



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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March 18, 2009

Proposed Changes to Workers' Compensation Medical Rules

The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules," and division 010, "Medical Services." Please review the attached documents for information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** April 21, 2009, 10:00 a.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone - (503) 947-7717; Fax - (503) 947-7514

The closing date for written comments is April 27, 2009.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –
<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>
Or call (503) 947-7627 to get free paper copies

Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services (DCBS),
Workers' Compensation Division

OAD CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

PO Box 14480, Salem, OR 97309-0405;

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Rules Coordinator

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RULE CAPTION

Proposed rules affecting workers' compensation medical treatment and fees

April 21, 2009	10:00 a.m.*	Room 260 (2 nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

***NOTE: The hearing will begin at 10:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through April 27, 2009.**

The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

AMEND: OAR 436-009 and 436-010-0230, 436-010-0275

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, primarily ORS 656.245, 656.248, 656.260

Stats. Implemented

RULE SUMMARY

The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules."

These proposed rules address: Adoption of updated medical fee schedules and resources for the payment of health care providers; good cause exceptions for late billing; compensability of cervical artificial disc replacements; requirement for procedural codes on hospital bills; the basis for the director to exclude rural hospitals from imposition of the adjusted cost/charge ratio; billing procedures for ambulatory surgical centers; and payment of physician assistants or nurse practitioners who perform or assist in surgery.

The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules address: Contraindications to cervical artificial disc replacement; and procedures for giving workers lists of eligible attending physicians in a managed care organization.

Request for public comment: The Workers' Compensation Division requests public comment on whether other options should be considered for achieving the rules' substantive goals while reducing the negative economic impact of the rules on business.

Address questions to:

Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7514; e-mail fred.h.bruyns@state.or.us

Proposed rules are available on the Workers' Compensation Division's Web site:

<http://wcd.oregon.gov/policy/rules/rules.html#proprules>

or from WCD Publications, 503-947-7627 or fax 503-947-7630.

April 27, 2009

Last Day for Public Comment

/s/ John L. Shilts

Authorized Signer and Date

3-12-2009

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Consumer and Business Services,
Workers' Compensation Division

Agency and Division

OAR CHAPTER 436

Administrative Rules Chapter Number

Rule Caption: Proposed rules affecting workers' compensation medical treatment and fees

In the Matter of)
The Amendment of OAR:)
436-009, Oregon Medical Fee and Payment Rules)
436-010, Medical Services)

Statutory Authority: ORS 656.726(4)

Other Authority:

Stats. Implemented: ORS chapter 656, primarily ORS 656.245, 656.248, 656.260

Need for the Rule(s): The agency is proposing changes: to update the medical fee schedules as required by ORS 656.248, and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

Documents Relied Upon, and where they are available: "Issues" document presented to an advisory committee; advisory committee meeting records; written advice from advisory committee members; and fiscal impact analyses.

These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

Fiscal and Economic Impact, including Statement of Cost of Compliance: References to "insurers" (below) include "self-insured employers." The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by proposed changes to OAR chapter 436.

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules"

- Adoption, in part, of the Centers for Medicare & Medicaid Services (CMS) 2009 Medicare Resource-Based Relative Value Scale (RBRVS) as the fee schedule for payment of medical service providers

The agency projects, due to some changes in the CMS relative value units (RVUs) for 2009, that adoption of the RBRVS would increase overall medical payments that are subject to the RBRVS by approximately \$420,000, or 0.21%. The effects would differ by service category: Anesthesiology, -0.02%; Surgery, -0.49%; Radiology, +0.24%; Lab & Pathology, +1.25%; Medicine, -0.41%; Physical Medicine and Rehabilitation, +0.72%; Evaluation/Management, +0.45%

These changes, overall, would increase payments to medical service providers and result in a corresponding cost increase for insurers.

- Maintaining the conversion factors at 2008 levels

Overall, the agency projects that keeping the conversion factors at 2008 levels would result in reduced net income, relative to inflation, for some medical service providers. Between 2007 and 2008, the Physicians' Services Component of the Consumer Price Index increased by 2.43%. Relative to increasing the conversion factors by the 2007-2008 CPI increase, 2.43% is the approximate, potential, maximum effect on Oregon medical service providers as a whole, but effects on individual providers may be more or less depending on the types of services provided.

The RVU increase of 0.21% will partially offset the CPI increase. Of potentially greater impact are recent rule changes. Effective 1/1/2009, OAR 436-009 disallowed discounting by provider networks of payments to medical service providers and clinics, except as required under contracts with certified managed care organizations. The agency does not have data about the size or the volume of network discounts. However, elimination of the discounts will increase payments to certain medical service providers and clinics and result in a corresponding increase in costs to insurers. The increases will vary by provider, depending on the types and quantity of network contracts in place. The agency will try to measure the effects on system-wide medical costs, but does not yet have data upon which to base any analysis.

- Restricting compensability of cervical artificial disc replacement

Under ORS 656.245(3), the director may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded, or experimental. Based on the advice of the Medical Advisory Committee, the director proposes to exclude cervical artificial disc replacements from compensability unless the devices and the patients meet specific conditions – with the goal to improve patient outcomes. Improved patient outcomes should lower overall medical costs paid by insurers. Restrictions affecting artificial disc replacement could have a slight negative fiscal impact on surgeons who perform disc replacements, though surgeons may perform other procedures on patients that do not meet the criteria for disc replacement. Because artificial disc replacement is not a commonly used procedure, the agency projects that the overall fiscal impact would be small.

- Proposed changes to billing procedures for ambulatory surgical centers(ASCs)

The proposed assignment of currently unassigned surgical CPT® codes to Medicare ASC Groups establishes maximum payment amounts for these codes. The agency projects a slight decrease in payments to ASCs under the proposed assignments. However, the agency expects a system-wide payment increase due to growing utilization of ASCs. It is difficult to project the rate of increased utilization. Accordingly, the agency cannot estimate the potential overall savings or costs to the system.

OAR chapter 436, division 010, “Medical Services”

- Proposed contraindications to cervical artificial disc replacement

See analysis under OAR 436-009: “Restricting compensability of cervical artificial disc replacement”

- Proposed procedures for giving workers lists of eligible attending physicians in a managed care organization

Allowing insurers to refer workers to Web sites to look up eligible attending physicians, instead of providing printed lists, should reduce insurers’ printing and mailing costs. Workers who can access on-line information should benefit from having more up-to-date lists. Because the agency does not know how many insurers and workers will use the new procedures, the agency cannot estimate savings, but the effect should be positive for insurers.

Regarding: Additional proposed changes:

- The agency estimates that additional changes will not have significant economic impacts on any persons or businesses, including small businesses.

2. Cost of compliance effect on small business (ORS 183.336):

- a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:**

Small businesses affected by these rules are primarily medical providers. Based on available data, we estimate approximately 12,000 medical providers are small businesses, as defined in ORS 183.310(10).

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

Reporting: The proposed changes do not require increased reporting for small businesses.

Record-keeping: The proposed changes do not require increased record-keeping for small businesses.

Other administrative activities and costs of professional services: The agency projects that, due to some changes in the Centers for Medicare & Medicaid Services (CMS) relative value units (RVUs) for 2009, adoption of the CMS schedule would increase overall medical payments that are subject to the schedule by approximately \$420,000, or 0.21%.

Overall, the agency projects that keeping the remaining conversion factors at 2008 levels would result in reduced net income, relative to inflation, for some medical providers. Between 2007 and 2008, the Physicians' Services Component of the Consumer Price Index increased by 2.43%. Relative to increasing the conversion factors by the 2007-2008 CPI increase, 2.43% is the approximate, potential, maximum effect on Oregon medical service providers as a whole; effects on individual providers may be more or less depending on the types of services provided. The RVU increase of 0.21% will partially offset the CPI increase. However, of potentially greater impact are recent rule changes. Effective 1/1/2009, OAR 436-009 disallowed discounting by provider networks of payments to medical service providers and clinics, except as required under contracts with certified managed care organizations. Elimination of the discounts will increase payments to certain medical service providers and clinics. The increases will vary by provider, depending on the types and quantity of network contracts in place.

Extent of economic impact: The agency projects that economic impacts specific to these proposed rule changes should be mild in extent and slightly negative for medical providers. However, as described above, these changes would follow very recent changes that should be economically positive for medical service providers and clinics. There is no basis to say that economic impacts would be "significantly adverse" (under ORS 183.540), but we invite public testimony on the probable extent of the impact.

c. Equipment, supplies, labor and increased administration required for compliance:

Equipment: The proposed rule changes do not require the purchase of equipment to achieve compliance.

Supplies: The proposed rule changes do not require the purchase of supplies to achieve compliance.

Labor: The proposed rule changes do not require increased labor costs to achieve compliance.

Administration: The proposed rule changes do not require increased administrative costs to achieve compliance.

Extent of economic impact: No increased costs for these categories.

How were small businesses involved in the development of this rule?

Representatives from small businesses participated on the rulemaking advisory committee.

Administrative Rule Advisory Committee consulted:

Yes. A rulemaking advisory committee met on 1/26/2009.

The agency asked the advisory committee for advice on the economic impact of the discussed changes, including any significant adverse impacts on small businesses.

/s/ John L. Shilts

3-12-2009

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



**Medical Services
Oregon Administrative Rules
Chapter 436, Division 010**

Proposed

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NOTE: Amendments are marked as follows:

Deleted text has a "strike-through" style, as in
Added text is bold and underlined, as in

~~Deleted~~
Added

HISTORY LINES: These rules include only the most recent "History" lines. A rule's history line shows when the rule was last revised and its effective date. To obtain a "Chapter 436 revision history index," please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: <http://www.wcd.oregon.gov/policy/rules/history.html>

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**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010**

436-010-0230 Medical Services ~~And~~ Treatment Guidelines

(1) Medical services provided to the injured worker must not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) An employer or insurer representative may not attend a worker's medical appointment without written consent of the worker. The worker has the right to refuse such attendance.

(a) The consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present.

(b) The consent form must be written in a way that allows the worker to understand it and to overcome language or cultural differences.

(c) The insurer must retain a copy of a signed consent form in the claim file.

(3) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services.

(4) (a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician will not be reimbursed unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A).

(b) The attending physician, authorized nurse practitioner, or specialist physician must sign a copy of the treatment plan within 30 days of the commencement of treatment and send it to the insurer. Failure of the physician or nurse practitioner to sign or mail the treatment plan may subject the attending physician or authorized nurse practitioner to sanctions under OAR 436-010-0340, but shall not affect payment to the ancillary medical service provider.

(c) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a chiropractor, naturopath, acupuncturist, or podiatrist will be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

(d) Unless otherwise provided for within utilization and treatment standards under an MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days,

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and 4 visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment or services. The attending physician or authorized nurse practitioner must document the need for medical services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

(5) The attending physician or authorized nurse practitioner, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, must complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner must notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker will be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090.

(7) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker or they are provided in accordance with a utilization and treatment standard adopted by the director. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(8) X-ray films must be of diagnostic quality and accompanied by a report. 14" x 36" lateral views are not reimbursable.

(9) Upon request of either the director or the insurer, original diagnostic studies, including but not limited to actual films, must be forwarded to the director, the insurer, or the insurer's designee, within 14 days of receipt of a written request.

(a) Diagnostic studies, including films must be returned to the medical provider within a reasonable time.

(b) The insurer must pay for a reasonable charge made by the provider for the costs of delivery of diagnostic studies, including films.

(c) If a medical provider does not forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

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(10) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the “nature of the injury or the process of recovery requires” the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(11) Physical restorative services may include but are not limited to a regular exercise program or swim therapy. Such services are not compensable unless the nature of the worker’s limitations requires specialized services to allow the worker a reasonable level of social and/or functional activity. The attending physician or authorized nurse practitioner must justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

(12) The cost of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury is a compensable medical expense, including when the worker received no physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eyeglasses.

(13) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(g) is always inappropriate for injured workers with the following conditions (absolute contraindications):

- (a) Metabolic bone disease – for example, osteoporosis;
- (b) Known spondyloarthropathy (seropositive and seronegative);
- (c) Posttraumatic vertebral body deformity at the level of the proposed surgery;
- (d) Malignancy of the spine;
- (e) Implant allergy to the materials involved in the artificial disc;
- (f) Pregnancy – currently;
- (g) Active infection, local or systemic;
- (h) Lumbar spondylolisthesis or lumbar spondylosis;
- (i) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or
- (j) Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

(14) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(g) may be inappropriate for injured workers with the following conditions, depending on severity, location, etc. (relative contraindications):

- (a) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS,

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lupus, etc.;

- (b) Arachnoiditis;
- (c) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);
- (d) Facet arthropathy – lumbar – moderate to severe, as shown radiographically;
- (e) Morbid obesity – BMI greater than 40;
- (f) Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;

radiographically;

- (g) Osteopenia – based on bone density test;
- (h) Prior lumbar fusion at a different level than the proposed artificial disc replacement;

or

- (i) Psychosocial disorders – diagnosed as significant to severe.

(15) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(h) is always inappropriate for injured workers with the following conditions (absolute contraindications):

(a) Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;

(b) Significantly abnormal facets;

(c) Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g. -2.7);

(d) Allergy to metal implant;

(e) Bone disorders (any disease that affects the density of the bone);

(f) Uncontrolled diabetes mellitus;

(g) Active infection, local or systemic;

(h) Active malignancy, primary or metastatic;

(i) Bridging osteophytes (severe degenerative disease);

(j) A loss of disc height greater than 75 percent relative to the normal disc above;

(k) Chronic indefinite corticosteroid use;

(l) Prior cervical fusion at two or more levels; or

(m) Artificial disc replacement at the level of a pseudo-arthritis.

(16) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(h) may be inappropriate for injured workers with the following conditions, depending on severity, location, etc. (relative contraindications):

(a) A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune

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disorders, AIDS, Lupus, etc.;

(b) Multilevel Degenerative Disc Disease – cervical – moderate to severe, as shown radiographically;

(c) Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;

(d) Prior cervical fusion at one level;

(e) A loss of disc height of 50 percent to 75 percent relative to the normal disc above;

or

(f) Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252

Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0275 Insurer's Duties under MCO Contracts

(1) Insurers who enter into an MCO contract in accordance with OAR 436-015, must notify the affected insured employers of the following:

(a) The names and addresses of the complete panel of MCO medical providers within the employer's geographical service area(s);

(b) The manner in which injured workers can receive compensable medical services within the MCO;

(c) The manner in which injured workers can receive compensable medical services by medical providers outside the MCO; and

(d) The geographical service area governed by the MCO.

(2) Insurers under contract with an MCO must notify all newly insured employers in accordance with section (1) of this rule, prior to or on the effective date of coverage.

(3) At least 30 days prior to any significant changes to an MCO contract affecting injured worker benefits, the insurer must notify in accordance with OAR 436-015-0035 all affected insured employers and injured workers of the manner in which injured workers will receive medical services.

(4) 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 service providers, and the MCO of enrollment. The notice must:

(a) ~~Notify~~ **Provide** the worker **a written list** of the eligible attending physicians within the relevant MCO geographic service area ~~and~~ **or provide a Web address to access the list of eligible attending physicians. If the notice includes only a Web address, then the notice must also:**

(A) Provide a telephone number the worker may call to ask for a written list; and

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(B) Tell the worker that he or she has seven days from the mailing date of the notice to request the list.

(b) Describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

~~(b)~~**(c)** Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;

~~(c)~~**(d)** Describe how the worker can receive compensable medical treatment from a primary care physician or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician or authorized nurse practitioner;

~~(d)~~**(e)** Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(6);

~~(e)~~**(f)** Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

~~(f)~~**(g)** Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and

~~(g)~~**(h)** Notify the MCO of any request by the worker for qualification of a primary care physician or authorized nurse practitioner.

(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance must inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever occurs first.

(6) Insurers enrolling a worker who is not yet medically stationary and is required to change medical providers, must notify the worker of the right to request review by the MCO if the worker believes the change would be medically detrimental.

(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician or authorized nurse practitioner, the insurer must notify the worker and medical service provider regarding provision of care under the MCO contract, including the provisions for continuity of care.

(8) An enrollment notice is complete:

(a) On the date the notice is mailed when the notice includes all required information and a written list of eligible attending physicians;

(b) On the date the notice is mailed when the notice includes all required

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information and a Web address to access the list of eligible attending physicians, and the worker does not request a written list within seven days; or

(c) On the date the written list is mailed when the insurer includes all required information and a Web address to access the list of eligible attending physicians, and the worker requests a written list within seven days of the notice.

~~(8)~~**(9)** When an insurer under contract with an MCO receives a dispute regarding a matter that is to be resolved through the MCO dispute resolution process and that dispute has not been simultaneously provided to the MCO, the insurer must within 14 days:

(a) Send a copy of the dispute to the MCO; or

(b) If the MCO does not have a dispute resolution process for that issue, the insurer must notify the parties in writing to seek administrative review before the director.

~~(9)~~**(10)** The insurer must also notify the MCO of:

(a) The name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, any changes in this information; and

(b) Any requests for medical services received from the worker or the worker's medical provider.

~~(10)~~**(11)** Insurers under contract with MCOs must maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

~~(11)~~**(12)** When the insurer is dis-enrolling a worker from an MCO, the insurer must simultaneously provide written notice of the dis-enrollment to the worker, the worker's representative, all medical service providers, and the MCO. The notice must be mailed no later than seven days prior to the date the worker is no longer subject to the contract. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer enrolled.

~~(12)~~**(13)** When a managed care contract expires or terminates without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO, that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days prior to the date of the contract's expiration or termination. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer subject.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist: Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

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