

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
OREGON ADMINISTRATIVE RULES**

CHAPTER 436, DIVISION 015

MANAGED CARE ORGANIZATIONS

PROPOSED

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BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of)	
436-010, Medical Services)	
436-015, Managed Care Organizations)	
436-030, Claim Closure and Reconsideration)	
436-035, Disability Rating Standards)	
436-050, Employer/Insurer Coverage Responsibility)	SUMMARY OF TESTIMONY AND AGENCY RESPONSES
436-055, Claims Examiner Certification)	
436-060, Claims Administration)	
436-105, Employer-at-Injury Program)	
436-110, Preferred Worker Program)	
436-120, Vocational Assistance to Injured Workers)	
436-160, Electronic Data Interchange)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to provide the Director with a record of the agency conclusions about the major issues raised.

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated October 1, 2005. On November 1, 2005, a public rulemaking hearing was held as announced at 10:30 a.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through November 7, 2005.

Six people testified at the public rulemaking hearing. The transcript of the hearing is marked as Exhibit 15 (“A” through “F”). In addition, fourteen written documents were submitted as testimony.

Testimony list:

Exhibit	Rule divisions	Testifying	Representing
1	060	Carmen Jones	Legacy Health System
2	010	Medical Advisory Committee	Medical Advisory Committee
3	060	Robert Hamre	DCBS Workers’ Compensation Division
4	010, 055, 060	George Goodman	Independent Medical Examination Association

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5	010	Scott Gallant	Oregon Medical Association
6	010	David Silver, M.D.	David J. Silver, M.D., P.C.
7	010, 015	Victor Breen & Sandra Cardelli	Kaiser on the Job
8	010	M. Joshua Haber, M.D.	
9	010, 030, 060	Linda Barno	Oregon Self-Insurers Association
10	010	John Di Paola, M.D.	Occupational Orthopedics
11	010, 030, 055, 060, 110	Nicole Schneider	Liberty Northwest Insurance
12	015	Ramona St. George	Oregon Health Systems, Inc.
13	010, 030, 035, 055, 060, 105, 110, 120	Chris Davie	SAIF Corporation
14	010	Laurel Gunderson	Providence MCO
15-A	060	Wendy Stone	DCBS Workers' Compensation Division
15-B	010, 055, 060	George Goodman	Independent Medical Examination Association
15-C	010	Scott Gallant	Oregon Medical Association
15-D	010, 015	Victor Breen	Kaiser on the Job
15-E	010	Vance Day	Attorney at Law
15-F	010	Nyla Jebousek	Law Offices of Nyla L. Jebousek, P.C.

Testimony: OAR 436-010

Exhibit #5 & 15-C

The Oregon Medical Association (OMA), representing both attending physicians and physicians who perform Independent Medical Examinations (IME), is concerned about the proposed rule changes to OAR Chapter 436. The OMA understands that these changes are a result of Senate Bill 311 that was originally designed to address the perceived bias towards insurers from IME physicians (*see Workers' Compensation Insurer Medical Examination Study, December 2004*). As a vehicle for implementing recommendations of the Management Labor Advisory Committee (MLAC) regarding IME examinations, SB 311 generated a great deal of discussion and debate. With full knowledge and understanding of the issues, the Legislative Assembly refrained from including many of MLAC's recommendations. It is apparent from the proposed rules that the Division has elected to go forward with several provisions that were considered by the legislature and deliberately excluded from SB 311.

On a going forward basis, the OMA would like to be an active participant in the development of the criteria for the IME Physician List. As noted during the legislative session, OMA members

remain concerned that the Division may propose rules regarding the ethical and professional standards applicable to physicians without their knowledge. It is the OMA's position that such matters are already addressed in state law and administrative rules and effectively enforced by the Board of Medical Examiners and were thoroughly debated during the SB 311 hearings.

While it may be appropriate to impose rules regarding ethical and appropriate conduct by claims examiners, such rules should not be extended to cover IME physicians nor used as a basis for the criteria by which the list of qualified IME physicians is developed. Notwithstanding the above, we look forward to assisting in the development of appropriate rules to implement the IME Physician List.

Response: Administrative rules must remain within the boundaries of the laws created by the Oregon Legislature, but almost always include procedural requirements necessary for the implementation of those laws. In effect, the legislature often paints with a broad brush and expects state agencies to do the detail work through public rule-making.

Senate Bill 311, SECTION 5, requires the director to adopt rules:

(3) The director, **in consultation with the advisory committee on medical care** of the Workers' Compensation Division of the Department of Consumer and Business Services, **the Workers' Compensation Management-Labor Advisory Committee and affected interest groups shall develop, and the director shall adopt by rule:** (Emphasis added)

(a) Professional licensing training requirements and educational materials for physicians participating in the workers' compensation system and conducting independent medical examinations required under ORS 656.325 (1); and

(b) A process for investigating and reviewing complaints about independent medical examinations conducted under the requirements of ORS 656.325 (1) that includes, but is not limited to, standards for referring complaints to the appropriate health professional regulatory board and an appeals process for a physician who disagrees with an action taken by the director under subsection (2) of this section.

The Management Labor Advisory Committee (MLAC) recommended a number of specific actions to implement SB 311, and most of these are included in the proposed rules. Upon request, we can provide "RECOMMENDATIONS | Management-Labor Agreements Approved through MLAC, 2/24/05." This set of recommendations distinguishes between regulations that should be implemented through statute and those appropriate for rule-making. Given the legislative direction in SECTION 5 of SB 311, we believe the director has the obligation to consider MLAC's recommendations and the authority to propose related rule changes.

The agency acknowledges the OMA's concerns that the Workers' Compensation Division may propose rules regarding the ethical and professional standards applicable to physicians and do so without their knowledge. The proposed rules do not address ethical and professional standards. The division will contact the OMA to invite participation on 2006 rule-making advisory committees to discuss final implementation of SB 311.

Testimony: OAR 436-010-0008(12)(a)(B)

Exhibit #13

The statement of hours spent by the attorney on the issue before the director should also be limited to the issue “on which the worker prevailed”.

Response: OAR 436-010-0008, section (12) already limits attorney fees to issues on which the worker prevails: “In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director will award an attorney fee * * *” Subsection (a) and paragraph (B) are subject to the limitation of section (12). We believe this amendment is not necessary and could lead to an expectation to restate other requirements in subordinate paragraphs.

Testimony: OAR 436-010-0230, 0265, 0340

Exhibit #5 & 15-C

Sanctions against physicians who fail to provide diagnostic records within 14 days: **The OMA understands that the goal of the proposed rule change is to ensure that IME physicians receive diagnostic studies in advance of the scheduled Independent Medical Examination. However, the penalty associated with failing to provide such records rests solely with "medical service providers," which are defined as persons duly licensed to practice one more of the healing arts and does not include hospitals, imaging centers or clinics. However, the practical reality is that in many cases the original diagnostic records are retained by the hospital, imaging center or clinic, and the attending physician/medical service provider is given only a summary report.**

Because of these circumstances, we suggest that, since the attending physician has control of only the records in his possession, the rule to ensure that IME physicians receive all diagnostic records in a timely fashion apply to those medical providers who directly possess such records.

Accordingly, the OMA requests that the language under OAR 436-010-0265 and OAR 436-010-0340 be revised to apply to "medical providers," defined as medical service providers, hospitals, medical clinics or vendors of medical services. Further, the rules should clarify that medical providers are only obligated to furnish diagnostic records in their possession at the time of the request and are not required to seek such records from another medical provider in order to comply with the IME physician's request.

Given that sanctions may be imposed for violating the reporting requirements, clarification is also warranted regarding the process by which a medical provider will be notified of the request for diagnostic records. For example, the rules should specify not only that request be made in writing, but also that payment is required prior to the release of records.

Response: This testimony makes three points:

1) The rules should refer to “medical providers” rather than “medical service providers.”

We agree. Due to an oversight, permanent rules were filed without the recommended change. The Workers’ Compensation Division will change the wording as recommended when OAR 436-010 is amended in 2006.

2) The rules should clarify that penalties are not applicable if the records are not in the possession of the medical provider at the time of the request.

We agree with the concept, but we believe the change is unnecessary. If the Workers' Compensation Division is asked to impose a penalty on a medical provider for non-provision or late provision of diagnostic records, and determines that the provider did not possess those records, the division will not apply the penalty.

3) The rules should specify not only that request be made in writing, but also that payment is required prior to the release of records.

We believe that requiring all such records requests to be in writing would be overly prescriptive. If two medical offices elect to communicate by telephone, a rule requiring written requests would merely increase administrative costs and slow the transfer of records.

OAR 436-009-0010(8) requires that services be provided prior to payment. Requiring pre-payment would substantially delay records transfers in many cases.

Testimony: OAR 436-010-0230(6)

Exhibit #10

I propose that OAR 436-010-0230(6) contains a provision which is contradictory to the rest of the rule and is counter to the generally accepted practice patterns of physicians in the State of Oregon (and the United States). The following statement should be removed from the OAR:

“Except in an emergency, drugs and medicines for oral consumption supplied by a physicians’ or authorized nurse practitioners’ office are compensable only for the initial supply to treat the worker with the medication up to a maximum of ten (10) days, subject to the provisions of this rule and OAR 436-009-0090.”

See additional information in the Appendix, “Exhibit #10 Supporting documents”

Response: We believe this testimony deserves further consideration. Because we did not propose an amendment to this rule section, we cannot modify the 10-day limitation at this time. During the scheduled revision of OAR 436-010 in 2006, the Workers’ Compensation Division will take this issue to a rule-making advisory committee.

Testimony: OAR 436-010-0230(9) & 0240(10)

Exhibit #9

OSIA recommends that the number of days to comply with the two above noted requirements [these rule/sections] be reduced to **7 calendar days**. To ensure that requested medical records and diagnostic studies are available in a timely manner, we believe that the medical provider should be required to provide requested studies within **7 calendar days** of their receipt of a written request by the director or insurer. Due to the time constraints on making timely payments of temporary disability benefits, scheduling independent medical examinations and making compensability determinations, it is critical that these requests be given priority by the medical provider’s office and we believe that a **7 calendar day** turnaround is appropriate.

Response: We agree that timely delivery of diagnostic records is very important in the performance of an effective independent medical examination. However, we have consistently allowed 14 days for the provision of medical records, and those records are critical for many decisions affecting claim compensability and workers’ eligibility for benefits. A seven-day

requirement would be burdensome for some medical providers and probably force more into a non-compliance/penalty situation. The Workers' Compensation Division intends to keep the 14-day requirement in place. We encourage parties who need records more quickly than that to work together to expedite delivery.

Testimony: OAR 436-0230(9) & 0240(10)

Exhibit #13

The existing rule allows physicians 14 days to provide diagnostic studies to IME doctors. However, IMEs can be scheduled at 10 days notice. As a goal of IME reform was to ensure the IME doctor has access to relevant information, this rule should be changed to require that diagnostic information is sent within seven days.

Response: See the response to this recommendation on Page 5.

Testimony: OAR 436-010-0230(9)

Exhibit #4 & 15-B

Suggest: *deletion* of “14 days” and **insertion** of “7 calendar days”

Rationale: The goal is to get the diagnostic studies to the IME doctor before the IME date. Existing rules require that workers be given at least 10 days notice of an IME. If the holder of the diagnostic study has 14 days to provide the study, there will inevitably be cases where even though the studies were provided “timely”, they were not received until after the IME date. Changing the timeline to 7 days negates this incongruity.

Response: See the response to this recommendation on Page 5.

Testimony: OAR 436-010-0240(10)

Exhibit #4 & 15-B

Suggest: *deletion* of “14 days” and **insertion** of “7 calendar days”

Rationale: The goal is to get the diagnostic studies to the IME doctor before the IME date. Existing rules require that workers be given at least 10 days notice of an IME. If the holder of the diagnostic study has 14 days to provide the study, there will inevitably be cases where even though the studies were provided “timely”, they were not received until after the IME date. Changing the timeline to 7 days negates this incongruity.

Response: See the response to this recommendation on Page 5.

Testimony: OAR 436-010-0240(14)

Exhibit #13

The proposed rule requires the attending physician to “timely” send a written report, without defining “timely”. As the worker’s time loss compensation is not payable without the report, physicians should be required to submit the report within three business days.

Response: We agree that “timely” should be replaced with a specific time frame. However, we will allow 14 days, as the type of report required may be fairly complex.

Testimony: OAR 436-010-0250

Exhibit #7

We do not have many situations where we cannot resolve disagreement with the insurer about whether a proposed surgery is medically necessary. However, in the event that we do, we are concerned that this rule stops us from allowing a surgery to proceed under Kaiser Health Plan if denied by a WC insurer.

Response: The Workers' Compensation Division proposed only procedural changes to this rule, so coverage of surgery under private health plans should not be affected by the amendments.

Testimony: OAR 436-010-0250(2)

Exhibit #11

This rule was changed to state a notice of elective surgery can be "given in a clear chart note." The intent was to clarify that a chart note can suffice as notification of surgery.

Comments: The proposed wording is confusing. We request the proposed language be removed and the following statement added to the end of paragraph (2) "A chart note will be considered "notice" of the proposed surgery if it includes this information."

Response: We agree that clarification is appropriate and have used wording similar to the recommended wording.

Testimony: OAR 436-010-0250(2)

Exhibit #13

The proposed rule states that a notice of elective surgery may be given "in a clear chart note". This is not defined. Is it intended to be clear handwriting or clearly expressed? We recommend clarification that if the request is included in a chart note, it must show clear intent that the physician is requesting approval to perform elective surgery for an accepted condition.

Response: We agree that clarification is appropriate and have replaced "in a clear chart note" with the statement at the end of section (2): "A chart note is considered "notice" if the information required by this section is included in the note."

Testimony: OAR 436-010-0250(2)

Exhibit #9

436-010-0250(2) "Notice" may be given in a clear chart note.

OSIA recommends the following modification to the above provision to provide clarity: **A chart note will be considered "notice" of the proposed surgery if it includes this information.**

Another option would be to simply delete this statement, period. Doctors must be required to present their notices in a clear and concise manner to ensure insurers/self-insurers have the opportunity to respond in accordance with these rules.

Response: We agree that clarification is appropriate and have replaced "in a clear chart note" with the statement at the end of section (2): "A chart note is considered "notice" if the

information required by this section is included in the note.”

Testimony: OAR 436-010-0250(3)(b)

Exhibits #11

(3)(b) states “if the form (elective surgery notification) is not completed **or insurer approval is not communicated to the physician**, the physician is not required to respond.

Comments: We are in agreement with the proposed change to this rule; however, the proposed language in this rule raised some questions. What is meant by the statement, “the physician is not required to respond”? When is the physician required to respond and to what? We request the division review this language and clarify its intent.

Response: “Respond” in subsection (b) refers to the notification required under OAR 436-010-0250(4)(c): “When the recommending physician determines that agreement cannot be reached and that further attempts to resolve the matter would be futile, the recommending physician must notify the insurer, the worker and the worker’s representative of such by signing Form 440-3228 or providing other written notification.” The Workers’ Compensation Division will leave the proposed wording in place for now, but will consider amending the rule if this or other aspects of the rule give rise to errors or disagreements.

Testimony: OAR 436-010-0250(7)

Exhibits #13

If the physician performs elective surgery without notifying the insurer, the rule should allow non-payment of the surgery bill, in addition to other sanctions at the discretion of the director.

Response: The insurer may dispute any treatment (including elective surgery) it believes is excessive, inappropriate, ineffectual, or in violation of the medical rules by requesting review of the treatment by the director. ORS 656.327(1)(c) states: “The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section.” Non-payment of the bill without review by the director would violate ORS 656.327. We believe the rule currently provides a remedy consistent with ORS 656.327.

Testimony: OAR 436-010-0265(1)

Exhibit #9

436-010-0265(1) For the purposes of this rule, ***independent*** medical examination (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5).....

OSIA strongly recommends that you delete from this paragraph “physical capacity or work capacity evaluation or consultation.”

ORS 436-010-0005(34) defines “Physical Capacity Evaluation” or “PCE” as an objective, directly observed, measurement of a worker’s ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator.....

ORS 436-010-0005(40) defines “Work Capacity Evaluation” or “WCE” as meaning a PCE

with special emphasis on the ability to perform a variety of vocationally oriented tasks based on special job demands.

There does not appear to be a reference to physical capacity or work capacity evaluation in the statute, definitely not in ORS 656.325. We see no correlation between these evaluations and an independent medical examination, and do not believe it is appropriate to reference these two distinct types of evaluations/examinations as the same or similar. For example, an IME is primarily used in determining the relationship of a worker's diagnosed condition to the claimed injury/disease. PCE and WCE are done to evaluate return to work options. While these evaluations are primarily scheduled by the claims professional, it is rarely if ever done without the approval and support of the worker's attending physician.

Response: ORS chapter 656 does not list or limit the purposes for an independent medical examination (IME). An administrative rule cannot limit the scope of a statute, and we believe there is no clear statutory basis for the director to define physical capacity evaluations (PCE) and work capacity evaluations (WCE) as other than IMEs. Both types of examinations are performed at the request of the insurer or self-insured employer. Deletion of references to PCEs and WCEs from OAR 436-010-0265(1) would have no effect - these evaluations are IMEs unless otherwise defined by statute.

Under OAR 436-010-0265(5)(a), the attending physician or authorized nurse practitioner could request a PCE or WCE, and such evaluation would not count against the limit of three IMEs.

Testimony: OAR 436-010-0265(5)

Exhibit #4 & 15-B

Suggest: deletion of "insurer" and insertion of "independent"

Rationale: SB 311 changes the statutory language from "insurer" medical examinations to "independent" medical examinations.

Response: This was an oversight - we have amended the wording consistent with the testimony.

Testimony: OAR 436-010-0265(8)

Exhibit #7 and 15-D

We agree that timely provision of medical records to the IME physicians is important. Like the injured worker, medical providers are not a part of the appointment process. If in fact a study for example an MRI, is said not to have arrived at the IME office, how does the state know where the mishap has occurred.

Examples of points in the chain that may break down are;

- Untimely notice of IME by insurer

- Original films out to another medical provider

- Lost in IME office

- Lost in transit

- Rescheduling of IME providers.

- Each case would need to be investigated rather than a standard rigid application of the

rules. I would think the dollars spent by the state investigating, would far exceed the dollars collected through fines.

We can't imagine how the state can police this issue effectively, and would rather see a cooperative response to problem solving, rather than a punitive approach.

Response: We much prefer that medical providers and other custodians of medical records work together to expedite the transfer of diagnostic records. The \$100 civil penalty is just a potential remedy if communication and cooperation break down. It is important for the regulator to retain the penalty option.

Testimony: OAR 436-010-0265(8)

Exhibit #4 & 15-B

Suggest: *deletion* of “*may be assessed a penalty*” and **insertion** of the words “**shall be sanctioned**”

Note: In addition, the definition of “medical service provider” (OAR 436-010-0005(28)) should be amended to include urgent care clinics and other medical facilities to comply with the spirit and intent of SB 311 (2005). Alternatively, the phrase, “medical provider” instead of “medical service provider” should be inserted into the rule. “Medical provider” as defined in OAR 436-010-0005(29) encompasses all affected parties.

Rationale: To be a real deterrent against non-compliance, this rule needs to be self-actuating; meaning those who are not providing diagnostic studies in a timely fashion will automatically be sanctioned.

Response: We agree that the rules should refer to “medical providers” rather than “medical service providers.” Due to an oversight, permanent rules were filed without the recommended change. The Workers’ Compensation Division will change the wording when OAR 436-010 is amended in 2006.

In almost all cases, the parties involved will find a way to send and receive the diagnostic records that provide for an effective medical examination. Other testimony points out that records may not be provided timely because they are not in the possession of the recipient of the request. The Workers’ Compensation Division investigates the facts of each case and will retain its discretion not to apply the penalty.

Testimony: OAR 436-010-0265(8)

Exhibits #8

Regarding “date deadlines”, I think that this should be based on “business days”, not calendar days. The “starting date” for the initiation of counting the days should be the date when the request is received by the medical provider’s office or clinic, not the “date written” for the letter of request produced per the requester (insurance or other entity). Too often, multiple days have passed between the date on the letter that requests an action (provide documents, clinic notes, a physician’s review and written or dictated report), and the date the correspondence is received at the medical provider’s clinic or office. Especially if a written report is needed to clarify a practitioner’s opinion, there needs to be an understanding for needed time allotment required for scheduling practitioner’s time for review of materials and dictation (review notes or IME, dictating, review of dictation), as well as turn around time for dictation. Often the practitioner’s

response becomes the premise for further activity, clinical or legal, regarding important case management. If penalties apply to timeliness, fairness should apply to the guidelines for the timeline parameters. Timeline should be structured in such a way that a delay in mail handling (per insurance, legal entities, post office, other) should not lead to practitioners being penalized or having to hastily prepare a report.

Additionally, a provision should be made of some type, in case a practitioner is away from their office or clinic on leave (vacation, illness, CME, etc.)

Response: The workers' compensation rules consistently use a 14-day time frame for provision of medical records. We are rarely asked to apply penalties because records are provided late. The parties usually resolve any issues that stand in the way of the records transfer. The \$100 civil penalty is just a potential remedy if communication and cooperation break down. The Workers' Compensation Division investigates the facts of each case and will retain its discretion not to apply the penalty if the facts do not support a penalty.

Testimony: OAR 436-010-0265(9)

Exhibit #4 & 15-B

Suggest: *deletion of subsection (9)* and insertion of the words **“A worker can object to the location of an IME within 6 business days of the mailing date of the appointment letter. The objection shall be submitted to the Director and shall request that:”**

Suggest: renumbering of (a) – (d) by moving proposed (d) to proposed (a)'s position (*Note: IMEA does not propose deletion of any of the content proposed within (a) – (d))

Suggest: WCD should develop essential uniform elements of information that must be contained in an objection and identify who may object (IMEA suggests an injured worker, treating physician or legal representative be empowered to object).

Rationale: The Notice to the worker needs to be as simple and straightforward as possible. Workers who do not fit into the “medically contra-indicated or other good cause” concept should not be misled into thinking it is worthwhile to submit an objection.

Response: The Workers' Compensation Division considered the recommended wording. We retained original proposed wording of section (9), but rearranged the subsections. We are concerned that insertion of: “The objection shall be submitted to the Director and shall request that:” implies a requirement for a formal, written request. Given the six business day limit, regular mail will seldom be a reliable way for the worker to request a review. With that in mind, we moved subsection (b) to the position of (a) “The request may be made in-person, by telephone, facsimile, or mail.”

We do not wish to mislead workers into filing objections, nor do we want to suggest there is a threshold for review. Revised ORS 656.325(1)(c) requires the director to adopt rules that provide a worker the opportunity to request review of the reasonableness of the location. The director then determines if there is substantial evidence for the objection.

Regarding provisions for parties other than the injured worker to object to the location of an IME, we find no statutory direction to do so. Administrative rulemaking to create a multi-party objection process might therefore exceed the director's authority.

With the described amendments, we believe the proposed wording is consistent with revised ORS 656.325.

Testimony: OAR 436-010-0265(9)

Exhibit #13

The rule should require the worker to first contact the insurer if the worker objects to the location of an IME. Very often, the insurer is able to address the worker's concern without invoking an appeal procedure.

Response: We encourage communication between the worker and the insurer. However, revised ORS 656.325(1)(c) requires the director to adopt rules that provide a worker the opportunity to request review by the director of the reasonableness of the location. We do not find a clear statutory basis for requiring a worker to contact the insurer before contacting the director and believe that doing so by administrative rule might exceed the director's authority.

Based on our experience during January 2006, the process appears to be working well. Of the ten location objections received by the Workers' Compensation Division, seven have been resolved to the satisfaction of the parties without the division having to issue an order. The division has issued one order and the two remaining cases are pending.

Testimony: OAR 436-010-0265(9)

Exhibit #15-E

I think that claimants' attorneys and, of course, their injured workers, would encourage you and other members who will be making these decisions to understand once again the context for IME scheduling and the purpose behind IME's. Number one, when you have an injured worker who, whether they're at work or off work, they're not consulted regarding the timing and scheduling of IME's. They're just sent a letter. They're not called up. Nobody spends any time to check their schedule, and yet they're only given six days under section (9) of 436-010-0265. I would suggest that (9) be expanded to say ten business days of the mailing date of the appointment notice, and then, therefore, working back, of course, to the appointment notice, adding time to that, as well.

The purpose of this is pretty obvious. If there is substantial evidence, as required by (d) of (9), that the travel is medically contraindicated, it takes time for an injured worker to develop that. If, out of the blue, they receive a letter that says, you know, you have to travel from Glide, Oregon, to OHSU, and it takes time for you to get in to see your doctor to say, you know, you told me not to ride in a car for more than a couple hours. Is this too far? Six business days makes it difficult for an injured worker to do that and for an attending physician to make comment on that.

Response: We agree that six business days will probably be insufficient in some situations. However, this is the time allowed by revised ORS 656.325(1)(g).

We do not expect workers to spend time gathering evidence before contacting the director. With that in mind, we moved subsection (b) to the position of (a) "The request may be made in-person, by telephone, facsimile, or mail." The director will then determine if there is substantial evidence for the objection.

Testimony: OAR 436-010-0265(9)(b)

Exhibit #15-F

Under this Administrative Rule, it says that if a worker is unable to attend the IME, they need to respond in person, by telephone, facsimile, or mail. I would suggest that perhaps a toll-free number would be a reasonable accommodation for workers who probably aren't going to be coming in person. Lots of them won't have a facsimile machine. Mail could be tremendously slow, and they might not meet their time line. And some of them may not have long distance or the ability to make a phone call like that. I think we in the business world assume that workers have those kinds of resources. But for folks who have denied claims and no income, that could be a significant hardship for them. Maybe they don't have transportation to get to some other location where they can use those facilities. So, it just seems like that would be an accommodation that might help everyone if that was available.

I also second everything that Mr. Day had to say.

Response: We agree with the testimony. Under OAR 436-060-0095(5), the IME appointment letter must contain the following wording: **“If you object to the location of this appointment you must contact the Workers’ Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice.”**

Testimony: OAR 436-010-0265(9)(d)(A)

Exhibit #4 & 15-B

Suggest: *Deletion of the subsection (9) (A)* and **insertion** of the words **“For purposes of this rule, the “medically contraindicated” standard is met if the Director finds there is persuasive medical evidence indicating that the travel required to attend the IME would be detrimental to the health of the worker by creating a present risk of injury, or a present risk of an objective worsening of a medical condition, and that alternative means of travel will not overcome the limitation.”**

Rationale: The underlying goal endorsed by MLAC was to encourage workers to attend IME’s unless such attendance would be harmful to their health, or there was a non-health related compelling need to re-schedule. To further that goal insofar as the health prong is concerned, objectivity, not subjectivity, is needed. Doctor’s need to understand that an opinion opposing the travel must be based on objective medical factors, not an accommodation to the subjective view of the worker. The phrase “present risk of injury” or “present risk of worsening...” is being proposed because that is the language used in the “fitness for duty” exam OAR’s promulgated pursuant to Chapter 659. Many IME and attending doctors are therefore already familiar with providing opinions pursuant to that standard.

Response: We believe that the overwhelming majority of attending physicians and nurse practitioners do not order travel restrictions as an accommodation to the subjective views of their patients. We also believe the originally proposed definition of “medically contraindicated” provides an objective and sufficient standard.

Testimony: OAR 436-010-0265(9)(d)(B)

Exhibit #13

“Good cause” should be defined more clearly. We suggest that “good cause” should always include a reason that predates receipt of the appointment letter, and is beyond the control of the worker.

Response: We find no statutory basis to require good-cause reasons to predate receipt of the appointment letter. The only limit is the six-business-day limit to bring the objection to the director under ORS 656.325(1)(g). We believe the originally proposed definition of “good cause” is sufficient for the director to determine if travel is unreasonable.

Testimony: OAR 436-010-0265(10)

Exhibit #4 & 15-B

Suggest: deletion of the subsection(10) and **insertion** of the words “If a worker fails to attend an IME and has not complied with OAR 436-060-0095-5(i) and OAR 436-060-135(5), the Director shall impose sanctions against the worker for such failure pursuant to OAR 436-010-0340.”

Rationale: Again, the goal is to provide an incentive for attendance, not an invitation for an after-the fact debate on what was reasonable. A self-actuating sanction rule is really the only effective way to achieve this.

Response: The Workers’ Compensation Division will conduct an investigation before applying the penalty, in order to determine if the conditions in ORS 656.325(1)(c)(B) have been met, i.e., that the worker failed to attend the IME without prior notification or without justification. We believe the originally proposed wording is sufficient for the director to carry out her statutory duties, and will not give rise to more disputes than the recommended language.

Testimony: OAR 436-010-0265(13)

Exhibit #13

The rule should be reworded to say that the physician must actually be on the WCD list.

Response: We agree and will make the recommended change.

Testimony: OAR 436-010-0265(13)

Exhibit #15-E

Regarding the list of IME doctors to be developed by the director, I suggest that we try to look at the IME physicians as real doctors. What I mean is that they are involved in actually treating people, so we don't end up with a list of certified IME physicians that meet the director's criteria, who perform only “independent medical examinations.” The evolution of legislation on IMEs was furthered by a study and report that found that IME physicians appear to be biased. The Legislature took action. I would suggest that physicians who wish to be part of the IME workers’ compensation list maintain a private practice at least 50 percent of the time. So if they're doing IME's 20 hours a week, they should be practicing medicine or their craft, whatever it may be – osteopathic, chiropractic -- 20 hours a week, so we don't have the potential to end up with a certified list of biased independent medical examiners who receive their pay not from injured workers but from insurance carriers. I believe that's a fair way to take a look at some of the director's criteria under section (13). Develop some language and add that to the language that is currently there.

Response: Senate Bill 311, SECTION 5., states the criteria for listing and de-listing IME providers and has not provided a clear legal basis to list or de-list IME physicians based on scope of practice. To give scope-of-practice such weight by administrative rule might exceed the director’s authority.

Testimony: OAR 436-010-0265(14)

Exhibit #5 & 15-C

Presence of an injured worker observer: Information shared during a patient/worker examination, including an Independent Medical Examination, is highly personal in nature, and both patient/worker and physician benefit from protecting that private interaction.

The presence of an unbiased observer may adversely impact both the patient/worker and the examining physician in any number of ways, for example: patients responses to questions may be coached, or the examination may be disrupted by an adversarial observer. Clearly, such factors would negatively affect the ability of a physician to conduct an effective examination and render an accurate professional opinion.

At a minimum, the observers should be an independent observer, mutually agreed upon by both the patient and physician. In addition, the right to request the presence of one or more independent observers should be afforded not only to the patient/worker, but also to the physician. The physician may want an independent observer present to avoid allegations of misconduct by the patient associated with the rendering of the exam.

Response: The Management Labor Advisory Committee (MLAC) recommended a number of specific actions to implement SB 311, including the right of the worker to have an unpaid observer present during the examination. The worker will be required to submit a signed form to the examining physician acknowledging that he or she understands that sensitive questions may be asked in the presence of the observer. If this requirement is not met, the physician may exclude the observer.

We believe the process of choosing an observer by mutual agreement would delay the examination and therefore the processing of the workers' compensation claims. The rules would also need to create a process for settling disagreements.

Physicians often use observers - coworkers - during some sensitive medical procedures. The workers' compensation laws and rules do not limit this. However, for anyone else to observe the examination, the patient must first provide written consent.

The originally proposed rule has been amended to state that an observer cannot participate in or obstruct the examination.

Testimony: OAR 436-010-0265(14)

Exhibit #15-F

There was a discussion about observers in insurer medical exams, and the idea that the doctor should have sole discretion to determine whether the observer's behavior is inappropriate and the opportunity to terminate the exam and document why. It is not a level playing field when a physician and an injured worker are in the same room together. We want to have an observer available to level that playing field somewhat. There is a current school of thought with medical care, that you should take an advocate with you when you see your own doctor, just to help you keep track of what's going on, if you are not feeling well, and you're having some kinds of physical problems. So I don't think it's unreasonable to have an observer there. If the IMEA thinks that the physician needs to have that kind of authority, then observers should be able to tape record the proceeding. Then we'll have an independent record that everybody can look at in

terms of what happened, as opposed to the physician being the only person with the ability to generate information about why there was a problem and be heard.

Response: Section (14) states that “The physician conducting the examination will determine the conditions under which the examination will be conducted.” Subsection (14)(c) of the final rules provides that an observer cannot participate in or obstruct the examination. The worker may record or videotape the examination, but only if the physician approves.

The Workers’ Compensation Division will develop methods to survey injured workers regarding their IME experiences. If rules regarding observers are determined to be inadequate, we will discuss alternatives with worker representatives and others at future rule-making advisory committees.

Testimony: OAR 436-010-0265(14)(a)

Exhibit #4 & 15-B

Suggest: following the second sentence **insertion** of the words “**An observer may not participate in or obstruct an examination in any way. If an examiner concludes that this requirement has been violated, the observer shall be excluded from the examination and the obstruction shall be documented.**” (*Note: OAR 436-060-0095(1) contains a provision similar to this).

Response: We agree that the rule should state the limits on observer participation and have added a new subsection (c) to section (14): “An observer cannot participate in or obstruct the examination.” Because section (14) already states: “The physician conducting the examination will determine the conditions under which the examination will be conducted,” we believe it is unnecessary to specify each way in which that control can be exercised.

Testimony: OAR 436-010-0265(14)(b)

Exhibit #4 & 15-B

Suggest: *deletion* of “*does not receive payment*” and **insertion** of the words “**is not compensated in any way**”

Response: We agree, and have amended section (14) to reflect this testimony.

Testimony: OAR 436-010-0265(14)(b)

Exhibit #14

Clearly, the intent is to exclude an attorney, an employee of an attorney or a representative of an attorney. The rule should so specify. In the alternative, the rule should say that the observer should not have an interest in any future compensation the worker might receive.

Response: We have amended section (14) to state that the worker’s attorney or a representative of the attorney cannot attend the examination. We do not believe it appropriate to exclude anyone with a future interest in compensation, as this would exclude the worker’s family members, probably the most common “observers” with or without a rule change.

Testimony: OAR 436-010-0265(15)

Exhibit #5 & 15-C

IME physician sending copies of final report to insurers: As proposed, the IME physician is required to provide a copy of the report to the insurer within seven (7) days of the examination. Many IME reports are lengthy and complicated. It is essential that IME physicians be given sufficient time to complete the report and review it for accuracy, particularly in light of the threat of sanctions for any false statements. Therefore, we request that the timeframe for sending the report be extended to ten (10) days because the extra three (3) days would improve the quality of the report and be less administratively burdensome on IME providers.

Response: The seven-day time frame is not a change from the existing rule. We recognize that seven days may prove difficult for a very complicated case. However, we must balance the demands placed on medical providers against the statutory time frames for insurers, such as a maximum of 60 days to accept or deny a claim. We think seven days is appropriate to maintain this balance.

Testimony: OAR 436-010-0265(15)

Exhibit #13

There is no reason for the rule to specify the time for an IME report to be submitted. This is an issue between the insurer and the IME provider. Most insurers will establish their own expectations for timely reporting.

Response: The seven-day time frame is not a change from the existing rule. We agree that insurers and IME providers will generally agree on time frames that work for both parties. However, the injured worker and attending physician or authorized nurse practitioner also have an interest in this information and a right to review the findings. We believe seven days is reasonable to meet the insurer's needs, as well as the needs of others who have a right or responsibility to review the report.

Testimony: OAR 436-010-0265(15)(a)

Exhibit #7

We support this rule as written and do feel that delay in receiving IMEs may delay our treatment of injured workers.

Response: The seven-day requirement will remain in the permanent rule.

Testimony: OAR 436-010-0265(15)(a)

Exhibit #4 & 15-B

Suggest: *deletion of (15)(a)* (*Note: WCD staff has indicated that this was in an old rule. IMEA suggests that it not be reinstated into the rules. However, IMEA takes no position on 15(b).

Response: The testimony does not state a reason for not retaining the seven day requirement (for the IME provider to send the report to the insurer). We believe seven days is reasonable to meet the insurer's needs, as well as the needs of others who have a right or responsibility to review the IME report.

Testimony: OAR 436-010-0265(15)(a)

Exhibit #15-E

I support the seven day limit to issue the IME report. For an IME physician, who understands the medical issues, an initial report is not that difficult to get out in seven days. Most of the time when we see IME reports, they're dictated that day or the next day, and they are produced by an IME facility. That production is their job. That's what they do. Typically, IME physicians do not have a lot of private practice. If the Department adds to their criteria list that IME physicians practice half-time, versus the IME production, as I've suggested earlier, then perhaps this rule should be expanded to 14 days or some other reasonable period, because they're busy physicians who are seeing patients, and not necessarily part of an IME organization that has as its sole purpose the production of IME reports. If their sole purpose is to produce reports, seven days seems to be very reasonable.

Response: The seven-day requirement will remain in the permanent rule.

Testimony: OAR 436-010-0265(16)

Exhibit #9

OSIA recommends: SB311 clearly changes the statutory language from “insurer” to “independent” medical examination; as such this change should be implemented.

Response: We agree that “insurer medical examination” should be changed to “independent medical examination” throughout these rules. The obsolete wording doesn’t occur in section (16) but does in section (5) of the proposed rule 0265. The permanent rule has been amended consistent with the testimony.

Testimony: OAR 436-010-0265(16)

Exhibits #11

(16) States the insurer must forward a copy of the IME report to the attending physician or authorized nurse practitioner (ANP) within 72 hours of its receipt of the report.

Comments: While this is not a new requirement we feel it is unreasonable for the insurance company to bear the burden of this strict time requirement. The IME company should be required to simultaneously send a copy of the report to the attending physician or ANP.

Response: Earlier editions of OAR 436-010 required the IME provider to send a copy of the IME report to the attending physician or authorized nurse practitioner. However, an IME provider’s primary point of contact is the insurer. Despite rules to the contrary, direct communication between the IME provider and the attending physician was inconsistent. We believe the 72-hour turnaround is appropriate, as only copying and forwarding are required.

Testimony: OAR 436-010-0265(16)

Exhibit #9

436-010-0265 (16) The insurer must forward a copy of the report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

OSIA recommends that the following:

1. Clarify the need to forward a “*signed*” copy of the IME report to the attending physician or authorized nurse practitioner.
2. Deletion of “72 hours” and replace with “**7 calendar days**”

Response: We have clarified the rule to add that the forwarded report must be signed.

Regarding the 72-hour time frame: We believe the 72-hour turnaround is appropriate, as only copying and forwarding are required.

Testimony: OAR 436-010-0265(16)

Exhibits #4 & 15-B

Suggest: **insertion** of the word “**signed**” before the words “copy of the report”

Suggest: *deletion* of “72 hours” and **insertion** of “**7 calendar days**”

Rationale: The practical reality is that 3 days is unreasonably short, and there is nothing “critical” about a fast turn around on IME reports.

Response: We have clarified the rule to add that the forwarded report must be signed.

Regarding the 72-hour time frame: We believe the 72-hour turnaround is appropriate, as only copying and forwarding are required.

Testimony: OAR 436-010-0265(16)

Exhibit #15-E

The requirement that the insurer forward a copy of the IME report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report seems to be very reasonable. The attending physician can then sit down and take time to discuss it with the injured worker.

Response: The 72-hour requirement is now part of the permanent rule.

Testimony: OAR 436-010-0265

Exhibit #2

The Workers’ Compensation Division provided the Medical Advisory Committee an update on Senate Bill 311, and shared related agreements that will be implemented through administrative rule. The committee was asked to provide input regarding rule issues.

In response, the committee would like to provide the following regarding the proposed requirement that an attending physician review all Independent Medical Examination reports with workers. While we concur that the agreement sounds good, we do not believe it is a practicable solution to any problem presented. We feel the requirement is more likely to produce negative outcomes.

The agreement is problematic to regulate and enforce. It requires either additional enforcement staff, or will not be enforced adequately to produce the desired outcomes. To the degree it is enforced, the requirement has the potential of driving physicians out of the workers’ compensation system to avoid the increased regulatory burden. However, we fundamentally believe that physicians are more likely to ignore the requirement.

In those instances where a physician does comply, the additional consultation will be billed to the insurer or self-insured employer. System costs will increase as a result.

We believe that the Management-Labor Advisory Committee should consider other alternatives

to attain the policy goal behind its agreement.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibits #4 & 15-B

Suggest: *deletion of subsection (17)* and **insertion** of the following words **“The claims handler will send the attending physician’s response to the concurrence letter to the claimant or to their representative.”** (*Note: the intent is to delete the tying of the attending physician going over the report with the doctor’s response to the concurrence letter.)

Rationale: By rule, attending physicians have 14 days to respond to concurrence letters. Failure to timely respond results in the attending physician being deemed to have concurred, and claims may be closed on that basis. If attending physicians wait to respond to concurrence letters until their patient is back for a follow-up visit, the result will be a large number of concurrence letters that are either late being sent back, or are never sent back. Concurrence letters are a necessary part of the claims handling process. Linking them to the attending doctor talking to the patient about IME letters creates the risk that claims will be closed without the benefit of the attending doctor’s comments on the IME. This serves the interests of no one. The linkage should be deleted from the OAR’s.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibits #7 and 15-D

Often, injured worker’s do not return for care following an IME. For this reason our ability to review the IME with the worker can be limited. If we schedule an apt for the injured worker, he/she may or may not arrive, and there will be delay in our ability to timely respond to concurrence.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibits #8

Giving an appropriate opinion on IME report and conclusions requires in depth review of the IME, supporting documents or records, and clinical notes. Whether this opinion is presented to the insurer, patient or other entities involved, the quality of the opinion should be the same since it may become the basis for important decision-making. If there is disagreement on the

conclusion opinions put fourth by the IME report, this can become the initiation point for the injured patient to develop an adversarial perspective. Therefore, I think that the required review of IME, with the implied development of the practitioner's conclusion opinion (agree, disagree, or other), should be allotted similar time, and billed as such, that the practitioner receives presently when insurance makes this request.

Furthermore, while the attending physician is an advocate for their patients' overall well being, they should not be biased regarding to what extent they think a patient's present condition is secondary to on job injury versus non-work related conditions. The IME physician should not be biased either. Bias, when perceived or justified, can challenge the validity premise of the present system.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #9

436-010-0265 (17) The concurrence letter sent to the attending physician under OAR 436-030-0035(5) and OAR 436-010-0280(4) must contain a check box to indicate that the attending physician discussed the report with the worker.

OSIA strongly recommends that this provision be removed. There is no statutory provision for this requirement. We recognize this proposed language is directly in response to recommendations from the Management Labor Advisory IME Sub-committee, but believe this would add no value to the execution a claims decisions and would unnecessarily add significant costs to claims. These unnecessary costs would include, but not be limited to:

1. The cost of the doctor visit that might not otherwise be necessary;
2. The cost to the employer for lost production due to worker's attendance at an appointment with their attending physician just to go over the IME report;
3. The likely payment of temporary disability or a reimbursement of wages for lost time from work;
4. The cost of mileage reimbursement or other transportation costs; and
5. The potential cost resulting from an adversarial relationship that could develop between the worker and their physician, if the physician concurs with an IME report that does not support the worker's claim.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #5 & 15-C

Attending physicians going over IME report with injured worker: **Arguably, the attending physician would be the most logical person to go over the IME report with the worker. However, this requirement presents challenges to well-meaning attending physicians who are put in the position of agreeing or disagreeing with the IME physician's diagnosis.**

Attending physicians who agree with IME physicians run the risk of fracturing the hard-earned trust of their patients. On the other hand, if the attending physician disagrees with the IME physician, then the patient will undoubtedly have no confidence in the opinion of the IME physician or the IME process.

The OMA believes that the primary role of the attending physician is to act in the best interests of the patient and to advocate for the patient's well being. For the reasons stated, the OMA requests that the requirement that the attending physician go over the IME report with the patient be eliminated.

Notwithstanding the above, if the proposed rule is to be adopted, the OMA recommends that the time physicians spend going over IME reports should be considered a billable portion of the exam. Studying and evaluating these reports is time-consuming and may affect the normal ebb and flow of the physician's patient schedule. The OMA would propose that additional codes be adopted for the purpose of billing for this time.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #6

I wish to comment on the idea in OAR 436-010-0265 section 17. In my opinion, there should be no obligation for an attending physician to review an IME report with an injured worker. The job of the attending physician is to provide medical care to the injured worker. Additionally, under the workers' compensation system, the attending physician is supposed to provide to insurers *unbiased* information regarding relationship of the reported injury to work. The attending physician may review an IME report with an injured worker, but should not be compelled to do so.

There are a number of medical conditions in which degenerative changes are a major cause of an injured worker's condition. Injured workers believe, unaware of the subtleties in some of these diagnoses and conditions, that the pain they are experiencing and their need for medical care is related to work activity or work injury. The value of an independent medical evaluation is to obtain an opinion, from an unbiased physician, regarding causation of an injury or an opinion about a treatment that may be controversial. At times, an attending physician will agree with an independent medical evaluation that states that the major cause of the patient's condition is unrelated to work activity/injury. Asking the attending physician to explain to the injured worker, in this case, his or her position, puts an unnecessary and inappropriate burden on the attending physician. It also has the deleterious consequence of pressuring the physician to disagree with the independent medical evaluation in order to support the patient's claim, as that is the "easy way out". Compelling an attending physician to go over the IME report with an

injured worker creates pressures that will lead to bias.

CPT code 99080 is the code utilized to bill for analyzing IME reports and providing a concurrence or non-concurrence letter. In my opinion, if section 17 is adopted, the 99080 code would also be appropriate for the time spent in explaining the IME to the worker. I do not believe that an additional code is necessary. However, the increased time will add to medical costs.

In summary, new rules are being adopted in an effort to reduce perceived bias in the IME program. In my opinion, the proposed change in section 17 is a bad one because it creates pressure on physicians that will lead to bias, a result unfavorable to the fair processing of workers' compensation claims. It will also increase medical costs without improving medical care.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #11

(17) This proposed change states the concurrence letter sent to the attending physician must contain a check box to indicate the attending physician discussed the report with the worker.

Comments: This is an ineffective mechanism of ensuring the results of the IME are reviewed with the injured worker and adds unnecessary costs to processing the claim along with a potential delay of benefits to the worker. For example, this change would prompt the injured worker and provider to schedule an additional appointment, in cases where this might not be necessary, such as an IME for closing purposes. This would unreasonably result in time lost from work for an additional appointment, loss of productivity, and additional increase in already skyrocketing medical costs that would be felt by the injured worker, insurer and employer. In addition, where benefits would be due to the worker as a result of and concurrence to the IME, this requirement would delay this information and processing of those benefits. This requirement was discussed and specifically rejected by MLAC during its consideration of Senate Bill 311 when it became clear that many physicians were uncomfortable with such an obligation. There is nothing in the statute that requires the attending physician review the results of the IME with the injured worker and based on the above argument, it is Liberty Northwest's request that this be removed from the rules.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #13

The check box should indicate "whether" the physician discussed the report with the worker, not "that" he or she did so. There is no statutory requirement for a report to be discussed with the

worker before the physician renders an opinion on concurrence. Although it is usually desirable, there are some circumstances where this may not occur, or the worker is unavailable.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #14

436-010-0265 (17) The concurrence letter sent to the attending physician under OAR 436-030-0035(5) and OAR 436-010-0280(4) must contain a check box to indicate that the attending physician discussed the report with the worker.

Providence MCO strongly supports the position of the Oregon Medical Association that this provision be removed. There is no statutory requirement that a physician review the IME with an injured worker. We agree with Mr. Gallant's testimony stating that it would be very difficult for most physicians to schedule appointments with workers for the purpose of discussing IMEs in a timely manner. Many physicians, especially specialists, schedule appointments for non-urgent services up to three months out. Requiring that a physician review the IME with the injured worker is unnecessary and the potential increased costs associated with the practice would be many, including but not limited to:

1. The cost of the doctor visit that might not otherwise be necessary;
2. The cost to the employer for lost production due to worker's attendance at an appointment with the attending physician just to review and discuss the IME report;
3. The likely payment of temporary disability or a reimbursement of wages for lost time from work;
4. The cost of mileage reimbursement or other transportation costs;
5. In some cases, additional payment of benefits while the claim remains in an open status, while waiting for the appointment to occur;

In addition, many physicians request that IMEs be scheduled and rely on the opinion given to direct or terminate treatment. IME reports are not always flattering, yet the attending physician can often communicate the opinion and explain how he or she agrees with the opinion without sharing the all the details of the questions and answers contained in the IME with the injured worker. Requiring physicians to discuss IMEs with injured workers places a great burden on the physician and the potential for an adversarial relationship developing is great.

Response: The Workers' Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #15-E

I don't read this rule to require that the concurrence letter be checked by the doctor, to show that

he discussed it with the injured worker. Other testimony suggested that these two concepts are tied together, and that the proposed rule requires that the doctor discuss the report with the worker. It is simply a box that says, “did you do that”? Sometimes the attending physician won't have to. They can get their reports back out, their concurrence. If they don't sit down with the injured worker for whatever reason, then they just check the box – “I didn't do it.” That doesn't seem to be an onerous requirement.

It is important for the injured worker to be brought into the process. And I support the idea behind this section (17) that indicates to the attending physician the importance of doing that. Although it's not required in (17), it does seem to push the attending physician in that direction. And, that conference does not have to be in person. You don't have to schedule an appointment. At least to my knowledge, doctors have telephones, and they can pick them up and call an injured worker and say did you get a copy of this? If not, let me tell you about it. I agree with this. I don't agree with this. Is the history right? So the doctor can have that conversation over the phone, and if the doctor chooses not to do that, they can check the box.

Response: The Workers’ Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0265(17)

Exhibit #15-F

I guess if there's a problem with this concurrence letter being sent back by the attending physician, perhaps we'd want to extend that time period for the return of the concurrence letter, if the physician wants to consult with the worker and needs more time.

Response: The Workers’ Compensation Division will consult further with the Management-Labor Advisory Committee regarding this question. Until that consultation and further research regarding alternatives, the division will not proceed to require by rule that the attending physician review the IME report with the workers.

Testimony: OAR 436-010-0290(3)

Exhibit #13

The rule omits the requirement for the physician to contact the insurer first. Only if the physician’s request has been denied by the insurer, should the physician submit a request to the director.

Response: ORS 656.245(1)(c)(K) requires director approval of curative care arising from a generally recognized, nonexperimental advance in medical science since the worker’s claim was closed * * *” We believe the proposed rule is consistent with this statutory requirement.

Testimony: OAR 436-010-0340(9)

Exhibit #4 & 15-B

Suggest: *deletion of “\$100 per occurrence” and insertion of “\$400 per physician”.*

*Note: See IMEA attachment A for information documenting why \$100 penalty is unacceptable.

Response: The Workers' Compensation Division researched meeting notes of the Management-Labor Advisory Committee. MLAC discussed penalties, but the amounts discussed were not as high as those recommended by the IMEA in this testimony. MLAC voted to put the penalty matter through public rulemaking.

The primary purpose of the penalty is to encourage attendance. For a worker who is not receiving time-loss payments, a potential \$100 penalty is probably a substantial incentive. The division chose to impose the same \$100 penalty amount on medical providers who do not timely provide diagnostic records to the IME provider.

We believe the proposed \$100 penalty for workers who fail to attend IMEs under ORS 656.325(1)(c) is sufficient.

Testimony: OAR 436-010-0340(9)

Exhibit #11

This rule adds that workers can be sanctioned \$100 per occurrence of failure to attend an IME without notifying the insurer.

Comments: This does not cover the cost of the no show fee and is not enough of an expense to the worker to compel their attendance. As this sanction may not be imposed unless there has been a finding that the worker's failure to attend was without sufficient reason, this sanction should be increased to be more consistent with the actual cost the insurer bears when a worker fails to attend an exam (generally about \$350).

Response: Please see the response to the previous testimony.

Testimony: OAR 436-010-0340(9)

Exhibit #15-E

Regarding some testimony by Mr. Goodman relating to increasing the fine from \$100 to \$400, I have to ask why. The IME physicians typically charge anywhere from \$600 to \$1,000. When a worker receives a notice, or putatively receives a notice -- sometimes they don't receive it for a few days. Somebody signs for it at their house, they get it a few days later if they're somewhere else, and they don't have time to call or to make a formal objection. A \$400 fine seems to be a bit rough. When we're asking an injured worker, particular those who are on time loss, total temporary disability, to receive 66.66 percent of their average weekly wages, and then slap them upside the head with a \$400 fine, I'm not sure how that's going to make an injured worker be more attentive to an IME, that they really may not have much time to object to. It just seems rather onerous. Remember that these injured workers are not a part of the scheduling. They're just sent a letter and said you shall appear or all these terrible things will happen to you. Workers are not part of this legal process. They don't live in this environment 365 days a year. Therefore, they should be afforded some sense of dignity and a measure of respect when these things are scheduled.

Response: The penalty can only be imposed on workers who are not receiving time-loss benefits. Please see the response to rule 0340(9) testimony on Page 26.

Testimony: OAR 436-010-0340(9)

Exhibit #15-F

Regarding the monetary penalty -- your rule says "may be imposed," and I think that that's reasonable language. Each situation can be looked at individually and it can be determined whether that's an appropriate action to take or not. I do not support this idea of mandatory penalties for workers who don't participate in the system, many of whom never worked in an office in their lives, and who don't have access to a lot of the equipment and means of communication that all of us take for granted every day. I just think that the idea of examining these things individually and deciding whether there's a good reason or there's not to impose a penalty, and hold it down to a more reasonable level would be a much more measured response. I appreciate the Department's current language.

Response: The permanent rule states that the director "may" impose the penalty. Very few civil penalties are automatic - investigation is required. Please see the response to rule 0340(9) testimony on Page 26.

Testimony: OAR 436-010-0340(9)

Exhibit #9

OSIA considers the amount of the monetary sanction proposed to be unreasonably low. This amount will not deter individuals from not complying with their responsibilities concerning IMEs. Also, the \$100 amount is an insignificant amount compared to the hundreds of dollars that the insurer and employer are responsible for when there are no shows to these scheduled exams. We recommend the amount be increased to more equitably offset the financial burden placed upon the employer when the worker fails to show for an IME.

Response: Please see the response to rule 0340(9) testimony on Page 26.

Testimony: OAR 436-015-0030(5)(c)

Exhibit #7 and 15-D

We support providing the state with copies of our MCO Medical Treatment Protocols. Because of our integrated model and electronic medical record, there are many other processes which are developed in multi disciplinary forums that are imbedded within our processes. It would be an administrative burden to provide copies of this to the state, and I suspect be considered proprietary information.

The correct people to build and manage medical protocols are the MCO Medical Providers, and thus although we respect the Director's review of our protocols, we do not feel that he should have final approval rights.

Response: Pursuant to ORS 656.260(4)(a), the director may only certify an MCO when that MCO provides services that meet quality, continuity, and other treatment standards reviewed and approved by the director. The requirement of "reviewed and approved by the director," follows the phrase "treatment standards." Therefore, the amended language requirement of review and approval also applies to treatment protocols.

Testimony: OAR 436-015-0030(5)(c)

Exhibit #12

It is the position of OHS that the proposed rule misinterprets the language of the statute. SB 670 amended ORS 656.260(4) to read:

“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 proposes to provide services that meet quality, continuity and other treatment standards reviewed and approved by the director”.

The amended statute confirms a legislative intent that the director “find” that an MCO “plan proposes to provide services that meet quality, continuity and other treatment standards reviewed and approved by the Director.” “Quality, continuity and other treatment standards” is a list which describes and limits what the Director is to review and approve. This list does not include “treatment protocols” at all. “Other treatment standards” are included, but use of the word “other” limited what is included to those which would be consistent “quality and continuity standards”. The rules of statutory construction tells one that the phrase “other treatment standards” must be interpreted to mean only such treatment standards that are similar in kind to the “quality” and “continuity” standards set out as the start of the list in the statute. Both of these types of standards are broad, generic categories, and are in no way case specific. As such, they are very susceptible to Director review and approval without subjecting the reviewer to being mired in a case by case analysis of what is appropriate. By being broad, “quality and continuity standards” allow the MCO to set up and adjust general quality and continuity standards that have been reviewed and approved by the Director on a case by case basis as needed, without having to go back to the Director for approval of any specific case. “Treatment protocols”, on the other hand, are by definition specific to a diagnosed condition. As such they are not consistent with what the legislature, in creating the list in the statute, indicated its intent was as to what areas of an MCO plan should be “reviewed and approved” by the Director. Any attempt in the Administrative Rules to regulate specific treatment protocols based on the underlying language of ORS 656.670 would exceed the statutory authority provided in that statute.

The statute is limited in scope. It requires only that the Director certify a *plan* for providing services that a managed care company proposes to adopt. The statute does not contemplate the Director reviewing all of the specific, procedures or protocols that a managed care company might develop consistent with the terms of its plan. To be consistent with the legislative intent as evidenced by the statutory language, OHS would propose that the rule require the inclusion of the process for developing or adopting treatment protocols or guidelines, rather than the specific guidelines themselves. OHS would recommend the following language be substituted for the current proposed language of 436-015-0030(5)(c):

“A summary of the process utilized by the MCO to develop and review treatment protocols or guidelines, or the criteria established for purchase or adoption of nationally published treatment protocols or guidelines”.

Should the director find the above argument unpersuasive, OHS would recommend amendment to the currently proposed rule to the following:

(c) Copies of all treatment standards and protocols developed or used by the MCO, including those from any companies, if any, from whom the MCO has purchased the right to use of treatment standards and protocols, shall be submitted for the director to review and approve under ORS 656.260(4)(a). The MCO must provide these copies at no cost to the director. If the guidelines purchased or adopted by the MCO are available online through the National Guideline Clearinghouse, and the MCO has so advised the director, the requirements of this rule will be deemed to be met.

Response: Pursuant to ORS 656.260(4)(a), the director may only certify an MCO when that MCO provides services that meet quality, continuity, and other treatment standards reviewed and approved by the director. The requirement of "reviewed and approved by the director," follows the phrase "treatment standards." Therefore, the amended language requirement of review and approval also applies to treatment protocols, not just the processes created and implemented by the MCO.

By requiring MCOs to provide copies of treatment standards and protocols, the director will be able to provide the oversight of MCOs as intended by the legislature in ORS 656.260(4)(a).

Testimony: OAR 436-030-0015(1)(e)

Exhibit #11

The proposed rules allow for a combined UNOA and NOC in those claims in which a worker dies within 24 hours of an injury.

Comments: Liberty Northwest supports this change, as the current processes are confusing and potentially disrespectful to beneficiaries. We request the division further consider the definition of "instant fatality". It is our position that this should apply to claims that result in death in the first 60 days of the injury/exposure or when the acceptance is issued, whichever occurs first. By limiting application of this rule to those claims in which death occurs within the first 24 hours of an injury, the rule requires the existing process must be used for those claims in which workers are fatally injured, but pass away after the 24-hour period. Whether the worker passes away within the first 24 hours, or several days later, is irrelevant.

Response: Not only is 24 hours a consistent threshold for similar regulations regarding death, but WCD sees a difference between those workers who die within 24 hours of the incident and those who die later. When a worker dies within the first 24-hour period, an insurer can limit their acceptance to the fatality. If a worker dies beyond the initial 24 hours, acceptance of the conditions must occur and, if the worker dies later, acceptance of the fatality (or the condition resulting in the fatality) is a separate issue. Another part of the difference is the potential entitlement to both TTD and PPD, which comes with surviving beyond the first 24 hours. An additional possibility is that, in the case of "delayed fatalities", the incident may have resulted in injuries which were not life-threatening at the time, but the worker subsequently died due to an (initially) undiagnosed condition which the insurer may or may not have accepted or been responsible for. For these reasons, WCD will not be changing how we define "instant fatality" for purposes of these rules.

Testimony: OAR 436-030-0015(1)(e)

Exhibit #13

The department deserves credit for attempting to respond to concerns about the insensitivity of required language acknowledging fatal claims. However, the proposed alternative has its own problems. The department should craft a unique rule for this situation, rather than trying to modify procedures that are designed for routine claims but are inappropriate and insensitive for these unique claims.

Response: Because there currently is no statutory provision for a different process to handle fatality claims and insurers are accustomed to the present process, WCD made the decision to

make as few changes to the existing process as possible. It was our thinking that, pending passage of a statutory change (which WCD is considering proposing), the more minor the deviation from the “norm”, the less difficult it would be to incorporate the processing changes into existing procedures. Additionally, in the absence of statutory authority to create a “unique” rule for such situations, WCD determined the proper procedure would be to secure that authority via a statutory change that could include some of the structural aspects we believe are needed. We do not believe we have authority to make such additions at this time.

Testimony: OAR 436-030-0015(6)(a)

Exhibit #13

[Summary of change: The existing rules require the insurer to notify the worker that their claim qualifies for closure within three working days of receiving sufficient information to close the claim.]

Comments: Three working days is an insufficient time for the insurer to notify the worker that the claim qualifies for closure. This is not critical information for the worker, and a more reasonable five days should be allowed.

Response: The three-day timeline was established by a prior advisory committee through negotiations as a viable resolution to concerns voiced by workers. While the information may not appear to insurers to be “critical”, to workers this information can be vital as they prepare to return to work, or pursue alternative employment or vocational endeavors. If time-loss (total or partial) is being paid, the impact on a worker’s ability to pay for family expenses or commitments needs to be considered. WCD will not be extending the timeline for providing this information to injured workers.

Testimony: OAR 436-030-0020(1)(e)

Exhibit #13

[Summary of change: The proposed rule adds the reduction of PTD awards to those circumstances under which a NOC must be issued by the insurer within 14 days.]

Comments: The department is attempting to apply a standard that is appropriate for closure of routine claims to the reversal of PTD awards. There is no relationship between the two. Determining that a worker is no longer entitled to PTD benefits is a complex analysis that requires sensitivity to the needs of the worker and often entails negotiation or mediation. Requiring a notice of closure within 14 days of receiving a couple of reports is not the way to deal with PTD claims. The department has issued public reports criticizing insurers for being too quick to reverse PTD benefits. This proposal would encourage hasty decisions and should be withdrawn.

Response: WCD is aware of the difference between PTD status determination and closing a routine claim. However, issuing a Notice of Closure is required for closing disabling claims and there is no exception for PTD claims which have been reduced, especially since the reduction results in an end to ongoing monthly benefits and rating of PPD. The process of getting to closure is different, but the act of closing the claim and awarding PPD is the same. While we recognize the likely need for a new form to use for notifying workers that they have been determined to be PTD, WCD does not see that there is latitude in the statute to change the Notice

of Closure process for reducing the PTD benefits to PPD and closing the claim.

Testimony: OAR 436-030-0020(2)(b) (D)&(E)

Exhibit #11

[Summary of change: (2)(b) (D)(E) states that the insurer must provide the worker's work history for a period of five years prior to the date of injury and the worker's level of formal education as part of "sufficient information."]

Comments: There is no method of compelling the worker to provide the above information, which only they can provide. This can cause delays in claim closure, the determination of impairment benefits, and costs to the employer and insurer due to additional processing requirements. We request that provisions be allowed in the rules to authorize suspension of benefits should the injured worker not provide this information, similar to what is outlined under 436-060-0105 or 436-060-0135.

Response: There are a variety of sources from which the insurer can draw the information needed to determine base functional capacity and levels of SVP and formal education. One is to provide the worker with a form to complete at the time the claim is filed with the employer. A second is to ask the worker early on in the claim while insurer-worker relationships are positive. Another is to use the worker's employment application, supplemented with information on work performed while employed with the employer at injury. Penalizing the worker for failing to provide the information increases the potential for creating an antagonistic relationship with both the employer and the insurer. Also, WCD does not have statutory authority to suspend benefits in these circumstances. WCD will investigate this recommendation further.

However, the basis for raising the issue may be a concern that a Notice of Closure could be rescinded on appeal based on questionable adequacy of or efforts to obtain this information as part of "sufficient information to close". Taking this perspective into consideration, we have modified both OAR 436-030-0015 and 436-030-0020 to allow insurers who make dutiful effort (but are unable to obtain the information from the worker) to document their efforts to do so and provide what they are able to gather.

Testimony: OAR 436-030-0020(2)(b)(D)

Exhibit #9

Regarding: The worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands

OSIA recommends language to compel the worker to respond to the request for this information. The inability to close a claim caused by the worker failing to complete the requested work/educational history brings additional costs to the employer and insurer. OSIA requests that suspension of benefits similarly outlined under 436-060-0105 and 436-060-135.

Response: Please see the previous response to a similar recommendation for this rule.

Testimony: OAR 436-030-0034

Exhibit #11

[Summary of change: ORS 656.268(c) allows for the closure of the claim if the worker fails to

seek medical treatment for a period of 30 days or the worker fails to attend a closing examination.]

Comments:

436-030-0034 applies ORS 656.268(1)(c) and sets forth the process for closing a claim when the worker fails to attend a closing exam. However, by placing this rule under the heading “Claim Closure When the Worker is Not Medically Stationary” the division has inaccurately restricted this process to those claims in which the injured worker has **not** been declared medically stationary. This is inconsistent with the actual statutory language in ORS 656.268(1)(c) authorizing the closure, which contains no reference or requirement regarding the worker’s status as stationary or non stationary. In many cases, the worker is declared medically stationary, but there is insufficient information to determine the extent of disability. They are then scheduled for a mandatory exam, but do not attend. Because they have already been declared medically stationary, the current rule unnecessarily restricts the insurer from closing the claim and forces an insurer to seek suspension of benefits. This error is perpetuated in OAR 436-030-0034(3), which erroneously states that the obligation to close a claim is limited to those in which the worker *is not medically stationary* and has not sought treatment. It is our request that the erroneous references to medically stationary status identified above be modified and all inappropriate references to the worker “not” being medically stationary be removed.

Response: At the time this avenue for closing a claim was requested by WCD and authorized by statute, WCD structured the rule and implemented the process based on our understanding of the legislature’s intent. ORS 656.268(1)(c) is not specific as to the application of the closure criteria—medically stationary or not—when the worker fails to seek treatment without the approval of the attending physician. In the absence of clear direction to the contrary, WCD is not persuaded that the proposed change will make the rules more consistent with statutory intent, so no change is being made.

Testimony: OAR 436-030-0155(1)(b)

Exhibit #11

[Summary of change: (1)(b) imposes the requirement that the insurer or self-insured employer must not send billing information and duplicate documents to the department, unless specifically requested by the director.]

Comments: The addition of this rule contradicts discussion and recommendations made by the external advisory committee. This places another needless administrative burden and cost on the insurer. Insurers would like to require that medical providers, WCD, attorneys and employers not provide the insurer with duplicate copies as well, but unfortunately processing requirements imposed by WCD often is the driver of duplicate records. It seems unfair that the insurer should bear this burden and further seems unreasonable that we are subject to penalties for providing duplicate records. Shouldn’t the division be more concerned about receiving a complete record?

Response: We recognize that the rule as proposed does not reflect the full range of discussions by the External Advisory Committee (EAC). The EAC was in agreement with the substance and extent of the problem, but they were unable to offer suggestions to resolve the problem. We know this change in the rule increases the need for insurers to take care in selecting the documents they send to the Appellate Review Unit when providing “the record” for purposes of reconsideration. Although we have not included the definition of “duplicate” in the rules, the

common definition of the term is a document which corresponds exactly with another. We also recognize the need to reduce the size of files WCD stores (at considerable expense) as documentation of “the record” for purposes of hearing. We routinely receive requests from insurers, attorneys, and workers for a copy of “the record” to which they all contributed and were to have provided copies to all other parties of the dispute. While we charge a fee for this service, it is not adequate to cover the cost of eliminating duplicate documents and forwarding “the record” to the requestor. Given that we neither want nor need billing information, duplicate documents, and select other materials, eliminating them from the process at the earliest possible point—which would be in the records the insurer sends to the department—seems the most reasonable approach. It is our intent to avoid the need for the insurer to re-copy and submit what has already been sent to WCD. WCD will entertain alternative methods of reaching the goal of reducing the record on reconsideration if they are offered at the next opening of these rules.

Testimony: OAR 436-030-0155(1)(b)

Exhibit #13

Everyone is frustrated by the number of duplicate documents in claim files, but often there are legitimate reasons to retain duplicates. While we all strive to eliminate duplicates, it is not always possible. Having to study all apparently duplicative documents to make sure none is slightly different than others would be unduly burdensome and could sometimes result in the erroneous removal of non-duplicative information from the record. Imposing a rule that duplicates must not be sent is not helpful. We suggest a rule that encourages insurers to eliminate duplicates from the record.

Response: Please see the previous response to a prior recommendation for this rule.

Testimony: OAR 436-030-0155(3)(a)

Exhibit #11

[Summary of change: This rule added that surveillance video provided for arbiter review must have been reviewed prior to claim closure by a physician involved in the evaluation or treatment of the worker.]

Comments: This is inconsistent with discussions and recommendations made by the external advisory committee. The committee felt that the arbiter should be allowed to view the surveillance video, regardless of whether it had been reviewed by a physician prior to claim closure. Furthermore, limiting the admissibility of surveillance film to that obtained prior to the Notice of Closure will enable fraud by the worker during the time the worker is seeking to increase his disability benefits. A worker’s disability is rated at the time of the Order on Reconsideration, not at the time of issuance of the Notice of Closure. ORS 656.283(7). By arbitrarily limiting what is available to the medical arbiter to film obtained prior to claim closure, the proposed rule contradicts ORS 656.283(7). Refusal to consider evidence of fraud generated during the reconsideration period enables fraud to go uncorrected and unaddressed. We request that this proposed rule be removed. Lastly, this rule does not consider other issues that will arise and penalize the insurer and employer, such as physicians refusing to view the video or leaving the area before the film can be presented to them.

Response: The purpose of the reconsideration proceeding is to evaluate the accuracy and appropriateness of decisions made by the insurer when the worker’s claim is closed and a Notice

of Closure issued. Statute is clear that additional information allowed in the record following that closure is strictly limited. [See ORS 656.268(6)(a)(B)] In and of itself, surveillance video—particularly that obtained after closure—does not satisfy the criteria of “medical evidence”. Thus, only video obtained prior to the Notice of Closure is appropriate and pertinent if viewed by the attending physician who is responsible for providing or verifying objective findings or concurring with those of a source he trusts. We recognize there is the potential for physicians to fail to view the film. However, responsibility for assessing and incorporating the impact of the film on the findings reported is the purview of the attending physician. Once the closing report has been completed, clarified as necessary, and the Notice of Closure issued, the role of the attending physician (for purposes of reporting objective findings) is completed. We believe the revision to this rule coincides with the statutory intent. Additionally, this change does not prevent insurers from providing video evidence for impeachment purposes.

Testimony: OAR 436-030-0575(3)

Exhibit #11

[Summary of change: This rule was added and requires the insurer/self-insured employer to provide within seven days of a request *any* data the director identifies as necessary to determine the impact of legislative changes on permanent partial disability awards.]

Comments: While we have a shared interest and stake in the results of studies on changes in PPD awards, the time frame imposed by this rule is unreasonable and unnecessary. Senate Bill 2408 requires DCBS report on the impact of the legislative changes on PPD awards “by January 30, 2007”. Given the time available to DCBS, there is no reason to require insurers to respond within such a limited time period. We request this time frame be changed to at least 30 days and the term “any” be removed.

Response: The 2006 legislature directed WCD to study the effects of SB 757 and HB 2408 on PPD. In preparation for the 2007 legislative session, WCD staff has already developed a process, implemented a pilot study, and will soon initiate research needed to compile data on a statistically valid sample and prepare the necessary report(s). Given the lead time we currently have to complete this initial study, we do not anticipate this process will result in requests for data from insurers with due dates of 7 days; however, long lead times are not always possible. Under ORS 656.726, the director has broad statutory authority to make requests for data and set due dates for receipt. Occasionally in the past, WCD has conducted studies where the information needed from insurers was requested promptly, but a response containing the data was delayed, resulting in untimely reporting to the requestor (legislature, MLAC, MAC, etc.). When demands for information and research require a short turnaround time, WCD must be able to secure the necessary data to respond in a timely fashion. We believe setting this timeframe is appropriate and not unduly burdensome; therefore, the rule will remain as proposed.

Testimony: OAR 436-030-0575(3)

Exhibit #13

The department has previously suggested that it might require insurers to collect claim data that is not required for the purpose of processing the claim, solely for the purpose of assembling a database for statistical purposes. We have previously objected to this proposal and we believe that it exceeds the department’s authority. We propose that this rule be amended to limit the required data to data “in the possession of the insurer”. In addition, it is not necessary for the

department to impose an arbitrary deadline for the submission of existing data. SAIF Corporation will always cooperate with reasonable requests from the director. Some requests take longer than others to fulfill. Whenever a deadline is written into a rule, it carries with it the threat of a sanction for noncompliance. We suggest a requirement that data should be provided within a reasonable period from the request.

Response: Please see the previous response to a prior recommendation for this rule.

Testimony: OAR 436-035-0110(6)

Exhibit #13

[Summary of change: The proposed rule considers that successful treatment of a skin disorder likely would result in no signs or symptoms of the disorder at the time of a closing examination. Thus, there would be evidence of permanent impairment even though the signs and symptoms could or would return if exposure to the agent recurred.]

Comments: The proposal to rate impairment in the absence of signs or symptoms of skin disorder is contrary to the statutory requirement for objective findings and is a complete reversal of the existing rule. It should be withdrawn.

Response: The change made in this rule is intended to correct an inadvertent oversight which occurred when we were “morphing” the rating of these conditions to be consistent with rating practices in OAR 436-035-0440. While it may seem contrary to statute to allow rating of impairment in the absence of signs and symptoms of a skin disorder, it is consistent with the focus on improvement in a worker’s condition when there is ongoing treatment and avoidance of the sensitizing agent. A worker can improve to the point where medications (only) control the signs and symptoms of an accepted, diagnosed condition without eradicating the disease or allergic process. In such a case, permanent impairment recognizes the long-term effects of the exposure and the ongoing need for treatment. Successful treatment does not mitigate the potential for appearance of the signs and symptoms should exposure recur. Additionally, the cases of SAIF Corp. v. Lewis and SAIF Corp. v. Drury have supported the practice of granting an award of permanent impairment in such situations. Thus, we feel that awarding PPD for the underlying condition is appropriate, even though signs and symptoms may not be present at the time the worker is seen for a closing examination.

Testimony: OAR 436-035-0110(6)(a) & 0230(6)

Exhibit #13

As written, the rule could require a 3% impairment rating for no limitation and no symptoms. This could apply to a worker who was exposed to poison oak and had a reaction at work. The work exposure does not cause the sensitivity, and the reaction will disappear without any residuals. At a minimum, the words “no more than” preceding “minimal” should be removed from this rule.

Response: The example provided represents what we interpret as a “systemic condition”. Systemic conditions are covered under “Immune System Responses” in OAR 436-035-0450. Additionally, the words proposed for deletion (no more than) are intended to set the upper limit for Class 1 (3% rating).

Testimony: OAR 436-035-0230(14)

Exhibit #13

[Summary of change: The proposed rule considers the potential for chronic condition to result in limitations to types and duration of movement(s) other than standing and walking which may also be limited.]

Comments: If a worker receives a 15% award for a walking or standing limitation, this should be in lieu of, not in addition to a chronic condition award.

Response: The “walking/standing” limitation does not address the other types of motion and is specific about the time spent performing that activity. “Chronic” is not specific to an amount of time spent performing an activity so much as looking at the other types of motion (bending, stooping, crouching, lifting, etc.). Because we believe there is a need to recognize both types of loss of use and function, the rule will remain as proposed.

Testimony: OAR 436-035-0400(4) to (6)

Exhibit #13

[Summary of issue: The existing rules name the classifications for mental illness as minimal, mild, and moderate; other conditions with classifications are categorized as mild moderate, and severe.]

Comments: The classifications of mental illness as minimal, mild and moderate are inconsistent with the other classifications in these rules. Whereas mental illness is classified as minimal, mild and moderate, other conditions are rated as mild, moderate and severe. The use of the same words to mean different degrees of severity is confusing to physicians, employers and insurers. Please modify these ratings in the interests of clarity and consistency.

Response: The classifications for mental illness originally included in the rules were extremely large, covering as much as 30%-40% impairment in each class. In an effort to recognize more discreet differences, the size of each classification was further subdivided into categories. There was a need for a “limiting” threshold for the upper end of each classification. Severe findings in a classification are considered to fall within the next higher classification. Over time, the terms associated with the subcategories became the “naming convention”. We also see evidence in the testimony of the possibility that physicians are attempting to rate the permanent impairment by placing the worker in a subcategory within a classification, rather than providing the objective findings of permanent impairment to the insurer for rating. For these reasons, we will retain the present categories and classification system and will not be changing the rule.

Testimony: OAR 436-055-0070(3)

Exhibit #11

Due to legislative changes, there is now a requirement that claims examiners have training related to interactions with IME providers.

Comments: The rules were changed to require at least 3 of the 24 hours required for certification is in interactions with IME providers. The 3-hour requirement places distorted weight of a claims examiners job on issues and interactions related to IMEs. In reviewing all that is encompassed in a claims examiners job, most important providing timely benefits according to the laws and

rules, IMEs is a very small portion. In the second quarter of 2005, Liberty Northwest scheduled approximately 660 IMEs with vendors. Considering the volume of open claims, this is a small percentage of that volume. A 3-hour training requirement, compared to the 4-hour requirement in rule training distorts the actual portion of a claims examiners job that encompasses IMEs. We request that this 3-hour requirement be decreased to 1 hour per reporting period.

Response: The Management-Labor Advisory Committee (MLAC) intent was that claims examiners remain “current” in their awareness of what constitutes appropriate interaction with independent medical examination providers. The rule as currently proposed requires three hours of training over a three year period of certification. This does not appear to be an unreasonable requirement in light of MLAC’s intent. The proposed rule will remain as written.

Testimony: OAR 436-055-0070(3)

Exhibit #13

The rule requiring training on interaction with IME providers needs to be phased in. As written, it could require this training for any adjuster whose certification needs to be renewed immediately after January 1. No training will have been approved by the department, or presented, in time for this requirement to be met. We suggest that the department should apply this requirement to renewals of certification occurring on or after July 1, 2006.

Response: The rule as currently proposed could cause examiners renewing their certification after January 1, 2006 to be unable to comply. In order to allow time for the development and approval of appropriate training, the rule will be revised to require that certification renewals on or after January 1, 2007 meet the independent medical examination provider interaction continuing education requirement.

Testimony: OAR 436-055-0085

Exhibit #11

This rule was added and outlines the training requirements for interactions with IME providers.

Comments: Liberty Northwest has concerns about the applicability of these changes as outlined in these rules. Considering the proposed, 3-hour requirement, and the fact that part of the curriculum, such as the IME providers’ standards of conduct requirement and IME complaint and investigations process, is not available yet, the 3-hour requirement (or any requirement) should not be applicable until 1/1/07 renewals.

Response: OAR 436-055-0070(6)(b) will be revised to require that certification renewals on or after January 1, 2007 meet the three-hour continuing education requirement.

Testimony: OAR 436-055-0085(1)

Exhibit #4 & 15-B

Suggest: *deletion of subsection (1)* and **insertion** of the following language “**The Director must first approve any training provided pursuant to OAR 436-005-007(1) or OAR 436-005-0100(4) relating to interactions with independent medical examination providers.**”

Response: The suggested language change does not appear to alter the meaning of the proposed language. The proposed language will remain as written.

Testimony: OAR 436-055-0085(2)(a)

Exhibit #4 & 15-B

Suggest: *deletion* of the word “*and ethical communication*” and **insertion** of the words “**interactions with independent medical examination providers**”.

Rationale: As the Oregon Medical Association has repeatedly noted, ethical issues fall within the purview of the licensing boards. In addition, MLAC explicitly rejected language that included “ethical” oversight. There is no enabling legislation that expands WCD’s regulatory powers to include infringement upon areas of concern, such as “ethics”, allocated specifically to licensing boards.

Response: The rule addresses a continuing education requirement that claims examiners must meet, not physicians and their appropriate licensing boards. As currently proposed, the rule supports the intended outcome of claims examiner education in appropriate interaction with independent medical examination providers.

Testimony: OAR 436-055-0085(4)

Exhibit #13

The rule should also require resubmission of training curricula following any significant changes to statutes or rules relating to IMEs.

Response: The rule as proposed requires the parties to resubmit training for approval if the content or number of hours of training changes. Hence, content changes resulting from statute changes will require the parties to resubmit training when that training no longer reflects the statutory requirements.

Testimony: OAR 436-060-0095(5)(h)

Exhibits #4, #13, & 15-B

The word, “paid” implies specific monetary exchange. Suggest change “paid to attend” to “compensated in any way.” This will more directly focus on keeping “professional” observers out of the system, and encourage personal support observers. Exhibit 4 & 15B

The intent is to exclude an attorney or any employee or representative of an attorney. The rule should specify this. In the alternative, the rule should say that the observer should have no interest in any future compensation the worker might receive. Exhibit 13

Response: One potential problem with the suggested language “compensated in any way” was discussed in the External Advisory Committee meeting. “If someone wants to bring a priest or rabbi, who is on salary, is this prohibited? If the observer is a paralegal, would this be prohibited? What about translators? The observer is there as a witness (not so for the translator). The proposed language was intended to prohibit someone from being paid to observe the exam, while not limiting a worker’s choice to exclude his or her clergy. We agree the intent is to encourage personal support observers for injured workers. However, “compensated in any way” is extremely broad language and would preclude an injured worker from the personal support of his or her clergy as an observer. Changing the rule to say that an “observer should have no interest in any future compensation the worker might receive,” might preclude a spouse or other relative from providing the personal support intended. However, we will modify the rule to read,

“the observer may not be compensated in any way for attending the exam.”

Testimony: OAR 436-060-0095(5)(i)

Exhibits #4, 13, & 15-B

Suggest deletion of “If there is any reason you cannot attend you must tell the insurer as soon as possible before the date of the examination.” And insert, “If you believe you have good cause for not attending this examination you must, whenever practicable, give notice to the insurer at least 6 business days before the date of the examination.” Suggest changing the “\$100” penalty to “\$400.” Exhibit 4 & 15-B

The rule should require the worker to contact the insurer first if the worker objects to the location of the exam. Very often, the insurer can address the worker’s concern without invoking an appeal procedure. Exhibit 13

Response: The language that the testimony suggests deleting is not new and is not as a result of SB 311. The intent is to convey to the worker the importance of notifying the insurer as soon as possible if the worker will be unable to attend the exam, so the insurer can cancel the exam if necessary and avoid a “no show” fee. SB 311 requires a worker who objects to the location of an exam, to do so within six business days of the exam notice. There is nothing in SB 311 about the worker giving the insurer notice that the worker will not attend the exam six business days before the exam. However, this testimony helped us realize that the notice incorrectly told the worker that if they failed to attend or cooperate with the exam, they might be penalized. SB 311 tied the penalty to non-attendance of the exam, not non-cooperation with it. We will modify the language to clarify the intent.

Having the worker contact the insurer about an objection to the location of the exam seems to be a good idea. However, with the insurer required to send the notice to the worker a minimum of 10 days prior to the exam and the worker required to object to the location within six business days of the notice, that leaves potentially very little time for the division to act on a worker’s objection to the location. Nothing prevents the division from calling the insurer and quickly resolving the worker’s objection to the location. And the division intends to resolve location objections as quickly as possible. The penalty in SB 311 was not intended to offset the insurer’s payment of a “no show” fee. It was intended to encourage the worker to attend the exam. The \$100 penalty will remain as proposed.

Based on our experience during January 2006, the process appears to be working well. Of the ten location objections received by the Workers’ Compensation Division, seven have been resolved to the satisfaction of the parties without the division having to issue an order. The division has issued one order and the two remaining cases are pending.

*Note: See IMEA attachment A for additional testimony.

Testimony: OAR 436-060-0095(6)

Exhibit #11

The proposed rule requires the insurer to send a brochure to the worker with the appointment letter. This requirement should be based on the availability of the brochure. If it will not be available by 1/1/06, the rule should not require that the insurer send it.

Response: The director hoped to have the brochure ready for distribution by 1/1/06. The rule

was modified, so it is clear that until the brochure is available, the requirement will not apply.

Testimony: OAR 436-060-0135

Exhibits #3, 4, & 15-A

Section (3)

Testimony: This rule contains a reference to section (5). The reference can be eliminated if section (5) is deleted as recommended. See testimony on OAR 436-060-0135(5). *Exhibits #3 & 15-A*

* * * * *

Response: As this change is due to a decision of the Oregon Supreme Court, the rule will be changed.

Section (5)

Testimony: After the proposed rules were filed, the Oregon Supreme Court reversed a Court of Appeals decision in the Marvin E Lewis case that allowed the insurer to deny the claim due to the injured worker's noncooperation with attendance at an independent medical examination (IME). The Supreme Court concluded that only the sanction of suspension under ORS 656.325(1)(a), not the sanction of claim denial under ORS 656.262(13) and (14), applies to a claimant's noncooperation with an IME. This rule prescribes the notification language that insurers must send to injured workers for whom the insurer has scheduled an IME. Delete this rule in its entirety, to remain consistent with the ruling of the Court. *Exhibits #3 & 15-A*

Response: Section (5) will be deleted.

* * * * *

Testimony: Same as for OAR 436-060-0095(5)(i) regarding deleting "as soon as possible" and replacing it with "within 6 business days whenever possible" and changing "\$100" to "\$400."
Exhibit #4

Response: See above - Section (5) will be deleted.

* * * * *

Section (6)

Testimony: This rule contains language that exclusively applies to sanctions for noncooperation in an IME. See testimony for OAR 436-060-0135(5). *Exhibits #3 & 15-A*

Response: The rule will be modified to remove language that applies to sanctions for noncooperation in an IME.

Testimony: OAR 436-060-0150(3)

Exhibit #13

We support efforts to improve timeliness of payments to injured workers. However, we oppose the imposition of a new timeliness standard without any prior warning or discussion. The change to this rule cuts the number of permissible late payments by 50% and threatens penalties for noncompliance. Yet, it is our understanding that this issue was not raised at the advisory committee. Please withdraw this proposal until the industry has had an opportunity to discuss the

implications with the department.

Response: The division sent an Industry Notice out on June 1, 2005, which announced this change. The notice included the information that the division is increasing some penalty amounts and performance thresholds for areas affecting coverage and timely and accurate benefits from 80% to 90%. Additionally, the notice indicated where necessary, the division will also revise administrative rules to adjust the penalty amounts, thresholds, and maximum amounts to be consistent with statute. The issue was discussed at the External Advisory Committee meeting on August 30, 2005. It is issue number 7 in the issues document. The rule will remain as proposed.

Testimony: OAR 436-060-0150(5)

Exhibits 1, 9, & 11

Testimony: Prior to this rule change in January 2002, payment was due within 14 days of the employer date of knowledge or time loss authorization. With the current interpretation of the administrative rules, you have effectively created a standard that is extremely difficult to reach and maintain. In addition, it is not consistent and I do not believe that it captures the intent of the law. If we are now going to be held to such a standard, it will make it very difficult for employers, and insurance companies, to maintain 80% compliance, let alone 90% compliance.

Exhibit #1

Response: This change was made in 2001 and was effective January 1, 2002. The September 20, 2001 Administrator's notice explained the need for this change and informed the industry the change would be incorporated into Division OAR 436-060. The division determined the statute did not support the existing rule. The rule will remain as proposed.

* * * * *

Testimony: We recommend adding language to this rule that makes it clear that under OAR 436-010-0240(14) a completed and signed aggravation form must be filed before there is an acknowledgement of a claim for aggravation benefits. Also, to be consistent with statute, we recommend language that the worker is unable to work due to a worsened "compensable" condition. Suggest, "The date the insurer receives a properly completed and signed Form 827, and medical evidence supported by objective findings that shows the worker is unable to work due to a worsened compensable condition under ORS 656.273." **Exhibit #9**

Response: See the response just below the text testimony.

* * * * *

Testimony: The wording is slightly different from the statutory language and should be modified to be consistent with HB 2405: We propose that the rule mirror the statute and state: "The first installment of compensation...shall be paid no later than the 14th day after the subject employer or paying agent of the subject employer receives a written report that verifies the worker's inability to work resulting from a compensable worsening and that establishes by medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury." **Exhibit 11**

Response: HB 2405 modified ORS 656.273(3) to read, "A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative and the worker's attending physician. When an insurer or self-insured employer receives a completed aggravation form, the insurer or self-insured employer shall process the

claim.” If the words “compensable worsening” were included in the rule as suggested, the result would be an insurer would not have to pay temporary disability to the worker until and unless the insurer determined if the aggravation was compensable. That was not the intent of the statutory change. However, we will modify the language so it is clear that the “worsening” must be on a previously accepted condition.

Testimony: OAR 436-105-0003(1)

Exhibit #13

As these rules include clarification and improvement of the July 1, 2005 rules, they should be applied to all reimbursement requests made since July 1, 2005, not just to new requests after January 1, 2006.

Response: After review the division agrees with the suggestion. The permanent rules will be filed with the dates in OAR 436-105-0003(1) unchanged from the current rules. The changes to OAR 436-105-0500(7) will apply to individual Employer-at-Injury Programs begun on or after July 1, 2005 and to reimbursement requests made to the division on or after July 1, 2005 with exceptions as stated in this rule.

Testimony: OAR 436-105-0500(7)(i)

Exhibit #13

We propose an amendment to this rule to permit reimbursement of Program Purchases when the training material is not formally accredited. The current rule limits employer options for Skills Building as transitional work. Self study programs may help an employee to develop a new skill, but sometimes a computer or other equipment might be required. We recommend amending the rule to allow reimbursement for Program Purchases whenever the class or course is reimbursed through the Employer-at-Injury Program.

Response: The rules will not be amended at this time to include changes to rules where changes were not already proposed. Your recommendation will be an issue to be considered the next time these rules are opened. At that time both internal and external advisory committees will consider this issue.

Testimony: OAR 436-110-0310(8)

Exhibit #13

A redetermination of eligibility should be requested within six months, to be consistent with OAR 436-120-0360 (5).

Response: Changing the re-determination timeframe to 6 months for a worker found not to be authorized to work in the United States would be inconsistent with how other workers are treated for Preferred Worker Program eligibility. There are times that a worker’s initial eligibility is denied, but through appeals or additional information the division re-determines and can find the worker eligible. This process is not limited to 6 months from the date of the first eligibility determination. The permanent rule will be filed as proposed.

Testimony: OAR 436-110-0330(7)

Exhibit #11

This rule requires for an insurer or self-insured employer to obtain reimbursement on a preferred worker claim that has been settled through a Claim Disposition Agreement, Disputed Claim

Settlement or stipulation, the settlement requires prior written approval of the disposition from the division.

Comments: While this rule is not currently under consideration for change, it is Liberty Northwest's position that this rule should be reviewed and revised such that a stipulation regarding compensability of the claim be excluded from the requirement to have the division's prior approval. The insurer/self-insured employer is not required to obtain the division's approval when the initial acceptance/denial of the claim is issued; therefore, it is inconsistent that the division be required to approve a stipulation to accept the claim. The way the rules are currently written does not motivate the carrier to aggressively determine compensability on preferred worker claims on behalf of the division. The insurer/self-insured employer runs the risk if they deny a claim, and evidence later developed supports it is compensable, that they will not be fully reimbursed for aggressively managing these benefits. It makes more sense that the justification and reasonableness of the stipulation be subject to audit, but the carrier should not be penalized for aggressively processing the claim on behalf of the division.

Response: The rules will not be amended at this time to include changes to rules where changes were not already proposed. Your suggestion can be considered when the rules are again opened, but statute may require the rule to remain the same. ORS 656.289(4)(a) deals with disposing of a claim where there is a bona fide dispute over compensability, and subsection (5) states:

Any claim in which the parties enter into a disposition under subsection (4) of this section shall not be eligible for reimbursement of expenditures from the Workers' Benefit Fund without the prior approval of the director.

Testimony: OAR 436-120-0755(1)

Exhibit #13

The timetable of events leading to reimbursement of vocational costs should include the intermediate step where the insurer's denial of benefits is reversed by a director's order.

Response: We agree with the testimony and have revised section (1) to include the intermediate step where the director issues an order overturning the insurer's or self-insured employer's denial of vocational benefits.

Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 3rd day of March, 2006.

WORKERS' COMPENSATION DIVISION

Fred Bruyns

Fred Bruyns, Hearings Officer

Attachments: Exhibit #3 Supporting document
Exhibit #4 Supporting document
Exhibit #10 Supporting document

Exhibit #3 Supporting document

436-060-0135 Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) When the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(13), the division will suspend compensation pursuant to ORS 656.262(14) by order under conditions set forth in this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation. The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation prior to issuance of the order.

(2) A worker must submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques reasonably requested by the insurer. For the purposes of this rule, "personal and telephonic interviews" may be audio or video taped by one or more of the parties if prior written notice is given of the intent to record or tape an interview.

(3) The division will consider requests for suspension of benefits pursuant to ORS 656.262(14) only after the insurer has notified the injured worker in writing of the worker's obligation to cooperate as required by section (4) ~~or (5)~~ of this rule and only in claims where there has been no acceptance or denial issued.

(4) For suspension of benefits to be granted under this rule, the insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements, and must give the worker at least 14 days to cooperate. The notice must be sent to the worker and copied to the worker's attorney, if represented, and must advise the worker of the date, time and place of the interview and/or any other reasonable investigation requirements. If the insurer contracts with a third party, such as an investigation firm, to investigate the claim, the notice shall be on the insurer's stationery and must conform with the requirements of this section. The notice must inform the worker that the interview, deposition, and/or any other investigation requirements are related to the worker's compensation claim. The notice must also contain the following statement in prominent or bold face type:

"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you fail to reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

~~(5) Notwithstanding section (4) of this rule, for suspension of benefits to be granted under ORS 656.262(14) for noncooperation during an investigation of a claim resulting from a worker's failure to attend or cooperate in an insurer medical examination, the notification requirements in OAR 436-060-0095(5) must be met; however, the notice required by 436-060-0095(5)(h) must be replaced with the following notice, in prominent or bold face type:~~

~~**"The workers' compensation law requires injured workers to cooperate and assist**~~

~~the insurer or self-insured employer in the investigation of claims for compensation. Therefore, you must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend or fail to cooperate, and do not have a good reason for not attending, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."~~

(65) The request for suspension must be sent to the division after the 14 days in section (4) have expired. ~~If the request is for failure to attend an insurer medical examination pursuant to section (5), the request must be sent to the division after the date of the examination, or after the insurer receives written documentation from the worker or the worker's representative that the worker will not attend the examination.~~ Any delay in requesting suspension may result in authorization being denied. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information sufficient to show the worker's failure to cooperate:

(a) That the insurer requests suspension of benefits pursuant to ORS 656.262(14) and this rule;

(b) Documentation of the specific actions of the worker or worker's representative that prompted the request;

(c) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons, whichever is appropriate. ~~Any written verification the insurer receives from the worker or the worker's representative of the worker's refusal to cooperate or attend an exam will be sufficient documentation with which to request suspension;~~

~~(d) The dates of any prior insurer medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate (if the suspension request is for not attending an insurer medical examination);~~

~~(e) A copy of any approvals given by the director for more than three insurer medical examinations, or a statement that no approval was necessary, whichever is appropriate (if the suspension request is for not attending an insurer medical examination);~~

~~(fd) A copy of the notice required in section (4) or (5) of this rule; a copy of any written verification received under subsection (65)(c); and~~

(ge) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating.

(76) After receiving the insurer's request as required in section (65) of this rule, the division will promptly notify all parties that the worker's benefits will be suspended in five working days unless the worker or the worker's attorney contacts the division by telephone or mails a letter documenting that the failure to cooperate was reasonable or unless the insurer notifies the division that the worker is now cooperating. The notice of the division will also advise that the insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired.

(87) If the worker cooperates after the insurer has requested suspension, the insurer must notify the division immediately to withdraw the suspension request. The division will notify all the parties. An order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(98) If the worker documents the failure to cooperate was reasonable the division will not suspend payment of compensation. However, an order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(109) If the worker has not documented that the failure to cooperate was reasonable, the division will issue an order suspending all or part of the payment of compensation to the worker. The suspension will be effective the fifth working day after notice is provided by the division as required by section (76) of this rule. The suspension of compensation shall remain in effect until the worker cooperates with the investigation. If the worker makes no effort to reinstate compensation within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(14) and OAR 436-060-0140(10).

(140) Under ORS 656.262 (13), an insurer who believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the division will consider assessment of a civil penalty against the attorney of not more than \$1,000. The worker's attorney must have the opportunity to dispute the allegation prior to the issuance of a penalty. Notice under this section must be sent to the division. A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:

- (a) What specific actions of the attorney prompted the request;
- (b) Any reasons given by the attorney for failing to participate in the interview; and
- (c) A copy of the request for interview sent to the attorney.

(121) Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request.

Stat. Auth: ORS 656.704 and 656.726(4); **Stat. Impltd:** ORS 656.262(14) and (15), 656.704, 656.726(4), and section 7 (6)(a), chapter 865, Oregon Laws 2001; **Hist:** Filed 2/2/96 as WCD Admin. Order 96-053, eff. 2/12/96; Amended 8/5/96 as WCD Admin. Order 96-066, eff. 8/12/96 (Temp); Amended 10/18/96 as WCD Admin. Order 96-070, eff. 11/27/96; Amended 11/30/01 as WCD Admin. Order 01-061, eff. 1/1/02; Amended 4/19/02 as WCD Admin. Order 02-056, eff. 5/10/02 (Temp.); Amended 10/2/02 as WCD Admin. Order 02-059, eff. 11/1/02, Amended 2/17/04 as WCD Admin. Order 04-051, eff. 2/29/04; Amended 10/26/04 as WCD Admin. Order 04-064, eff. 1/1/05

Exhibit #4 Supporting document

**IMEA Financial Impact Review
 of IME "No-Shows" including
 Worker Sanctions**

(Note: #'s are estimates based on industry input)

<u>Type of Physician</u>		<u>No Show Cancellation Notice</u>	<u>Cancellation Fee</u>
Orthopedic		2-3 Days	\$350-400
Neurosurgeon		2-3 Days	\$400-700
Psychiatry		5-10 Days	\$700-1400
Neuro-psych		5-10 Days	\$1000- 1800
Annual Number of Work Comp IME's			15,000
"No Show" Rate			15%
Orthopedic	\$375.00	73%	\$615,938
Neurosurgeon	\$525.00	21%	\$248,063
Psychiatry	\$1,050.00	4%	\$94,500
Neuro-psych		2%	\$63,000

	\$1,400.00	
Total No-Show Cost to Insurers/Self-Insured's w/no sanction offset		\$1,021,500
Cost to Insurers/Self-Insured's less \$100 sanctions (full recovery assumed)		\$927,000
Cost to Insurers/Self-Insured's less \$400 sanctions (full recovery assumed)		\$643,500

Estimated Stats Used

Annual Number of Work Comp IME's	15,000
"No Show" Rate	15%
% of "No Show" Workers not on Time Loss	42%

IMEA EXHIBIT "A" to 11/1/05 WCD Testimony

Exhibit #10 Supporting documents

PRODUCING THE BEST OUTCOMES

The most important player in any workers' compensation case is the treating physician. They diagnose the condition, determine causality, develop the treatment plan, and order the tests. Ideally, they work with the adjuster and employer to arrange for transitional duty and encourage the injured worker to get back to work as quickly as is practical; and, they account for less than one-third of workers' compensation medical costs.

Discounted fee schedules and discriminating against physicians in reimbursement arrangements for usual and customary, necessary medical and surgical services, has never been proven to reduce the overall medical costs of a workers' compensation claim.

There are studies that show that those physicians who are most experienced in the care of injured workers. (??)

Occupational medicine and occupational specialty physicians are a unique provider group that require special consideration because of the positive economic impact they have on the care of injured workers. **They are highly skilled at meeting the unique needs of the workers' compensation system and avoiding the pitfalls which result in over-utilization, increased administrative costs, higher rates of disability and impairment, higher rates of litigation, and overall increased medical costs.**

The California Workers' Compensation institutes a 2003 report entitled, "Provider Experience and Volume-Based Outcomes in California Workers' Compensation," indicates that a relatively few "expert" providers deliver by far the best outcomes and lowest medical costs for workers' compensation cases. The study included 1.1 million claims over an eight-year period treated by some 40,000 separate providers. Key findings include:

- The medical costs of claims treated by the highest volume workers' compensation providers are LESS THAN HALF than that of their peers who treat the fewest workers' compensation cases.
- For temporary disability claims, the average length of disability for the highest volume providers was less than half than that of the lowest volume providers (17.2 days versus 35.9).
- For permanent disability claims, the highest volume providers' length of disability was 71 days less than that delivered by the lowest volume providers.

We feel that providing the largest spectrum of services possible to the worker in a single location is important in reducing the apprehension and confusion surrounding the workers' perception of the treating environment.

PROVISION OF PRESCRIPTION MEDICINES

For similar reasons noted above relating to the "one stop shopping" concept and its beneficial effects on the care of injured workers, the following comments are offered on the provision of generic medications to injured workers by physicians.

There is a provision in OAR 436-009-0080(3), "The worker shall have the right to select a service provider, except for claims enrolled in a managed care organization (MCO) where service providers are specified by the MCO contract."

OAR 436-009-0090 describes the application of a pharmacy fee schedule. It specifically states in (1)(C)(c), “All providers who are licensed to dispense medications in accordance with their practice must be paid similarly regardless of profession.” Under OAR 436-009-0090(3), under ORS 689.515(2), licensed providers may dispense generic drugs to injured workers.

PHARMACY REGULATIONS

Everything in the ORS and OAR point to the attending physician as the decision maker and provider of comprehensive medical care to injured workers.

In the area of pharmacy, ORS 689.515 and 656.245 clearly give the attending physician the authority to dispense generic drugs to injured workers.

In addition, it clearly indicates that the worker may choose an attending doctor or physician within the State of Oregon.

OAR 436-009-0090 is clearly in harmony with the above provisions. It states that all providers who are licensed to dispense medications in accordance with their practice must be paid similarly regardless of profession.

It makes reference to ORS 689.515(2), licensed providers may dispense generic drugs to injured workers.

OAR 436-010 indicates clearly that a “medical service provider” means a person duly licensed to practice one or more of the healing arts. It also states that a “medical service” would include drugs and medicine.

It is usual and customary for insurers in the State of Oregon to pay for generic medicines dispensed from a physicians’ clinic in accordance with the fee schedule outline in OAR 436-009. The majority of workers’ compensation insurance carriers reimburse physicians for this service.

It is of interest that certain MCOs which serve more than one insurer will pay usual and customary fee for appropriate generic medications prescribed to injured workers for accepted conditions for most of the insurers they contract with; however, they make exception with other insurers who cite OAR 436-010-0230(6) as a reason not to reimburse according to the fee schedule for generic medications. It is interesting that this paragraph contains one statement which is totally in concert and consistent with all other ORS and OAR statements regarding generic pharmacy. It states, “A pharmacist, dispensing physician, or authorized nurse practitioner shall dispense generic drugs to injured workers in accordance with and pursuant to ORS 689.515.” It further states that, “Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract.”

The one contradictory statement in all the rules and regulations relating to the provision of medications to injured workers appears in OAR 436-010(6) and reads as follows:

“Except in an emergency, drugs and medicine for oral consumption supplied by a physicians’ or authorized nurse practitioners’ office are compensable only for the initial supply to treat the worker with the medication up to a maximum of ten (10) days, subject to the provisions of this rule and OAR 436-009-0090. “

This statement not only contradicts every other reference and rule regulating dispensing medications to injured workers, it is in direct contradiction to the usual and customary medical practices followed throughout the State of Oregon and the United States.

Typically, a patient presenting to the emergency room will be provided with a small supply of appropriate medications to treat their condition. It will then be up to the treating or attending physician to determine whether those medicines should be continued. Typical treatment patterns and dispensing practices of physicians throughout the United States are predominantly geared towards providing supplies of medications in 30-day increments. This is consistent with the monitoring practices to oversee the utilization of pharmaceuticals prescribed by physicians.

It is also interesting to note that most workers' compensation insurance carriers review eligibility for medical benefits every 30 days.

The contradictory statement in OAR 436-010(6) is being utilized to deny payment for medical services that are otherwise supported by all other references within the ORS and OAR as well as the usual and customary practices of physicians throughout the United States.

This rule is not necessary since the typical dispensing patterns of emergency and community physicians are such that it would result in no net increase or decrease in the amount of medications required.

This rule creates an adverse financial impact by requiring a subset of workers within the State of Oregon to seek prescription medications at other sources despite the availability of those medications within some providers' offices.

The lack of understanding by injured workers of the existence of pharmacy benefits often leads to them not obtaining the medicines that are prescribed by physicians. This is either because they lack the means of transportation to go to a participating pharmacy, or the funds to be able to pay for the medications up front.

I have had personal experience with cases in which patients have not obtained needed medications because of MCO restrictions and have gone on to develop devastating consequences. In other cases, disputes about timely reimbursement for prescribed medications to workers has led to litigation and prolongation of activity within the claim. This has resulted in extended time loss and increased expense because of the additional time required by the attending physician to mitigate the financial impact on the worker and dispel the anger and frustration thus resulting between the worker and the workers' compensation system (insurer/employer).

In other cases, quite simply, workers have been frustrated by misunderstandings regarding the requirements of reimbursement of expenses (saving receipts and a copy of the prescription) in order to receive reimbursement. In one case, submission of the receipt alone failed to be sufficient for the worker to be reimbursed for medications paid out of pocket.

In other instances, patients have presented their pharmacy cards for prescriptions written from our office only to be told that certain generic medications are not covered under the pharmacy benefit program. This again results in the need for them to pay for these medications out of pocket which is usually not feasible.

This rule penalizes the least sophisticated and "weakest" of those injured workers. These lower income, less sophisticated workers are the most liable to become enmeshed in disputes over seemingly insignificant amounts of money required to receive appropriate medical treatment.

At the very least, it is not infrequent that a doctor will give a written prescription to a worker expecting that the medications will be obtained and utilized. The workers do not understand that they have a pharmacy benefit and do not get the medications because they do not have the funds.

When they return to the doctor they are embarrassed to convey to the doctor that they did not have the funds available to obtain the medications and are often not forthcoming in advising the doctor that they have, in fact, not been treated. This places them at risk of their doctor recommending more aggressive and invasive types of treatment because they are under the impression that conservative measures have failed.

The greater the delay in obtaining appropriate medications to treat traumatic injuries, the more likely that chronic changes in symptoms will prevail resulting in increased utilization of medical services and prolongation of disability.

I believe the removal of this contradictory statement from OAR 436-010(6) will have a very positive impact on reducing the costs to the workers' compensation system.

Since most physicians who specialize in non-injured worker care have no incentive to offer generic medicines in their offices, this will not result in a large number of Oregon physicians providing these medications.

However, those of us who specialize in the care of injured workers understand the benefits of the "one stop shopping" concept and its mitigating effect on the adverse outcomes in workers' compensation claims.

Eliminating the ambiguity from this rule would likely impact only those few physicians in Oregon who do the highest volume of injured-worker care. The possibility of large numbers of physicians providing unregulated services would not be a factor.

CASE STUDY #1

L.A. – DOI: 04/23/2002

This is a 46-year-old framer and drywaller who was on a scaffold when the wheel rolled into an open floor vent. This caused the scaffolding to fall. The patient sustained an accepted right knee injury. Failing conservative treatment, he was taken to the operating room on August 7, 2002 for shaving and debridement of a Grade 3 chondral flap tear of the medial femoral condyle. Following surgery, he had some drainage from the right knee around the medial portal. He had no signs of infection. The portal healed uneventfully.

His knee pain complaints continued and were unresponsive to further conservative measures. He underwent repeat arthroscopy on January 29, 2003 just before I went on vacation.

He once again presented postoperatively with persistent drainage from one of his portals. My new associate ordered antibiotics; the patient was provided a prescription for Keflex 500 mg q.i.d. This is a generic antibiotic which is quite inexpensive.

The pharmacy would not fill the prescription because Dr. Bowman had not yet been admitted to the MCO. I was out of town and unavailable. Mr. Lockett could not afford to pay for the medication having been out of work for nearly one year. Numerous phone calls were made, the situation straightened out, but unfortunately the worker developed a very serious knee joint infection resulting in the need for three wash-out procedures. A letter to the adjuster is enclosed.

It is interesting to note his arthroscopic evaluation demonstrated no additional injury or pathology and had he not developed this infection, he would have been declared medically stationary and released to full duty at some time early in 2003. Instead, he remained off duty and required extensive treatment including home intravenous antibiotics, profound atrophy (withering) of the

limb, and stiffness of the knee joint.

Despite a subsequent knee manipulation and months upon months of physical therapy, his condition continued to deteriorate.

He subsequently underwent another procedure in September 2004 in which he was shown to have advanced degenerative changes of the entire knee with a large loose body which required extensive dissection for removal.

The patient has lost his job, been divorced, has suffered extensive financial devastation, lives in constant pain for which he is taking various narcotics and neuroleptic medications supervised on an ongoing basis by a physiatrist. He has required the use of a brace which has been replaced once and will likely need further replacement in the future. He will undoubtedly require a total knee replacement within the next five years and he is 49 years old.

It was this gentleman's situation that convinced us to provide generic medications in our office so that we could dispense these essential medicines in a timely manner and be certain of the patient's compliance with treatment.

CASE STUDY #2

This patient was treated for a knee injury occurring on May 21, 2003. At his first visit to our office on July 24, 2003 he was given a prescription for Etodolac, a generic anti-inflammatory medication. He paid for this prescription with his own funds. He submitted the appropriate information to obtain reimbursement which was never forthcoming for some reason. For a period of time we supplied medications through our in-office generic pharmacy, but because of lack of reimbursement, we again began writing prescriptions to be filled outside the office. Due to his frustration in being reimbursed for medications prescribed through our office, he obtained an attorney. As I attempted to move his claim through closure, most of our conversations were related to his frustrations with the carrier, and issues brought to the forefront to his attorney. I believe his claim closure was delayed by at least two to three months over the frustration he experienced in dealing with medication issues relating to the treatment of his accepted condition.

436-010-0230 → Medical Services And Treatment Guidelines ¶

The following changes are proposed to (4)(a) to reduce the administrative burden on the attending physician and the ancillary provider. The current routine is for the attending physician writing a prescription for the rapy, the the rapist then faxing and mailing a treatment plan to the physician who signs it and faxes it back to the the rapist who then sends it to the carrier. The costs of handling these administrative tasks can easily be in the tens of thousands per year to all concerned. ¶

The rule should be altered so that if a physician is willing to provide sufficient detail in their treatment plan to satisfy the carrier that they are appropriately managing the patients' care, that the physician can send copies of the treatment plan to all required at the time services are requested. This would provide appropriate guidance to the ancillary provider and advise the carrier of the specific treatment prescribed, eliminating several additional costly steps in the communication process. ¶

The financial impact of this would be positive in that it would reduce redundant activities and save money and resources for all parties. ¶

(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 dated and comprehensive 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 a copy provided to the insurer within seven days of beginning treatment signed by the attending physician, authorized nurse practitioner, or specialist physician indicating approval of the treatment plan. The treatment plan shall include short and long term objectives, modalities, limitations or precautions, 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)(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. ¶

¶

436-010-0230 → Medical Services And Treatment Guidelines ¶

The following change for (6) is proposed to insure the workers' prompt access to generic prescription medicines. The rationale for this rule change is supplied in the supporting documents attached. ¶

(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 provisions of this rule and OAR 436-009-0090. Compensation for certain drugs are limited as provided in OAR 436-009-0090. ¶

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services,
 Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns

(503) 947- 7717 Fax (503) 947-7581

Rules Coordinator

Telephone

PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879

Address

Room 260 (2nd Floor, Labor & Industries Building)

November 1, 2005

10:30 a.m.*

350 Winter Street NE, Salem, Oregon

Fred Bruyns

Hearing date

Time

Location

Hearings Officer

***NOTE: The hearing will begin at 10:30 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through November 7, 2005.**

**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

ADOPT: OAR 436-055-0085, 436-060-0137, 436-060-0510, 436-120-0755

AMEND: OAR 436-010; OAR 436-060; and

436-015-0008	436-030-0020	436-035-0007	436-035-0350	436-050-0110	436-110-0335
436-015-0030	436-030-0023	436-035-0008	436-035-0360	436-050-0170	436-110-0337
436-015-0040	436-030-0034	436-035-0009	436-035-0380	436-050-0220	436-110-0345
436-015-0070	436-030-0055	436-035-0011	436-035-0390	436-050-0230	436-120-0003
436-015-0080	436-030-0065	436-035-0012	436-035-0395	436-055-0070	436-120-0008
436-015-0110	436-030-0115	436-035-0016	436-035-0400	436-055-0100	436-120-0320
436-030-0002	436-030-0155	436-035-0017	436-035-0410	436-105-0003	436-120-0900
436-030-0003	436-030-0165	436-035-0019	436-035-0420	436-105-0500	436-160-0003
436-030-0005	436-030-0175	436-035-0110	436-035-0430	436-110-0002	436-160-0005
436-030-0007	436-030-0185	436-035-0190	436-035-0500	436-110-0005	
436-030-0009	436-030-0185	436-035-0190	436-035-0500	436-110-0005	
436-030-0015	436-030-0575	436-035-0230	436-050-0003	436-110-0310	
	436-030-0580	436-035-0330	436-050-0008	436-110-0326	
	436-035-0005	436-035-0340	436-050-0100	436-110-0327	

REPEAL: None

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, ch. 26; ORS 656.268, Enrolled HB 2404 – OL 2005, ch. 569; ORS 656.273, Enrolled HB 2405 – OL 2005, ch. 50; ORS 656.726, Enrolled HB 2408 – OL 2005, ch. 653; ORS 656.262, Enrolled HB 2718 – OL 2005, ch. 189; Enrolled HB 3318 – OL 2005, ch. 511; ORS 656.262, 656.313, 656.605, 656.622, Enrolled Senate Bill (SB) 119 – OL 2005, ch. 588; ORS 656.268, 656.745, Enrolled SB 172 – OL 2005, ch. 221; ORS 656.325, Enrolled SB 311 – OL 2005, ch. 675; ORS 656.206, 656.268, 656.319, 656.605, 656.319, Enrolled SB 386 – OL 2005, ch.461; ORS 656.260, Enrolled SB 670 – OL 2005, ch. 364

Stats. Implemented

Notice of Proposed Rulemaking Hearing

RULE SUMMARY

Proposed amendment of workers' compensation rules affecting injured workers, employers, medical providers, insurers, and others.

Changes directly related to 2005 legislation are marked with asterisks *. Some changes apply only to injuries that occur on or after 1/1/2006. Proposed substantive amendments affect:

- *Hearings on workers' compensation matters currently processed by the Office of Administrative Hearings – moved to the Workers' Compensation Board, for all hearings held on or after January 2, 2006.
- *Independent medical examinations (IME)s – including a worker's right to contest the location of the exam and associated increase to 90 days for the insurer to accept or deny the claim if the worker prevails; penalty to worker for failure to attend; penalty to medical provider for failure to forward diagnostic records to the IME provider; requirement (effective 7/1/2006) for the director to develop a list of medical providers who are authorized to perform IMEs and for all IMEs to be scheduled with a physician on the list.
- *The reporting and processing of aggravation claims;
- Elective surgery notification;
- Types of care that are reimbursable after the worker becomes medically stationary (clarification only);
- *Requirements that managed care organizations submit copies of their treatment standards and protocols to the director for review and approval;
- Closure notice requirements in fatal claims;
- Reduced insurer reporting requirements for claims in which workers have no permanent impairment;
- *Permanent total disability – including limitations on benefits if the worker incurs a new injury; criteria for re-examination or reduction; required vocational evaluations and suspension of benefits for failure to attend or non-cooperation; appeals of termination; automatic eligibility for vocational assistance upon termination of permanent total disability (by final order);
- The reconsideration record – video recordings, duplicate records;
- *Penalties upon reconsideration – limitations;
- *Insurer data reporting necessary for the Workers' Compensation Division to assess the impact of legislative changes on permanent partial disability awards;
- *The effect of a regular work release on awards of work disability and social/vocational factors;
- Requirements to round percentages of impairment – hearing and vision no longer taken to the 100th of a percent;
- Rating of impairment for skin disorders – signs and symptoms need not be present upon examination;
- Insurer's notice to employer of policy cancellation to include a statement that the guaranty contract will terminate;
- Insurers' reporting of names or positions of key contacts to the Workers' Compensation Division;
- *The right of self-insured public utilities with assets in excess of \$500 million to obtain excess workers' compensation insurance coverage from an eligible surplus lines insurer;
- *Required training for certified claims examiners on interactions with independent medical exam providers;
- Adjustments – up and down – of insurer claims processing compliance thresholds (affecting penalties);
- *The dollar amount employers can pay for medical services on non-disabling claims;
- *Requirement (effective 7/1/2006) that Worker Requested Medical Examinations be conducted by a medical

Notice of Proposed Rulemaking Hearing

provider on the list of authorized independent medical examination providers maintained by the director;

- Increase of certain maximum penalty amounts to the \$2,000 statutory maximum;
- Eligibility for Preferred Worker Program benefits – workers must be authorized to work in the United States;
- *Reimbursement from the Workers' Benefit Fund of permanent total disability (PTD) payments made by the insurer during an appeal of termination of PTD – if the insurer prevails;
- For the purposes of reimbursement of wage subsidies under the Employer-at-Injury Program, allowance for supplemental documentation to clarify information not fully explained by the payroll record;
- *Provision for direct assistance to workers under ORS 656.622 to promote re-employment;
- *Reimbursement from the Workers' Benefit Fund of the insurer's vocational assistance costs incurred after the insurer appeals an administrative order to provide such assistance (if the insurer prevails);
- Deletion of the penalty matrix for three types of violations of the vocational assistance rules;
- Requirement that insurers submit the legal name of the employer (not a "doing business as" name, etc.), whether reporting by paper or electronically;
- Provision for the director to impose a civil penalty for violation of ORS chapter 656, in addition to violation of rules and orders of the director.

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 503-947-7581; 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.

November 7, 2005
Last Day for Public Comment

/s/ John L. Shilts 9/15/05
Authorized Signer and Date

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

OAD CHAPTER 436

Agency and Division	Administrative Rules Chapter Number
In the Matter of)
The Amendment of OAR:)
436-010, Medical Services)
436-015, Managed Care Organizations)
436-030, Claim Closure and Reconsideration)
436-035, Disability Rating Standards)
436-050, Employer/Insurer Coverage Responsibility)
436-055, Claims Examiner Certification)
436-060, Claims Administration)
436-105, Employer-at-Injury Program)
436-110, Preferred Worker Program)
436-120, Vocational Assistance to Injured Workers)
436-160, Electronic Data Interchange)

Statutory Authority,
 Statutes Implemented,
 Statement of Need,
 Principal Documents Relied Upon,
 Statement of Fiscal Impact

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, ch. 26; ORS 656.268, Enrolled HB 2404 – OL 2005, ch. 569; ORS 656.273, Enrolled HB 2405 – OL 2005, ch. 50; ORS 656.726, Enrolled HB 2408 – OL 2005, ch. 653; ORS 656.262, Enrolled HB 2718 – OL 2005, ch. 189; Enrolled HB 3318 – OL 2005, ch. 511; ORS 656.262, 656.313, 656.605, 656.622, Enrolled Senate Bill (SB) 119 – OL 2005, ch. 588; ORS 656.268, 656.745, Enrolled SB 172 – OL 2005, ch. 221; ORS 656.325, Enrolled SB 311 – OL 2005, ch. 675; ORS 656.206, .656.268, 656.319, 656.605, 656.319, Enrolled SB 386 – OL 2005, ch.461; ORS 656.260, Enrolled SB 670 – OL 2005, ch. 364

Need for the Rule(s): These proposed rule changes implement changes to Oregon laws. Some additional changes are proposed to clarify and simplify existing rules.

Documents Relied Upon: Enrolled House and Senate Bills listed next to “Statutes Implemented”; rulemaking advisory committee meeting records. These records are available for public inspection in the Administrator’s Office, Workers’ Compensation Division, 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: This statement of fiscal impact does not address those impacts associated with the House and Senate Bills implemented by these rules, except to the extent proposed rule changes may modify the impact of the law, as when the law gives the director the discretion to set penalty amounts.

Regarding: Transfer of hearings from the Office of Administrative Hearings to the Workers’ Compensation Board: Proposed rules related to passage of HB 2091 do not substantially alter the actions required of the parties to a hearing, and should not have any significant economic impact on any persons or businesses, including small businesses.

Regarding: Penalties to insurer upon reconsideration of the claim closure: Proposed rules related to passage of HB 2404 should have no effect in addition to any effect caused by the law change.

Regarding: Reporting and processing of aggravation claims: Proposed rules related to passage of HB 2405 should have no effect in addition to any effect caused by the law change.

Regarding: Regular work release and the relevance of social vocational factors and impact on awards for work disability: Proposed rules related to passage of HB 2408 should have no effect in addition to any effect caused by the law change.

Statement of Need and Fiscal Impact

Regarding: Allowing self-insured public utilities to obtain excess workers' compensation insurance coverage from eligible surplus lines insurers: Proposed rules related to passage of HB 2718 should have no effect in addition to any effect caused by the law change.

Regarding: Allowing employers to pay up to \$1500 for medical services on non-disabling claims (for dates of injury on or after 1/1/2006): Proposed rules related to passage of HB 3318 should have no effect in addition to any effect caused by the law change.

Regarding: Providing direct assistance to workers under ORS 656.622 to promote re-employment; and reimbursement from the Workers' Benefit Fund of the insurer's vocational assistance costs during an appeal of an administrative order to provide such assistance (if the insurer prevails): Proposed rules related to passage of SB 119 should have no effect in addition to any effect caused by the law change.

Regarding: The director's authority to impose a civil penalty for violation of ORS chapter 656 (not just violations related to rules and orders of the director): Proposed rules related to passage of SB 172 have no immediate effect, but should facilitate a reduction in future rulemaking and elimination of some rules that repeat statutory wording.

Regarding: Changes to requirements for independent medical examinations (IME)s –

1) The penalty amount to the worker for failure to attend an IME was not set by statute. The rules propose \$100. Independent medical examination firms have indicated a 10% to 20% no-show rate, though these may include non-workers' compensation cases, where failure to attend has fewer consequences. We estimate a 15% no-show rate: 15% times 15,000 (estimated annual IMEs) = 2,250 no-shows. The \$100 penalty may only be applied if the worker is not receiving time-loss payments. We have no data on the percentage of no-shows who are receiving time-loss. However, if we assume as many as 50% are not, the potential fiscal impact would be $2,250/2 \times \$100 = \$112,500$. This is a theoretical impact on injured workers, as the penalty may only be recovered from future benefits, if any. It is probable that no more than \$50,000 per year will be recovered. This would be a negative fiscal impact to affected workers and a positive impact for insurers, though insurers would have associated administrative costs in recovering this money. The purpose of the penalty is improved attendance at the IMEs. To the extent this is achieved, claim processing will be expedited, IME providers will lose fewer dollars due to no-shows, and overall system costs will be lowered.

2) The penalty amount to a medical provider for failure to forward diagnostic records to the IME provider was not set by statute. The rules propose \$100. We do not have data on the number of providers who unreasonably fail to provide diagnostic records. We estimate a maximum of 5%. 5% of 15,000 IMEs annually $\times \$100 = \$75,000$. This would be a negative fiscal impact to affected medical providers. Again, to the extent the penalty promotes compliance, IME examinations will be more effective and certain diagnostic procedures will not be repeated. To the extent this is achieved, overall system costs will be lowered.

3) In order to implement SB 311 and the recommendations of the Management-Labor Advisory Committee, the rules require some new notices and forms. We estimate that the IME notice and related materials the insurer sends to the worker will rise to greater than 1 oz (but less than 2 oz). This would raise the cost of each mail piece by \$0.23. $15,000 \text{ IMEs} \times \$0.23 = \$3,450$. Paperwork requirements for medical providers may add about \$1 per appointment to providers' costs, or about \$15,000 per year system wide.

4) Additional Proposed rules related to passage of SB 311 should have no effect in addition to any effect caused by the law change.

Regarding: Permanent total disability: Proposed rules related to passage of SB 386 should have no effect in addition to any effect caused by the law change.

Regarding: Requirements that managed care organizations submit copies of their treatment standards and protocols to the director for review and approval: Proposed rules related to passage of SB 670 should have no effect in addition to any effect caused by the law change.

Regarding: Reporting and notice requirements

1) Reduced reporting requirements at closure for workers who have no permanent impairment and reduced notification requirements for elective surgery: These changes should have a small positive impact on insurers and medical providers.

2) Requiring insurers to remove duplicates from the record submitted for reconsideration of claim closures: This change will increase labor costs for insurers to review their files. The exact dollar amount cannot be estimated, because insurers have very different record management systems. If the average insurer cost was \$5 per claim, the

Statement of Need and Fiscal Impact

overall cost to insurers would be somewhat less than \$25,000 per year. However, insurers and the Workers' Compensation Division should gain processing efficiency by having a more compact file, so the system as a whole may see a net cost reduction; requiring insurers to include guaranty contract termination language on their policy cancellation letters will raise costs for those insurers who do not do this currently. Because this is an Oregon-specific requirement, this affects national carriers who may have standard letters for many states. The set-up costs will be significant; however, insurers who fail to include proper notice of termination can be held liable for future claims by the "covered" employer, and we estimate that such claims costs would be greater than the costs of modifying policy cancellation letters.

Regarding: Changes to penalty amounts and compliance thresholds: Increasing the maximum penalty to the statutory maximum allows the director to address particularly egregious or frequent violations. The net effect on the parties in the workers' compensation system should be minor or possibly zero. The purpose of penalties is to encourage compliance with the law. To the extent this is achieved, penalties may decline and the net effect would be positive. The same can be said of thresholds. The Workers' Compensation Division published an industry notice dated June 1, 2006 announcing that the thresholds would change, thus allowing insurers time to adjust processes to meet certain time frames. The focus is on timely acceptance or denial of claims and payment of benefits, so these thresholds will be 90% (effectively an increase – the 95% threshold in OAR 436-060-0140 was not applied), while reporting of claim information to the division will be held to a lower standard, 80% (a decrease). We cannot project the net fiscal impact because we cannot anticipate the compliance rate, but it is likely that insurers will see some increased penalties in the near term.

Regarding: Additional proposed changes: We estimate that additional changes will not have any significant economic impact on any persons or businesses, including small businesses.

Administrative Rule Advisory Committee consulted: Yes, 8/25/05, 8/26/05, 8/30/05 (two meetings), & 8/31/05

/s/ John L. Shilts

9/15/05

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

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

**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 015**

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 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 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] **Hearings** before [the director] **an administrative law judge**: Any party [that] **who** disagrees with an order [pursuant to this] **under these rules** 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] **by filing a request for hearing as provided in OAR 436-001-0019** 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 **applies to the hearing.**

[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

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

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 **administrative law judge or** 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 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 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 **for hearing as provided in OAR 436-001-0019** [with the administrator] within 60 days of the **mailing** date [of service] of the order.

(D) **(C)** [The contested case hearing will be conducted in accordance with the rules governing contested case hearings in] OAR 436-001 **applies to the hearing.**

(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

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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 **for hearing** [with the administrator] **as provided in OAR 436-001-0019** within 60 days of the **mailing** 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 **applies to the hearing.**

(c) An emergency revocation issued pursuant to OAR 436-015-0080(7) is effective immediately. The MCO must file a request **for hearing as provided in OAR 436-001-0019** [for contested case hearing] within 60 days of the **mailing** 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 **applies to the hearing.**

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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;

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(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;

(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,

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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[.]; **and**

(c) Copies of all treatment standards and protocols developed or used by the MCO, including those from any companies, if any, from whom the MCO has purchased the use of treatment standards and protocols for the director review and approval under ORS 656.260(4)(a). The MCO must provide these copies at no cost to the director.

(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.

(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

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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 record keeping 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 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.

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(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] **009**.

(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:

- (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

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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[.] **with the following exception:**

(a) Within 30 days of implementation, the MCO must provide copies of any new or revised treatment standards and protocols developed or used by the MCO, including those from any companies, if any, from whom the MCO has purchased the use of treatment standards and protocols. The MCO must provide these copies at no cost to the director.

(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 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.

(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.

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(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.

(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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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);

(b) The nurse practitioner or physician 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

(c) The nurse practitioner or physician 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] **that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.**

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(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 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)

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436-015-0080 Suspension; Revocation

(1) Pursuant to ORS 656.260, the certification of a managed care organization issued by the director may be suspended or revoked if:

- (a) The director finds a serious danger to the public health or safety;
- (b) The MCO is providing services not in accordance with the terms of the certified MCO plan;
- (c) There is a change in legal entity of the MCO which does not conform to the requirements of these rules;
- (d) The MCO fails to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, or orders of the director.
- (e) The MCO or any of its members commits any violation for which a civil penalty could be assessed under ORS 656.254 or 656.745;
- (f) Any false or misleading information is submitted by the MCO or any member of the organization;
- (g) The MCO continues to utilize the services of a health care practitioner whose license has been suspended or revoked by the licensing board; or
- (h) The director determines that the MCO was or is formed, owned, or operated by an insurer or by an employer other than a health care provider or medical service provider as defined in these rules.

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(2) The director shall provide the MCO written notice of an intent to suspend the MCO's certification.

(a) The notice shall:

(A) Describe generally the acts of the MCO and the circumstances that would be grounds for suspension;

(B) Advise the MCO of their right to participate in a show cause hearing and the date, time, and place of the hearing.

(b) The notice shall be served[, as provided in OAR 436-015-0130,] upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served at least 30 days prior to the scheduled date of the hearing.

(3) The show cause hearing on the suspension shall be conducted as provided in OAR 436-015-0008 (5).

(4) An order of suspension shall suspend the MCO's authority to enter into new contracts with insurers for a specified period of time up to a maximum of one year. During the suspension, the MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension.

(a) A suspension may be set aside prior to the end of the suspension period if the director is satisfied of the MCO's current compliance, ability, and commitment to comply with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan.

(b) Prior to the end of the suspension period the division shall determine if the MCO is in compliance with ORS chapter 656, OAR 436-009, 436-010, 436-015, orders of the director, and the certified MCO plan. If the MCO is in compliance the suspension will terminate on its designated date. If the MCO is not in compliance the suspension may be extended beyond one year without further hearing or revocation proceedings may be initiated.

(5) The process for revocation of a MCO shall be as follows:

(a) The director shall provide the MCO with notice of an order of revocation. The order shall:

(A) Describe generally the acts of the MCO and the circumstances that are grounds for revocation; and

(B) Advise the MCO that the revocation 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 the revocation to the satisfaction of the director or files an appeal as provided in OAR 436-015-0008(5).

(b) The order shall be served upon the MCO's designated in-state communication liaison and to the registered agent or other officer of the corporation upon whom legal process may be served[as provided in OAR 436-015-0130].

(c) A show cause hearing on the revocation shall be conducted as provided in OAR 436-015-0008(5).

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(d) If revocation is affirmed, the revocation is effective ten days after service of the order [in accordance with OAR 436-015-0130] upon the MCO unless the MCO appeals.

(6) After revocation of an MCO's authority to provide services under these rules has been in effect for 3 years or longer, it may petition the director to restore its authority by making application as provided in these rules.

(7) Notwithstanding section (5) of this rule, in any case where the director finds a serious danger to the public health or safety and sets forth specific reasons for such findings, the director may immediately revoke the certification of an MCO without providing the MCO a show-cause hearing.[The order must be served upon the MCO as provided in OAR 436-015-0130.] Such order shall be final, unless the MCO requests a hearing. The process for review shall be as provided in OAR 436-015-0008(5).

(8) Insurer contractual obligations to allow a managed care organization to provide medical services for injured workers are null and void upon revocation of the MCO certification by the director.

Stat. Auth.: ORS 656.726(4)

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436-015-0110 Dispute Resolution/Complaints of Rule Violation

(1) Disputes which arise between any party and an MCO shall first be processed through the dispute resolution process of the MCO.

(2) The MCO shall promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary shall include at least the following:

(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;

(b) The types of issues the MCO will consider in its dispute resolution process;

(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and

(d) Advise that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director.

(3) Notification must be provided to the worker and the worker's attorney when the MCO:

(a) Receives any complaint or dispute pursuant to this rule; or

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(b) Issues any decision pursuant to this rule.

(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO shall 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 shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you [disagree with] want to appeal this decision[and want to appeal it], you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.

(5) If an MCO receives a complaint or dispute which is not included in the MCO dispute resolution process, the MCO shall, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director pursuant to OAR 436-015-0008. The notice shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter which we handle. To pursue this issue, you must request administrative review of the issue by the director of the Department of Consumer and Business Services (DCBS). Send written requests for review to: DCBS, Workers' Compensation Division, Medical Review Unit, 350 Winter Street NE, [Room 27] PO Box 14480, Salem, OR 9730^[1-3879]9-0405. If you do not notify DCBS in writing within 60 days of your receipt of this notice, you will lose all rights to appeal the decision. For assistance, injured workers may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant. All others, or those who are calling from outside Oregon, should call 1-503-947-7585 (TTY 503-947-7993).

(6) The time frame for resolution of the dispute by the MCO shall not exceed 60 days from the date of receipt of the dispute by the MCO until issuance of the final decision by the MCO. After the MCO resolves a dispute pursuant to ORS 656.260(14), the MCO shall notify all parties to the dispute in writing, including the worker's attorney where written notification has been provided by the attorney with an explanation of the reasons for the decision. This notice shall inform the parties of the next step in the process, including the right of an aggrieved party to seek administrative review by the director pursuant to OAR 436-015-0008. The notice shall include the following paragraph, in bold text:

NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you [disagree with] want to appeal this decision[and want to appeal it], you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days

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

of your receipt of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Review Unit, 350 Winter Street NE, [Room 27] PO Box 14480, Salem, OR 97301-3879] **9-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. If you have questions, call a Workers' Compensation Division Benefit Consultant at (503)947-7585 (TTY 503-947-7993) or (toll-free in Oregon) 1-800-452-0288.**

(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO shall notify the parties of the next step in the process, including the right of an aggrieved party to seek administrative review by the director pursuant to OAR 436-015-0008 including the appeal rights provided in (6) above.

(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further the dispute resolution process. Any of the parties also may request in writing that the director assist in resolution if the dispute cannot be resolved by the MCO.

(9) Complaints pertaining to violations of these rules shall be directed in writing to the Compliance Section of the division. The division may return the complaint to the originating party for completion if the complaint does not satisfy the requirements of this rule. The complaints must:

- (a) State the grounds for alleging rule violation;
- (b) Include the specific contention of error;
- (c) State the complainant's request for correction and relief; and
- (d) Include sufficient documentation to support the complaint.

(10) The division may investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers, chosen in the same manner as provided in OAR 436-010-0330.

(11) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to ORS 656.745 and OAR 436-015-0120.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.260

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