

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
 WORKERS' COMPENSATION DIVISION  
 MANAGED CARE ORGANIZATIONS

REVISION-MARKED COPY

[Bracketed 8-point text is deleted]; **bold/underlined text is added**

EFFECTIVE JUNE 29, 2004

OREGON ADMINISTRATIVE RULES  
 CHAPTER 436, DIVISION 015

NOTE: Only adopted, amended, and repealed rules are included in this document:

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EXHIBIT "A"

**436-015-0008**      **Administrative Review and Contested Cases**

(1) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, administrative review shall continue.

(2) Administrative review before the director: The process for administrative review of such matters shall be as follows:

(a) Any party that disagrees with an action taken by an MCO pursuant to these rules [shall] **must** first use the dispute resolution process of the MCO. **If the party does not appeal the MCO's decision, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision.**

(b) The aggrieved party shall file a written request for administrative review with the administrator of the Workers' Compensation Division within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process. If a party has been denied access to

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an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party may request administrative review within 60 days of the failure of the MCO to issue a decision. The request must specify the grounds upon which the action is contested.

(c) The director shall create a documentary record sufficient for judicial review. The director may require and allow the parties to submit such input and information appropriate to complete the review.

(d) The director shall review the relevant information and issue an order. The order shall specify that it will become final and not subject to further review unless a written request for hearing is filed with the administrator within 30 days of the mailing date of the order.

(3) Contested cases before the director: Any party that disagrees with an order pursuant to this rule may request a contested case hearing before the director as follows:

(a) The party shall file a written request for a contested case hearing with the administrator of the Workers' Compensation Division within 30 days of the mailing date of the order. The request shall specify the grounds upon which the order is contested.

(b) The hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(c) In the review of orders issued pursuant to ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be remanded to the MCO for further evidence taking, correction, or other necessary action if the director determines the record has been improperly, incompletely, or otherwise insufficiently developed.

(4) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) The party shall file a written request for a hearing with the administrator of the Workers' Compensation Division within 60 days after [service] **the mailing date** of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

(5) Hearings on the suspension or revocation of an MCO's certification:

(a) At a hearing on a notice of intent to suspend issued pursuant to OAR 436-015-0080(2), the MCO must show cause why it should be permitted to continue to provide services

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under these rules.

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings pursuant to OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director shall issue an order withdrawing the notice.

(B) The order must be served upon the MCO as provided in OAR 436-015-0130.

(C) If the MCO disagrees with the order, it may request a contested case hearing before the director by filing a written request with the administrator within 60 days of the date of service of the order.

(D) The contested case hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(b) A revocation issued pursuant to OAR 436-015-0080(5) shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for hearing with the administrator of the Workers' Compensation Division.

(A) If the MCO appeals, the administrator shall set a date for a hearing and shall give the MCO at least ten days notice of the time and place of the hearing. At hearing, the MCO shall show cause why it should be permitted to continue to provide services under these rules.

(B) Within thirty days after the hearing, the director shall issue an order affirming or withdrawing the revocation. The director shall serve a copy of the order upon the MCO as provided in OAR 436-015-0130.

(C) If the MCO disagrees with the order, it may request a contested case hearing before the director by filing a written request with the administrator within 60 days of the date of service of the order.

(D) The contested case hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(c) An emergency revocation issued pursuant to OAR 436-015-0080(7) is effective immediately. The MCO must file a request for contested case hearing within 60 days of the date of service of the order. The contested case hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

**Stat. Auth.:** ORS 183.310 thru 550 and ORS 656.726(4)

**Stats. Implemented:** ORS 656.260

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**436-015-0030     Applying for Certification**

(1) A health care provider or group of medical service providers applying for certification as an MCO must submit to the director, within 120 days of the filing of the Notice of Intent to Form, the following:

- (a) Four copies of an application which includes specific information indicating the manner in which the MCO will be able to meet the provisions of these rules;
- (b) The MCO certification of incorporation and a copy of the MCO by-laws;
- (c) A non-refundable fee of \$1,500 which will be deposited in the Department of Consumer and Business Services Fund; and
- (d) The approved MCO plan.

(2) The MCO shall provide a description of the initial GSA. The GSA shall be designated by a listing of the postal zip codes in the service area.

(3) The MCO plan shall provide a description of the times, places, and manner of providing services under the plan adequate to ensure that workers governed by the MCO shall be able to:

(a) Access an MCO provider panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;

(b) Receive initial treatment by **the worker's choice of** an attending physician **or authorized nurse practitioner** within 24 hours of the MCO's knowledge of the need or a request for treatment;

(c) Receive initial treatment by **the worker's choice of** an attending physician **or authorized nurse practitioner** in the MCO within 5 working days, subsequent to treatment by a physician outside the MCO;

(d) Receive treatment by an MCO physician in cases requiring emergency in-patient hospitalization;

(e) Receive information on a 24-hour basis regarding medical services available within the MCO which shall include the worker's right to receive emergency or urgent care, and the hours of regular MCO operation if assistance is needed to select an attending physician or answer other questions;

(f) Seek treatment from any category of medical service provider as defined in subsection (6)(a) of this rule and have a choice of at least 3 medical service providers within each category. The worker shall also have at least 3 choices, as needed, of ancillary service providers including, but not limited to, physical therapists and psychologists. Treatment by all medical service providers including attending physicians will be governed by the MCO treatment standards and protocols;

(g) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;

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(h) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographical service area. Such workers may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category and if they agree to the terms and conditions of the MCO;

(i) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker; and

(j) Receive specialized medical services the MCO is not otherwise able to provide. The application must include a description of the times, places, and manner of providing such specialized medical services.

(4) The MCO plan must provide a procedure which allows for workers to receive compensable medical treatment from a primary care physician **or authorized nurse practitioner** who is not a member of the MCO. The procedure must identify the criteria the MCO will use for approval or disapproval of such treatment, and provide written notice of the MCO physician qualification procedures to the worker.

(5) The MCO shall provide:

(a) Copies of contract agreement(s) or other documents signed by the MCO and each participating medical service provider/health care provider representative which verify membership; and

(b) A list of the names, addresses, and specialties of the individuals who will provide services under the managed care plan together with appropriate evidence of any licensing, registration or certification requirements for that individual to practice. This list shall indicate which medical service providers will act as attending physicians in each GSA within the MCO.

(6) The MCO plan shall provide:

(a) An adequate number of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractor, dentist, naturopath, optometrist, osteopath, physician, and podiatrist, as listed in ORS 676.110. The requirements of this section must be met unless the MCO shows evidence that the minimum number is not available within a GSA.

(b) **A process that allows workers to select a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010. If the MCO has fewer than three authorized nurse practitioners from which workers can choose within a GSA, the MCO must allow workers to seek treatment outside the MCO from authorized nurse practitioners, consistent with the MCO's treatment and utilization standards. Treatment must also be consistent with ORS 656.245(2)(b)(C), which limits the authorization of treatment of the worker by a nurse practitioner to 90 days and authorization of payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the initial claim. Such authorized nurse practitioners are not themselves bound by the MCO's treatment and utilization standards; however, workers are subject to those standards.**

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(c) A program which specifies the criteria for selection and de-selection of physicians and the process for peer review. The processes for terminating a physician and peer review shall provide for adequate notice and hearing rights for any physician.

(7) The MCO plan must provide adequate methods for monitoring and reviewing contract matters between its providers and the MCO to ensure appropriate treatment or to prevent inappropriate or excessive treatment including but not limited to:

(a) A program of peer review and utilization review to prevent inappropriate or excessive treatment including, but not limited to, the following:

(A) A pre-admission review program of elective admissions to the hospital and of elective surgeries.

(B) Individual case management programs, which identify ways to provide appropriate care for less money for cases which are likely to prove very costly, such as physical rehabilitation or psychiatric care.

(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, time loss of claimant, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile shall not be released to anyone outside the MCO without the physician's specific written consent except that the physician's profile shall be released to the director without the necessity of obtaining such consent.

(D) Concurrent review programs, which periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary.

(E) Retrospective review programs, which examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate.

(F) Second surgical opinion programs which allow workers to obtain the opinion of a second physician when elective surgery is recommended. Second surgical opinions must be required prior to repeat surgeries.

(b) A quality assurance program which includes, but is not limited to:

(A) A system for resolution and monitoring of problems and complaints which includes, but is not limited to, the problems and complaints of workers and medical service providers;

(B) Physician peer review which shall be conducted by a group designated by the MCO or the director and which must include, but is not limited to, members of the same healing art in which the physician practices;

(C) A standardized claimant medical recordkeeping system designed to facilitate entry of information into computerized databases for purposes of quality assurance.

(c) A program for monitoring and reviewing other contract matters that meets the requirements of ORS 656.260(4) and which are not covered under peer review, service utilization review, dispute resolution, and quality assurance.

(8) The MCO plan must include a procedure for internal dispute resolution to resolve complaints by enrolled injured workers, medical providers, and insurers in accordance with OAR

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436-015-0110. The internal dispute resolution procedure shall include a provision allowing the waiver of the time period to appeal a decision to the MCO upon a showing of good cause.

(9) The MCO plan shall 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 injured workers; and

(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program shall include:

(A) Identification of how the MCO will promote such services.

(B) A method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer.

(C) A method by which an MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001.

(D) A provision that all notifications to the insurer from the MCO shall be considered as a request to the insurer for services as detailed in OAR 437-001.

(E) A provision that the MCO shall maintain complete files of all notifications for a period of 3 years following the date that notification was given by the MCO.

(10) The MCO shall establish one place of business in this state where the organization administers the plan, keeps membership records and other records as required by OAR 436-015-0050.

(11) The MCO plan must include a procedure for timely and accurate reporting to the director necessary information regarding medical and health care service costs and utilization in accordance with OAR 436-015-0040 and OAR 436-010.

(12) The MCO shall designate an in-state communication liaison for the department and the insurers at the MCO's established in-state location. The responsibilities of the liaison shall include, but not be limited to:

(a) Coordinating and channeling all outgoing correspondence and medical bills;

(b) Unless otherwise provided by the MCO contract, providing centralized receipt and distribution of all reimbursements back to the MCO members and primary care physicians; and

(c) Serving as a member on the quality assurance committee.

(13) The MCO must provide satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.

(14) The MCO plan shall describe the reimbursement procedures for all services provided in accordance with the MCO plan. The members must comply with the following billing and report processing procedures:

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(a) Submit all bills in accordance with the MCO contract with the insurer.

(b) Submit all reports and related correspondence to the insurer's authorized claims processing location with copies to the MCO in-state communication liaison or as otherwise provided by the contract.

(15) The MCO plan shall provide a procedure within the MCO plan to provide financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(16) The MCO plan must describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers within the plan and how workers can access those providers.

(17) Within 45 days of receipt of all information required for certification, the director shall notify the applicant of the effective date of the certification and the initial geographical service area of the MCO. If the certification is denied, the applicant will be provided with the reason therefore.

(18) The application for certification for an MCO shall not be approved if the MCO fails to meet the requirements of these rules.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.260

**Hist:** Filed 6/19/90, as Admin. Order 5-1990, eff. 7/1/90 (Temporary)

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#### **436-015-0040 Reporting Requirements For an MCO**

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO shall provide the director with a copy of the entire text of any MCO/insurer contract agreement, signed by the insurer and the MCO, within 30 days of execution of such contracts. Amendments, addendums, and cancellations, together with the entire text of the underlying contracts, shall be submitted to the director within 30 days of execution.

**(2) Notwithstanding section (1), when an MCO/insurer contract agreement contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination, or workers will no longer be subject to the contract after it expires or terminates without renewal pursuant to ORS 656.245(4)(a).**

**(3)** Any amendment to the approved MCO plan must be submitted to the director for approval. The MCO shall not take any action based on the amendment until the amended plan is approved.

**(3)4** Within 45 days of the end of each calendar quarter, each MCO shall provide the following information, current on the last day of the quarter, in a form and format as prescribed by the director: specify quarter being reported, MCO certification number, membership listings

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by category of medical service provider (in coded form), including provider names, specialty (in coded form), Tax ID number, Oregon license number, business address and phone number. (All fields are required unless specifically excepted by bulletin.) When a medical provider has multiple offices, only one office location in each geographical service area needs to be reported. In addition, the updated membership listing shall include the names and addresses of all health care providers participating in the MCO.

([4]5) By April 30 of each year, each MCO shall provide the director with the following information for the previous calendar year:

- (a) A summary of any sanctions or punitive actions taken by the MCO against its members;
- (b) A summary of actions taken by the MCO's peer review committee; and
- (c) An affidavit that the approved MCO plan is consistent with the MCO's business practices, and that any amendments to the plan have been approved by the director.

**(6) 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.**

([5]7) 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.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.260

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**Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04**

**436-015-0050 Notice of Place of Business in State; Records MCO Must Keep in Oregon**

(1) Every MCO shall give the division notice of one in-state location and mailing address where the MCO keeps records of the following:

- (a) Updated membership listings of all MCO members;
- (b) Records of any sanctions or punitive actions taken by the MCO against its members;
- (c) Records of actions taken by the MCO's peer review committee;
- (d) Records of utilization reviews performed in accordance with the requirements of utilization and treatment standards pursuant to ORS 656.260 showing cases reviewed, the issues involved, and the action taken;
- (e) A profile analysis of each provider in the MCO listed by the International Classifications of Disease-9-Clinical Manifestations (ICD-9-CM) diagnosis;

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(f) A record of those enrolled injured workers receiving treatment by non-panel primary care physicians **or authorized nurse practitioners** authorized to treat pursuant to OAR 436-015-0070; and

(g) All other records as necessary to ensure compliance with the certification requirements in accordance with OAR 436-015-0030.

(2) Records retained as required by section (1) of this rule must be maintained at the authorized in-state location for 3 full calendar years.

(3) If the MCO/insurer contract is canceled for any reason, all MCO records, as identified in section (1), relating to treatment provided to workers within the MCO must be forwarded to the insurer upon request. The records included in subsections (1)(b), (c), (d), and (e) of this rule are confidential in accordance with ORS 656.260(6) through (10).

(4) Individual MCO providers must maintain claimant medical records as provided by OAR 436-010-0240.

(5) Nothing in this section is intended to otherwise limit the number of locations the MCO may maintain to carry out the provisions of these rules.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.260

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**Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04**

#### **436-015-0060 Commencement/Termination of Members**

(1) Prospective new members of an MCO shall submit an application to the MCO. The directors, executive director, or administrator may approve the application for membership pursuant to the membership requirements of the MCO. The MCO shall verify that each new member meets all licensing, registration, and certification requirements necessary to practice in Oregon. If the MCO requires a membership fee, the fee shall be the same for every category of medical service provider. An MCO may not require membership fees or other MCO administrative fees to be paid by primary care physicians **or authorized nurse practitioners** [as defined in **who provide services under** OAR 436-015-0070].

(2) Individual members may elect to terminate their participation in the MCO or be subject to cancellation by the MCO pursuant to the membership requirements of the MCO plan. Upon termination of a member, the MCO shall:

(a) Make alternate arrangements to provide continuing medical services for any affected injured workers under the plan.

(b) Replace any terminated member when necessary to maintain an adequate number of each category of medical service provider.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.260

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**436-015-0070 Primary Care Physicians and Authorized Nurse Practitioners Who Are Not MCO Members**

(1) The MCO shall authorize a **nurse practitioner or** physician who is not a member of the MCO to provide medical services to an enrolled worker if:

**(a) The nurse practitioner qualifies as an authorized nurse practitioner under ORS 656.245 and OAR 436-010-0005 or the physician qualifies as a primary care physician under ORS 656.260(4)(g);** [ For the purposes of this rule, the physician must:

(a) Qualify in accordance with ORS 656.005(12) as an attending physician and must be a general practitioner, a family practitioner, or an internal medicine specialist;

(b) Maintain the worker's medical records;

(c) Have a documented history of treatment of that worker;

(d) **(b) The nurse practitioner or physician** [A] agrees to comply with all terms and conditions regarding services governed by the MCO. For purposes of this section, the phrase "all terms and conditions regarding services governed by the MCO" means MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services in accordance with OAR 436-015-0090. **However, the MCO's terms and conditions may not place limits on the length of services unless such limits are stated in ORS chapter 656;** and

[e] **(c) The nurse practitioner or physician** [A] agrees to refer the worker to the MCO for specialized care, including physical therapy, to be furnished by another provider that the worker may require.

(2) The MCO cannot deny authorization of a primary care physician **or authorized nurse practitioner** based on past practices.

(3) The primary care physician **or authorized nurse practitioner** who is not a member of the MCO will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's **or nurse practitioner's** medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if an injured worker has selected a primary care physician **or authorized nurse practitioner** through a private health plan, prior to the date of injury, the requirements of subsections (1)(b) and (c) shall be deemed to be met.

(4) Notwithstanding section (1), for those workers receiving their medical services from a facility which maintains a single medical record on the worker, but provides treatment by multiple primary care physicians **or authorized nurse practitioners** who are not MCO members, the requirements of sections (1) and (3) will be deemed to be met. In this situation, the worker shall select one physician **or authorized nurse practitioner** to treat the compensable injury as the primary care physician **or authorized nurse practitioner**.

(5) Any questions or disputes relating to the worker's selection of a primary care

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physician or authorized nurse practitioner who is not an MCO member shall be resolved pursuant to OAR 436-015-0110.

(6) Any disputes relating to a worker's non-MCO primary care physician's, non-MCO authorized nurse practitioner's, or other non-MCO physician's compliance with MCO standards and protocols shall be resolved pursuant to OAR 436-015-0110.

**Stat. Auth.:** ORS 656.726(4)  
**Stats. Implemented:** ORS 656.260  
**Hist:** Filed 6/19/90, as Admin. Order 5-1990, eff. 7/1/90 (Temporary)  
 Amended 12/12/90, as Admin. Order 31-1990, eff. 12/26/90  
 Amended 1/10/92, as Admin. Order 4-1992, eff. 2/1/92  
 Amended 12/20/94, as Admin. Order 94-062, eff. 2/1/95  
 Amended 5/3/96, as Admin. Order 96-061, eff. 6/1/96  
 Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99  
 Amended 2/25/02 as WCD Admin. Order 02-053, eff. 4/1/02  
 Amended 12/12/03 as WCD Admin. Order 03-070, eff. 1/1/04 (Temporary)  
Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04

#### **436-015-0090 Charges and Fees**

(1) Billings for medical services under an MCO shall be submitted in the form and format as prescribed in OAR 436-009. The payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to OAR 436-009.

(2) Notwithstanding section (1) of this rule, fees paid for medical services provided by primary care physicians who qualify under ORS 656.260(4)(g) or authorized nurse practitioners who qualify under ORS 656.245(6)[are not MCO members] shall not be less than fees paid to MCO providers for similar medical services. Fees paid to medical providers who are not under contract with the MCO, shall be subject to the provisions of OAR 436-009.

**Stat. Auth.:** ORS 656.726(4)  
**Stats. Implemented:** ORS 656.245 and 260  
**Hist:** Filed 6/19/90, as Admin. Order 5-1990, eff. 7/1/90 (Temporary)  
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 Amended 5/3/96, as Admin. Order 96-061, eff. 6/1/96  
 Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99  
 Amended 12/12/03 as WCD Admin. Order 03-070, eff. 1/1/04 (Temporary)  
Amended 6/14/04, as Admin. Order 04-059, eff. 6/29/04

#### **[436-015-0130 Service of Orders]**

[(1) When the director suspends or revokes certification of an MCO pursuant to OAR 436-015-0080, or imposes a sanction or assesses a civil penalty under the provisions of OAR 436-015-0120, the order, including a notice of the party's appeal rights, shall be served upon the party.

(2) The director shall serve the order by delivering a copy to the party in the manner provided by Oregon Rules of Civil Procedure 7D(3), or by sending a copy to the party by certified mail with return receipt requested.]

**Stat. Auth.:** ORS 656.726(4)  
**Stats. Implemented:** ORS 656.260  
**Hist:** Filed 6/19/90, as Admin. Order 5-1990, eff. 7/1/90 (Temporary)  
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 Amended 5/3/96, as Admin. Order 96-061, eff. 6/1/96  
 Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99  
Repealed 6/14/04, as Admin. Order 04-059, eff. 6/29/04