WCD Workers' Compensation Division
Department of Consumer and Business Services
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Meeting Minutes

Medical Advisory Committee (MAC) Meeting

Date

24, April, 2026

Time

01:00 p.m. to 03:30 p.m.

Location

https://www.zoomgov.com/j/1600574821?pwd=VyQraApO64q20O7RrX3LPambhamriv.1/
16760 SW Upper Boones Ferry Rd., Tigard, OR 97224 OSHA Training Room, 1st Floor

Committee members present

MAC member	Specialty
Chair Ronald Bowman, MD (Med. Member)	Board Certified Orthopedic surgery
Vice-chair Brad Lorber, MD (Med. Member)	Board Certified Physical medicine and rehabilitation
Paul McMahon, MD (Med. Member)	Board Certified General psychiatry
Tom Williams, PT (Med. Member)	Physical Therapy
Ryan Weeks (Employer Representative)	
Constantine Gean, MD (Insurer Representative)	Board Certified Occupational medicine
Raymond Brumbaugh, MD (MCO Representative)	Physical Medicine & Rehabilitation

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Committee members absent

MAC member	Specialty
Eric Hubbs, DC (Med. Member)	**Chiropractic**
Emily Nguyen, MD (Med. Member)	**Board Certified Orthopedic surgery**
Lon Holston (Employer Representative)	
Jennifer Lawlor, MD (Med. Member)	**Board Certified Occupational medicine**

DCBS staff

- Juerg Kunz
- Angela Blake
- WCD Administrator Matt West
- Robert Andersen
- Baaba Ampah

Meeting Presentation

Agenda item	Discussion
Welcome, introductions (0:00:00)*	Chair Ron Bowman called the meeting to order at 1 p.m., and Baaba Ampah called the roll of members.
Administrative discussion (0:02:03)*	Dr. Lorber moved to approve the minutes, and Dr. Constantine Gean seconded the motion. The motion passed unanimously.
(00:02:21)	Angie Blake announced that this is her last meeting and that she is handing off responsibilities to Baaba Ampah, who has been co-assisting, leaving MAC staff to only Juerg Kunz and Baaba Ampah. Chair Bowman shared his appreciation to Angela Blake. Angela Blake also noted that Ryan Weeks and Lon Holston agreed to serve another three-year term.

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Form 3245 Return to Work Status (00:03:13) *	Dr. Brumbaugh re-introduced the 3245 'Return to Work Status form', noting that several additional suggestions have been incorporated in the form. He invited additional final suggestions, cautioning that adding more content would push the form to multiple pages and likely reduce provider's completion quality.
(00:04:01)	Vice-chair Lorber expressed his approval for the form but suggested adding more options in the "climb" section, such as indicating occasional stairs or frequency. Dr. Brumbaugh suggesting moving the "climb" option to the section with carry/push/pull tasks, without the pounds behind it.
(00:04:49)	Chair Bowman asked whether the form is concordant with how ergonomists conduct job analyses, clarifying that such teams typically separate lifting, carrying, and similar processes done for the job. Vice-chair Lorber responded that there are so many different analyses and the data you want is the data you get.
(00:05:30)	To limit confusion, Dr. Gean recommended "total **HRs** in a ___hour shift" in the mobility section, otherwise it may be filled out as percentages or other formats.
(00:06:20)	Juerg Kunz explained that once the final version is ready, it will be sent to be shared with internal WCD staff for review. They will then look at it and provide any questions or suggestions. After that review, the updated version will be brought back to the committee to work toward a finalized version.
(00:06:58)	Dr. Brumbaugh will discuss the changes, and turn it in. The final product will replace the old version. Juerg Kunz explained that there is no formal administrative process required to make the updated form official; the division will simply replace the old version. An industry notice may be issued to explain how long insurers and providers can continue using the previous form. Dr. Bowman noted informing adjusters and insurers to ensure distribution of the correct version. He also noted EMR systems will incorporate the new form as part of their routine updates. Juerg Kunz clarified that providers are allowed to use their own form unless an insurer specifically requests the official version. If a provider submits their own form and an insurer claims it is incorrect, the provider can point out that their form is acceptable unless the insurer has explicitly required the official one.
(00:10:06)	Juerg Kunz showed his appreciation to Dr. Brumbaugh for his work on the forms.
Member Updates (0:10:48)*	Dr. Paul McMahon introduced himself as a psychiatrist in private practice, noting that about half of his practice is workers' compensation patients. He explained that he began treating workers' compensation cases around

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	2022, his practice is fully telemedicine, allowing him to see patients statewide. Members welcomed him.
Provider pre-authorizations (0:11:40)*	Juerg Kunz explained that in the Oregon workers' compensation system, providers generally do not need to obtain pre-authorization except in MCO settings. Because this differs from most other jurisdictions, some providers seek optional pre-authorization to avoid later disputes with insurers. This led to the idea of adding limited pre-authorization options into administrative rule, focused on areas where problems most commonly arise such as referrals to specialists, physical therapy, diagnostic imaging, and surgeries (which already follow a separate notification and response process). The Oregon Trial Lawyers Association (OTLA) pushed for a much broader approach, wanting providers to have the opportunity to request pre-approval for any service, not just the defined categories. The purpose of the discussion was to gather provider input on whether it is realistic to allow pre-authorization requests for any service, or whether only certain services truly need this option.
(00:17:01)	Matt West, WCD administrator, explained that the proposed pre-authorization rule was pulled and not implemented due to the amount of feedback. The plan is to revisit the rule in the fall during the annual fee-schedule update and medical-rule review. He continued that the purpose of the rule is to support providers. Administrator West emphasized the need to find a balance, avoiding a system where providers request pre-authorization for every office visit, which could slow the entire process. He asked providers to identify the treatments in their own practices where this option would be most beneficial so those can be brought to the fall stakeholder group. The issue originated from the MLAC's Access to Care Subcommittee discussions held the previous summer, to create a rule that works for both providers and the system.
(00:18:36)	Dr. Lorber explained that his office seeks pre-authorization for new evaluations, electro diagnostics, and post-injection procedures (but not trigger points), yet authorization still does not guarantee payment. He continued that problems arise with the 14-day automatic-acceptance rule because adjusters often fail to respond, and claims are frequently reassigned without notice, leaving the office communicating with the wrong adjuster for weeks or months. As a result, his office may assume acceptance, only for the correct adjuster to later state that they never received the request, and these delayed denials lead to large bills when patients lack private insurance. He emphasized that there needs to be a way to make the 14-day rule satisfactory for doctors when non-response could lead to non-payment.
(00:20:03)	Dr. Bowman suggested a mechanism that gets a receipt that the adjuster received the request. Juerg Kunz shared the opinion that even when something is sent to the wrong adjuster, it is the insurers responsibility to

	send it to the right adjusters. Administrator West mentioned the creation of a preauthorization form. Robert Andersen, WCD, described that any request under this rule would need to be in writing and sent to the general fax line of the insurer rather than to a specific adjuster's phone. He explained that the provider must be able to show evidence that it was sent, and that a fax confirmation showing it was received.
(00:22:16)	Dr. Lorber noted that a form would be very useful and acknowledged that his office has never requested authorization for follow-up visits. He also explained that sometimes claims are settled without the office being informed, and if a form were created, his office would plan to submit authorization for the follow-up visit at the same time as the initial visits. He added that patients often become angry when private insurers are asked to cover the costs of a denial.
(00:22:44)	Dr. Brumbaugh expressed concern about the amount of paperwork that would be placed on small clinics, as it seems like a lot to require pre-authorization for every visit because appointments change all the time. Juerg Kunz clarified that it will not be a requirement.
(00:23:38)	Dr. Gean acknowledged that although it is an option, problems arise when a provider performs a test without exercising that option and the insurer later decides it is not appropriate. He also talked about the administrative work on providers, asking whether there could be a set level of services, for example certain number of office visits, x-rays, etc., that would be accepted as legitimate before advanced imaging and other works. Dr. Gean cautioned that requiring approval for every single service could also be a problem.
(00:24:31)	Dr. Bowman described a recurring issue example in his practice in which a worker injures a shoulder, but the pain generator is unclear, raising concern about possible neck involvement even though the neck was not part of the accepted injury. He explained that in these situations, tests such as an MRI are needed to rule out. However, he noted that such testing would not be accepted through the court process. Dr. Bowman asked how these types of situations are decided.
(00:25:11)	Juerg Kunz answered that the Workers' Compensation Board handles such disputes. He explained that the Workers' Compensation Division handles disputes about how much something should cost, or how much should be paid. If the insurance company says it is not related to the work compensation injury, then it goes to the Workers' Compensation Board instead.
(00:25:48)	Dr. Bowman mentioned that often in physical therapy denials are made based on the ODG. He asked about the administrative rules regarding the scope of treatment of the attending physician's authority to order. Juerg

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	Kunz explained that, outside of MCOs, Oregon does not have treatment guidelines that are recognized. Even though insurers frequently cite ODG guidelines during denials, WCD will review it on individual cases.
(00:27:07)	Dr. Bowman asked about request for approvals for routine follow-ups and issues are extra things or more expensive treatments. Rob Andersen clarified that the information needed is what the committee thinks is the most important. Dr. Lorber noted that routine follow-ups have been getting denials lately.
(00:27:57)	Juerg Kunz asked what insurers base their disapproval on. Dr. Lorber answered that sometimes the closure of claims itself without informing the provider. He explained that denials often cite conditions as “not related,” even when the rest of the report clearly supports other related conditions, forcing providers to appeal the decision that can be time-consuming. Dr. Lorber added that insurers also deny payments when they feel like a condition has gone on too long or is no longer related to the injury, and while this used to be uncommon, these types of denials have become more frequent over the past year.
(00:28:55)	Juerg Kunz explained that particularly if a claim is not related, it can be a real problem to providers, because it goes to the WCB and statutorily, the provider does not have standing at the Board.
(00:29:30)	Dr. McMahon explained that his practice frequently encounters delays when seeking timely authorization. He described a recent case in which they submitted a justification letter, only to later discover that the adjuster had retired without notifying anyone, causing the request to stall for about a week until the patient provided updated contact information. Dr. McMahon added that in some cases they never receive a response at all, leaving him unsure about what to do.
(00:30:26)	Tom Williams argued that from a physical therapy standpoint, voluntary authorization has little incentive and two weeks is far too long for physical therapy. He stated that evidence shows that sooner therapy after injury means less time loss, and that post-surgical cases, like hand injuries, need early active motion right away; 2-3 days makes a huge difference. Dr. Williams proposed replicating MCOs, like Majoris, where no authorization is needed for the first 12 visits or first 30 days, then time to gather info and seek authorization. He also mentioned that voluntary authorizations may overload the adjusters.
(00:32:20)	Dr. Gean noted that Tom Williams’ suggestion sounds reasonable logistically. He recognized that second rule by OTLA sounds reasonable because when non-response results in an approval, it will reduce insurers’ administrative burden because the adjuster does not have to do anything if they agree.

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(00:33:16)	Juerg Kunz replied that once the proposed rules were published, OTLA opposed it. He commented on reducing insurers' burden by approving non-response authorization request, noting that it would be required to be noted on a form. Dr. Gean noted that is how it is done in California and the lawyers are aware of it.
(00:34:14)	Juerg Kunz asked about the time frames in California. Dr. Constatine was unsure but thought it was about 5 days for UR submission. He will send Juerg the timeframes.
(00:34:40)	Dr. Bowman suggested block authorizations for certain procedures like elective surgeries post op protocols.
Rules, effective 4/1/26 update (0:39:41)*	Juerg Kunz noted that new rules were in effect April 1st: - New requirements are that insurers must return phone calls during the providers regular business hours. This was prompted by out-of-state insurers calling as early as 5 in the morning.
(00:40:32)	Dr. Bowman asked whether he and insurers can agree to earlier calls. Juerg Kunz answered that the rule requires calling withing business hours, but if both parties agree, it is fine.
(00:41:16)	- Platelet-rick plasma (PRP) injections have been compensable since 2025 but lacked a fee-schedule amount; now set at $550 per injection, inclusive of all procedure and components.
(00:42:10)	- Oregon-specific code W0001, is used to bill for Workers' Request for Medical Exam (WRME) generally in response to an IME. Previously, there was no mechanism to pay for a WRME addendum report that was authored in response to an IME addendum. The descriptor for W0001 now includes that provision and therefore, an addendum may now be payable, but only when it is in response to an IME addendum.
(00:43:44)	- When a worker was deemed medically stationary, previously insurers had to notify the worker and attending physician immediately what services remained compensable (palliative care, curative care, prescriptions etc.). Now the insurer has 7 days to notify the worker and attending physician and must also notify any actively treating ancillary care provider, i.e., those with an active treatment plan filed with the insurer. This will help Physical therapists (PT) and Occupational therapists (OT).
(00:45:28)	Dr. Bowman asked about a situation where an IME declares a patient is medically stationary six months ago, and time loss received must be repaid. But there's a limit of about 60 days on how far back the med. stationary date was selected.

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(00:46:16)	Administrator West confirmed that there's a cap on how far back the medical stationary date can reach. Any time loss payment is paid post medical stationary date, it is considered an overpayment, but worker does not have to pay it back, but it comes out of future benefits if the claim reopens.
(00:47:23)	- If a worker gets enrolled in an MCO, the period to keep treating their current provider before transferring to an MCO is extended from 14 to 30 days.
(00:47:55)	Tom Williams asked whether this included ancillary providers like physical therapy. Ann Klein, Majoris MCO, explained that the Majoris interpretation is that it is all providers for those 30 days. Kaiser representative agreed.
HB 4040 **(00:48:55) ***	Juerg Kunz announced that previously nurse practitioners (NPs) and Physician Associates (PAs) could be attending physician for only 180 days; the bill removes that limit. They can be attending physician indefinitely, authorize time loss unlimitedly, perform closing exams, make impairment findings, and continue as attending physician past claim closure. He further noted that previously NP licensed in Oregon could authorize time loss; now any NP, in or out of state, can authorize time loss. However, they do have to certify that they have read certain required informational materials. It was discussed that this would be helpful when workers relocate out of state mid-claim and for rural areas where attending physicians are overloaded.
(00:53:03)	The rule went into effect on April 8th.
(00:53:40)	Dr. Bowman asked if there are resources or education for NPs and PAs to learn about these rules. Juerg noted that there are certain published materials for NPs and PAs about the Oregon workers' compensation system. Kaiser representative noted their medical regulation team does outreach and education and is available for questions.
(00:55:24)	Dr. Bowman asked if there are any medical queries that are available. He also asked if there was anything in WCD similar to the Ombudsman but for providers. Dr. Gean mentioned that Liberty Mutual is getting into AI for administrative work. He stated that large language models answer Oregon workers' compensation law questions as possible referral aid. Juerg Kunz cautioned that AI could spit out the wrong information.
(00:58:00)	With no additional business, Dr. Bowman adjourned the meeting. The meeting adjourned at 1:58 p.m. The next MAC meeting will be held on July 24, 2026.

* The audio files for the meeting minutes and public testimony (both written and audio) can be found here: http://wcd.oregon.gov/medical/mac/Pages/mac-meetings.aspx.

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