. Then, the worker can go to the actual decision maker, the division, for the ultimate decision. Jovanna added that, if a third of all requests are being withdrawn without appeal rights, there is a huge constitutional access to justice issue for workers at hand. Workers are not able to meaningfully challenge what is essentially a denial of medical services. Jovanna clarified that she does not mean MCOs cannot communicate with doctors, but the MCO shouldn't be pressuring the doctors one way or the other. She added that these requests from the MCOs to the doctors create trust issues between the workers and their providers. The workers end up thinking their providers work for the insurance company. She added that she has seen files adjusters emailing MCOs asking if they were able to get a doctor to change their mind about something; she does not believe that pressure should be on doctors, and that workers need to be able to access their appeal rights.
- Ryan Hearn noted that the data shows this MCO outreach is working; nearly a third of the cases receive approval once the provider provides the correct information. Turning all of these cases into denials does not protect the worker, it delays care.
- Kirsten Adams acknowledged that this is worth discussing. However, she believes that the language, as drafted (e.g. "may not ask"), may be overly prohibitive for MCOs.
- Ivo Trummer echoed the concerns raised by Ryan Hearn: the process now is collaborative as the MCO and provider try to figure out the best treatment forward. To change all of these matters to denials will clog up the appeals process and cause delays for workers. Ivo also added that he has yet to meet a provider that is afraid to stand up to MCOs and the insurance companies.

- Lauren Grace, reflecting on Ann Klein's comments regarding a worker and provider's ability to advocate for themselves, noted that workers often do not feel capable of advocating for their own care. Some workers do not speak English as a primary language and require an interpreter; there are inherent power dynamics at play that prevent workers from standing up to the MCOs. She noted that, for many of the workers she sees, a denial of care without an appeal would end the matter; they would not advocate for themselves and they would simply not get that care.
- Jovanna, responding to Ivo Trummer, noted that she has communicated with many doctors afraid to stand up to MCOs because they fear being kicked out of the MCO system. She noted that these providers don't appear to comment because they may have their attending physician status removed, which can impact their offices and their personal finances.
- Maureen Sacon noted that there is not merely a fear of getting kicked off the panel, but there is additional paperwork to face. If she doesn't check the box to withdraw, there is follow up by phone or just additional work, generally. That extra work is not paid.
- Sydney Montanaro echoed the sentiments shared by Jovanna Patrick, Maureen Sacon, and Lauren Grace.
- Joy Chand thanked Jovanna Patrick for her comments. She noted that this current system does create extra unpaid work and it does delay care.
- Scott Winkels reiterated that he sees a statutory issue with this proposed rule. He believes that it will delay care and remove collaboration. He believes, if this proposed language goes forward, there will be significant unintended consequences.
- Kris Gorriaran of Majoris noted that she believes this proposed language shifts the burden 100% to the worker. Currently, the MCO and the provider can communicate to reach a conclusion—no burden on the worker. She added that they've only taken one provider off the panel in the last 18 months.
- Ann Klein with Majoris acknowledged that there is a problem. The current system intends to keep medical conversations between medical professionals. She added that Majoris is very open to feedback regarding communications that come across as bullying. She has not seen such bullying in the letters sent by Majoris, but welcomes such evidence and feedback. She reiterated that Majoris does not intend to threaten or bully providers.
- Ted Heus noted, responding to Scott Winkel's statutory concerns, that ORS 656.260(7) allows for director review. Therefore, the director/division can likely put forward any rules it wishes to on this matter without issue.

Level 3 - Restricted

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:

Minutes:

- Note: Juerg Kunz described issue #9 and issue #10 together (asking how do we clarify "processing, assessment, or determination" in a way that allows MCOs to operate without stepping out of their lane?) – some of the minutes are below issue #10.
- Ted Heus noted, regarding the proposed language, that the emphasis is on the insurer initiating contact with the MCO. He noted that, in every instance he's seen, the insurer is only intending to close a claim when the insurer initiates communication with the MCO asking for something. This is what he believes the proposed language is trying to achieve: to stop the insurer from reaching out to MCOs initially with the intent of closing a claim. (He noted a common example is when insurers ask MCOs to concur with IMEs.)
- Maureen Sacon noted that she has been bullied on the phone by a physician and she would love a union representative or someone there to support her and document the phone call. She noted a recent example in which a worker hit their head and had a contusion. Maureen received a call from a Majoris physician asking if the contusion was medically stationary. Maureen replied that yes, the contusion may be medically stationary but Maureen believed she was treating a condition directly related to, i.e., a sequela to the contusion. The Majoris physician told Maureen that they were an expert in this field, had worked in this area for 30 years, and disagreed with Maureen. They then told Maureen she needed to file a new Form 827. When Maureen said that was not her understanding, the Majoris physician disagreed with her.
- Ann Klein acknowledged the tension outlined by Juerg: what constitutes claims processing? She noted that this issue has come up multiple times and part of that tension is designed into the system and likely not going anywhere. Majoris is supportive of the

intent of drawing clear lines that the MCO should not process, assess or determine non-medical benefits. She noted that the proposed language, as written, may be overly broad in how various parties could interpret what constitutes "communication." She noted one of the things that Majoris is struggling with is the tension when the clinical record informs many activities—so when does discussion on that clinical record become claims processing? She noted that it does not matter if there's a workers' compensation insurer covering the medical services one is receiving or it's group health insurance. The patients still need to know what is safe to do. So, it remains medical even if it may inform non-medical benefits. It may also inform an insurer about time loss benefits. But, it really doesn't turn into eligibility for time loss benefits until it goes to another component which is the attending physician identifying what is safe or not safe for the worker to do. The employer then needs to determine whether they can accommodate any such limitations. If we learn the employer cannot accommodate those limitations, there is time loss that an insurer is going to need to understand that there is a non-medical aspect at play. She believes the question of medically stationary remains the same: there is a question of whether we've reached maximum medical improvement. She noted that it does not matter what insurer is covering those medical services. The patient and the provider are having a conversation regarding treatment. So, that would be a part of Majoris' recommendation when considering what is and what is not medical. We need to recognize that we have two entities utilizing the same clinical information, but that does not mean that the clinical information itself falls into just one of the categories. Majoris recommends affirming everyone's lane: "the insurer will not dictate to the MCO what medical decisions to make." And, "The MCO can communicate with the treating providers, but they cannot dictate that provider's clinical conclusions regarding the treatment plan." And, "The MCO will not benefit in non-medical benefit processing." She noted that these suggestions will also hinge on how "medical services" is defined (issue #10).

- Ryan Hearn agreed with Ann: the MCO should not be performing claim processing work for insurers, but a blanket prohibition on communication is just too broad. Insurers need clinical context from MCOs in order to make accurate medical determinations. He was an adjuster for a long time and recognized that often one needs medical information. He noted that, if there was no MCO, the adjusters would be reaching out to the doctors directly. So, this is a way to help providers navigate requests from insurers, to put them into layman's terms to help the doctor understanding what is going on. Ryan believes the open communication between insurers and MCOs add value for everyone, and helps to avoid longer care and more serious injuries.
- Ted Heus responded to Ryan Hearn by saying that whether work restrictions are medical treatment and how they interplay with medical management could be a fuzzy issue. He noted that he hasn't seen providers characterize work restrictions as treatment; he has also never seen an MCO disapprove work restrictions saying that those restrictions do not meet the MCO's treatment guidelines and disapprove of them as medical services. He doesn't believe there is that type of confusion as it is being discussed here. Instead, he sees an attempt to obtain those work restrictions for the purposes of permanent and temporary disability. He believes that is always the case. He noted that he has never seen

an MCO disapprove work restrictions such that it goes to MRT and MRT decides whether or not those restrictions are reasonable, necessary medical treatment. So, what he wants the division to focus on, is—why is the insurer communicating with the MCO? If there is a dispute or some kind of benefit issue, that is a process to be resolved from the insurer's perspective. If the MCO needs information, that communication happens between the MCO and the provider. He noted that just yesterday he had received another email of an insurer asking whether or not they can get the provider to return a concurrence letter—specifically because they needed the information to close the claim. On that letter, he says there is a box to check if the worker is medically stationary, and, if they're not, the provider is to state whether the accepted condition causes permanent impairment. In that example, which he sees all the time, the insurer was not trying to sort out medical services. Instead, the insurer wants to close the claim. He noted that the insurers should talk with providers—that is how the system is set up. The system is not set up, however, for insurers to communicate with MCOs about the contractual relationships with providers who have an obligation to behave a certain way under that contract.

- Kevin Barrett asked the division how many disputes the division has seen involving this type of behavior.
- Rob Andersen of the division noted that there have been only a small number of such disputes.
- Kevin then noted that there is already a process in place for this type of behavior. SAIF agrees that the proposed language is overly broad and agreed with potential alternative language. However, he noted that these elements are part of utilization review, there is already a dispute process, and if there is a complete prohibition on communication, the letter just described by Ted Heus would need to be broken in two. As a result, the doctor then receives two letters instead of just one. He doesn't believe providers want more letters, more processes. He believes, as proposed, this change would make things more challenging. If the division moves forward with this concept, he urges the division to consider alternative language.

Level 3 - Restricted

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:

Minutes:

- Note: Juerg Kunz described issue #9 and issue #10 together (asking how do we clarify "processing, assessment, or determination" in a way that allows MCOs to operate without stepping out of their lane?) – some of the minutes for these issues are below issue #9.
- Following Kevin Barrett's comment (see issue 9), Ann Klein commented about the component re: return to work. She noted that it is not just a question about what makes good medicine best practices. The American College of Occupational and Environmental Medicine lists as part of their own guidelines to medical providers treating injured workers that it's important to incorporate into their treatment planning opportunities and pathways to stay at work and early return to work. Beyond that, we also have a statutory component. It is part of the requirements for an entity to become an MCO to have a plan in place for cooperative return to work. There are rules in place that reinforce that, appropriately, in order for an MCO to be certified, they need to have a cooperative program among the worker, employer, insurer, and MCO to promote early return to work. So, it's not just documenting when the worker is capable of returning to work. There is a component of promoting early return to work as an understanding that that's best practice in the care of injured workers. Ann believes that it's important that work restrictions, and restrictions on activities as well as a consideration of how to actively promote return to work as a component of good medical managed care in the workplace.

- Ted Heus, in response, points out that Ann brought up a good point; he noted that the rule does not mirror the statute and should probably be modified. When talking about a program that involves cooperation between different parties to produce a safe early to work programs, Ted's interpretation—from review of legislative history—is that those entities should work together to work on safety programs for injuries and early return to work programs like, e.g., light duty opportunities. Further, the rule states that the cooperation program should happen between the insurer, employer, workers, and MCO. The statute doesn't say that. The statute says the program should be developed between the employer, the workers, and the MCO—not the insurer. He reiterated that, upon reviewing the legislative history, it's clear that there were concerns about MCOs and insurers getting too close. He urged the division to review that history and the Mahonia Hall Act. He added that he does not believe that statute gives authority to MCOs to get involved in work restrictions as they relate to other benefits other than medical treatment.
- Scott Winkels reflected on the division's meeting regarding MCOs in the summer 2026. He noted that, at that meeting, there was discussion regarding the division's dispute resolution process (and whether or not it was adequate). He wondered why that dispute resolution process was not discussed in the meeting materials, as that process, he believes, could be a resolution to some of these issues. He would like the division to address its dispute resolution process.

Level 3 - Restricted

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:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Scott Winkels noted that this would create a significant administrative burden—more so than public records law. This would generate a lot of data that would be expensive to store and never used. And, as he understands, there are already means of tracking written communications between these parties.
- Ivo Trummer, echoing Scott, noted that one might need an entire data center to store all of that data. And, he noted there may be a concern regarding gathering consent from all providers to be recorded. It may also discourage providers from being candid and frank in communications. And, as Scott noted, the existing written communications are trackable.
- Ryan Hearn noted that he understands the desire for transparency, but the proposed language goes too far. He noted that providers may be less candid if this were implemented (ultimately diminishing the value of care). He added that the director already has authority to investigate should there be concerns about the MCO conduct.
- Ann Klein echoed the sentiments of others: significant administrative burden, significant investment, change in processes. She raised that this would also increase risk of inadvertently breaching medical confidentiality. And, as others had mentioned, there is already a process in place to handle issues with MCO misconduct. She does not believe there is a lack in transparency as alleged by this issue and rule proposal. Insurance communications are, as already addressed, discoverable under the claim record disclosure. And, provider and MCO clinical deliberations—those conversations provide an opportunity for candid conversation. The medical provider can document the conclusions reached in those conversations. They can document the components of the conversation that were relevant to their decisions and treatments—and that's within the medical record and available to the patient. She added that it is standard to maintain some level of confidentiality for medical professional peers having such conversations. Finally, she noted that, if there are concerns about MCO misconduct, there is an opportunity to request investigation and appropriate sanctions from WCD. She believes that is a more efficient, effective way to provide oversight regarding MCO behavior (rather than recording everything and having an overwhelming amount of information/communication available to the worker).
- Kirsten Adams reiterated Ann Klein's concern regarding inadvertent disclosure of confidential information. This proposal would create a lot of data that would need to be secured. As written, this is overly broad and burdensome.
- Ted Heus noted that this was not his rule proposal, but he understands the point is transparency. He reiterated that transparency is an issue, although he is not sure this proposal is the way to address it. He reflected on comments from others and highlighted that the conversations between MCOs and insurers, or MCOs and the provider, are full of unknowns. There is no evidence generated supporting the misconduct, because all of the conversations happen in the dark.

Level 3 - Restricted

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:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Dan Miller noted that he is not sure what the stakeholder means by "recently," and he has seen this issue for the entire 30 years in which he's been practicing. He knows that employers are directing care.
- Juerg noted that the MCOs can decide where the worker can go if they see, for example, that the current provider is not equipped to deal with the worker's condition. The MCO can present a new provider—e.g. a specialist. According to this stakeholder, however, insurance companies are now approaching MCOs and telling the MCOs where to direct workers. Juerg noted, addressing Dan Miller's comment, that employers should not be directing care.
- Ivo Trummer noted that the stakeholder merely "believing" that this is happening does not warrant a rule change. He noted that the rules already prohibit the insurer from directing care for workers. He suggested the division provide a list of providers that offer workers' compensation services—this, he believes, would be helpful for workers.
- Dan Miller responded that there is such a list—at least for MCOs. He noted that it is absolutely inaccurate. He sees workers all the time having called providers on the list but those providers are not accepting workers' compensation patients.
- Juerg, responding to Dan Miller, said that he could direct such workers to reach out to the MCOs in the future.
- Ann Klein agreed and said that, should workers reach out to the MCO to let them know that the provider is not accepting workers' compensation patients, it allows the MCO to both assist the worker in finding someone and update their directory. She noted the MCO is constantly trying to update their list. She noted that they have dedicated resources for trickier cases (to help workers).
- Ted Heus noted that he recently saw an insurer face a penalty for doing exactly this.
- Thais Lomax noted that she is approaching her 27th anniversary of adjusting or supervising Oregon specific workers' compensation claims. She's worked with 100s of adjusters. The perception of insurers reaching out to MCOs to dictate what they do is not what she has seen. Instead, she sees adjusters receiving calls from workers asking where they should seek care because they can't find providers. The insurer does not direct care but instead connects the worker with the MCO. She acknowledges that there may be outliers—like the one just noted by Ted—and those face penalties under the current rules. So, she does not believe new rules are necessary.
- Ann Klein noted that Majoris does not have an issue with prohibiting this insurer behavior. Majoris wonders if this proposed language does something different or merely maintains what the rules already state. As far as Majoris understands, and as outlined by Ted's example in which an insurer faced a penalty, this is already addressed in rule.

Marie then provided her email address and encouraged committee members to provide written comment to her via email (marie.a.rogers@dcbs.oregon.gov). She noted that the division will accept written comment through November 13, 2026. She noted that the meeting minutes would be circulated in the coming days. Because the committee discussed all of the issues, the November 10 meeting is cancelled. She thanked the committee and closed the meeting.