



# Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
350 Winter St. NE  
PO Box 14480  
Salem, OR 97309-0405  
1-800-452-0288, (503) 947-7810  
TTY (503) 947-7993  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

August 18, 2006

## Proposed Changes to Workers' Compensation Rules

The Workers' Compensation Division proposes changes to:

### **OAR chapter 436, division 015, "Managed Care Organizations," to:**

- Describe how managed care organizations (MCOs) report new or updated treatment protocols and guidelines to the Workers' Compensation Division; and
- Require that the MCO plan include a summary of the process it uses to develop and review treatment guidelines, standards, and protocols.

Additional information about proposed changes and the public hearing are on the enclosed documents.

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

**When is the hearing:** September 21, 2006

**What time is the hearing:** 10:00 a.m.

**Where is the hearing:** Labor & Industries Building,  
350 Winter Street NE, Room F (basement)  
Salem, Oregon

**How can I make a comment:** Come to the hearing and speak, submit written testimony, or both.

### **How can I obtain a copy of the proposed rules:**

Visit the Workers' Compensation Division's Web site,  
<http://www.wcd.oregon.gov/policy/rules/rules.html#proprules>  
or contact Fred Bruyns (see below)

### **If you have questions, or wish to submit written testimony, please contact:**

Fred Bruyns, Rules Coordinator  
Workers' Compensation Division  
350 Winter Street NE (for courier or in-person delivery)  
PO Box 14480, Salem, OR 97309-0405  
Email - [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us)  
Phone - (503) 947-7717; Fax - (503) 947-7581

**Comment period closes:** September 27, 2006

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
<b>Agency and Division</b>		<b>Administrative Rules Chapter Number</b>
Fred Bruyns	PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879	(503) 947- 7717 Fax (503) 947-7581
<b>Rules Coordinator</b>	<b>Address</b>	<b>Telephone</b>

**RULE CAPTION**

**Revised requirements affecting managed care organizations' treatment guidelines, standards, and protocols.**

September 21, 2006	10:00 a.m.*	Room F (basement), Labor & Industries Building 350 Winter Street NE, Salem, OR 97301-3879	Fred Bruyns
<b>Hearing date</b>	<b>Time</b>	<b>Location</b>	<b>Hearings Officer</b>

**\*NOTE: The hearing will begin at times shown and end when all present who wish to testify have done so. Written testimony will be accepted through September 27, 2006.**

*Auxiliary aids for persons with disabilities are available upon advance request.*

**RULEMAKING ACTION**

**AMEND:** OAR 436-015-0005, 436-015-0030, 436-015-0040

ORS 656.726

Stat. Auth.

Other Authority

ORS 656.260; Enrolled Senate Bill 670 – Oregon Laws 2005, chapter 364

Stats. Implemented

**RULE SUMMARY**

**The agency proposes to amend OAR chapter 436-015. These proposed rules:**

- Define treatment guidelines, treatment standards, and treatment protocols;
- Clarify that protocols and guidelines may be made available to the director online under specified conditions;
- Require that the managed care organization plan include a summary of the process used by the managed care organization to develop and review treatment guidelines, standards, and protocols; and
- Require that the managed care organization include with its annual report to the director, copies of any new or revised treatment protocols and guidelines developed or used by the managed care organization during the previous calendar year, or a written statement that no new or revised treatment protocols or guidelines were developed or used during the calendar year.

**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; 503-947-7717; fax 503-947-7581; e-mail [fred.h.bruyns@state.or.us](mailto: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, fax 503-947-7630.

September 27, 2006  
Last Day for Public Comment

/s/ John L. Shilts  
Authorized Signer and Date

8/14/06

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  

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Agency and Division

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OAR CHAPTER 436  
Administrative Rules Chapter Number

In the Matter of  
The Amendment of OAR: )  
436-015, Managed Care Organizations )  
)

**Rule Caption:**  
**Revised requirements affecting managed care organizations' treatment guidelines, standards, and protocols.**

**Statutory Authority:** ORS 656.726

**Other Authority:**

**Stats. Implemented:** ORS 656.260; Enrolled Senate Bill 670 – Oregon Laws 2005, chapter 364

**Need for the Rule(s):** Enrolled SB 670 – OL 2005, ch. 364 – requires the director to review and approve the treatment standards of managed care organizations. These proposed amendments would give managed care organizations clear direction on what to provide to the director and when to provide it, in order to comply with the revised laws on managed care.

**Documents Relied Upon, and where they are available:**

Enrolled Senate Bill 670 – Oregon Laws 2005, chapter 364  
Rulemaking advisory committee minutes for 6/12/06  
Advice from managed care organizations regarding the fiscal impacts of revised reporting requirements  
Management-Labor Advisory Committee meeting minutes for 4/14/05 and 4/28/05

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

**Fiscal and Economic Impact, including Statement of Cost of Compliance:**

A statement of fiscal impact identifying state agencies, units of local government and the public which may be economically affected by the adoption, amendment or repeal of the rule and an estimate of that economic impact on state agencies, units of local government and the public.

We project no significant fiscal impact of proposed rule changes on state agencies or units of local government. The only parties significantly affected are managed care organizations.

The following is a list of significant changes (see bullet points) and their estimated fiscal/economic impact on managed care organizations:

- **Define treatment guidelines, treatment standards, and treatment protocols**

The purpose of the definitions is to make clear what managed care organizations must report to the director. We anticipate no significant fiscal impact, though clarity may avert unnecessary or inappropriate reporting and associated administrative costs for managed care organizations and for the department.

- **Clarify that protocols and guidelines may be made available to the director online under specified conditions**

For managed care organizations that have the ability to make guidelines and protocols available in this electronic format, there should be a small cost savings over what would be required to print and handle an equivalent amount of paper.

- **Require that the managed care organization plan include a summary of the process used by the managed care organization to develop and review treatment guidelines, standards, and protocols**

A currently certified managed care organization would submit updated process information only if it is changed, as an amendment to its approved plan. There would be a small associated cost to document and report any updated information to the director.

- **Require that the managed care organization include with its annual report to the director, copies of any new or revised treatment protocols and guidelines developed or used by the managed care organization during the previous calendar year, or a written statement that no new or revised treatment protocols or guidelines were developed or used during the calendar year.**

This would replace the existing requirement to submit new or revised treatment protocols and guidelines within 30 days of implementation. The agency surveyed managed care organizations (MCOs) to ascertain the impact of this change. One MCO reported that the ongoing reporting requirement could cost up to \$50,000 per year, because the MCO would have to hire an additional staff person to perform this function, but that annual reporting should cost approximately \$200 per year. Another MCO estimated the cost for the annual reporting at just over \$100. However, one MCO estimates an annual cost of \$40 - \$50,000, with or without a change in the reporting frequency, because the administrative burden is not lessened by the frequency change.

Based on industry input and our understanding of the practical effects of the proposed rule change, the agency projects that the proposed annual reporting should be less costly. However, costs to generate the reporting of treatment protocols and guidelines may vary according to the volume of changes and the organization's ability to sort protocols and guidelines by creation/revision dates. Taking the high and low estimates for compliance with current rules versus proposed rules, we would reduce managed care organizations' annual costs from \$200,000 to \$400, a savings of \$199,600; in practice, we think the savings (due to annual versus ongoing reporting) will be less than \$100,000. MCOs have established processes for notifying their panel providers about new or revised protocols and guidelines, and these established notification processes should mitigate the costs of reporting to the director.

The net fiscal impact of the proposed changes on managed care organizations should be positive, primarily due to the simplified reporting process for new and revised treatment protocols and guidelines.

#### **Cost of compliance effect on small businesses:**

- (a) **An estimate of the number of small businesses subject to the proposed rule and identification of the types of businesses and industries with small businesses subject to the proposed rule:**

The proposed rule amendments will affect managed care organizations. Of the four managed care organizations certified and active in the Oregon workers' compensation system, one managed care organization meets the definition of a small business under ORS 183.310.

- (b) **A brief description of the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:**

The rule changes decrease certain reporting requirements and increase certain reporting requirements, but we project a net reduction in reporting. Record-keeping and administrative activities may be affected, depending upon how the managed care organization keeps track of revisions to treatment protocols and guidelines. However, we do not project that reductions in these areas will be substantial. For managed care organizations that contract with companies that specialize in provision of guidelines and protocols, there is the potential for professional services

cost impacts. If so, annual reporting of new/revised treatment protocols and guidelines is projected to be less costly if accomplished annually rather than on an ongoing basis.

**(c) An identification of equipment, supplies, labor and increased administration required for compliance with the proposed rule:**

The simplified reporting of new/revised treatment protocols and guidelines should reduce labor costs. Current rules require updates to be sent on an ongoing basis; the proposed requirement is for annual reporting. This may require approximately the same amount of machinery time and supplies such as paper and toner, but the annual process should reduce the staff time, including time required for administrative oversight, needed to report to the director.

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

All active managed care organizations, including the organization that qualifies as a small business, participated on the rulemaking advisory committee. The agency has also consulted with the managed care organizations a number of times to obtain fiscal impact data and to address other issues.

**Administrative Rule Advisory Committee consulted?:** Yes - June 12, 2006

If not, why?:

*/s/ John L. Shilts*

*8-14-06*

\_\_\_\_\_  
**Signature and Date**

\_\_\_\_\_  
John L. Shilts, Administrator, Workers' Compensation Division

**Printed name**

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION



**Managed Care Organizations**  
***Proposed Oregon Administrative Rules***  
**Chapter 436, Division 015**

**For Public Hearing, September 21, 2006**

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**Revisions are marked as follows:**

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

**436-015-0005 Definitions**

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.

(1) "GSA" means a geographic service area.

(2) "Health Care Provider" means an entity or group of entities, organized to provide health care services or organized to provide administrative support services to those entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.

(3) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with these rules.

(4) "Primary Care Physician" means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.

**(5) "Treatment Guidelines" means general treatment recommendations or a range of treatment options, thought to be acceptable by most physicians and providers, that are available to assist medical providers in determining appropriate medical treatment for a medical condition.**

**(6) "Treatment Protocols" means detailed treatment criteria, developed through consensus of physicians and providers, about what is acceptable medical treatment for a medical condition.**

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**(7) "Treatment Standards" means the MCO's certified plan, expectations and clinical requirements, generally agreed to be acceptable by physicians and providers, to which medical providers agree to comply. This includes, but is not limited to, the MCO's internal process, terms and conditions, treatment guidelines and treatment protocols.**

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

**Stats. Implemented:** ORS 656.260

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

Amended 12/10/90, as Admin. Order 31-1990, eff. 12/26/90

Amended 6/14/91, as Admin. Order 4-1991, eff. 6/14/91

Amended 1/10/92, as Admin. Order 4-1992, eff. 2/1/92

Amended 12/20/94, as Admin. Order 94-062, eff. 2/1/95

Amended 5/3/96, as Admin. Order 96-061, eff. 6/1/96

Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99

Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

Amended 5/11/06 as Admin. Order 06-053 eff. 6/1/06 (Temporary)

**Amended xx/xx/xx as Admin. Order 06-xxx eff. xx/xx/xx**

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

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

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

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

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

- (a) Access an MCO provider panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;
- (b) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner within 24 hours of the MCO's knowledge of the need or a request for treatment;
- (c) Receive initial treatment by the worker's choice of an attending physician or authorized nurse practitioner in the MCO within 5 working days, subsequent to treatment by a physician outside the MCO;
- (d) Receive treatment by an MCO physician in cases requiring emergency in-patient hospitalization;
- (e) Receive information on a 24-hour basis regarding medical services available within

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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, 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 **and guidelines** developed or used by the MCO, including ~~these protocols and guidelines~~ from any companies, ~~if any,~~ from whom the MCO has **may have** purchased the ~~m,~~ **m,** ~~use of treatment standards and protocols~~ for the director

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review and approval under ORS 656.260(4)(a). The MCO must provide these copies at no cost to the director. **The MCO may meet the requirements of this subsection if the protocols and guidelines purchased or adopted by the MCO are available online through the MCO or through a company from whom the MCO has purchased them. If the MCO chooses this option, the MCO must ensure the director has access to them at no cost to the director. The online protocols and guidelines must be complete and not in an abbreviated version. Standards, protocols and guidelines approved by the director are for certification purposes only and may not necessarily apply to an individual case dispute regarding medical services brought before 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

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diagnosis. A physician's profile shall not be released to anyone outside the MCO without the physician's specific written consent except that the physician's profile shall be released to the director without the necessity of obtaining such consent.

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

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

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

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

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

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

(C) A standardized claimant medical 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 must include a summary of the process used by the MCO to develop and review treatment standards, protocols or guidelines. This summary must include, but is not limited to:**

**(a) A description of the medical expertise or specialties of the clinicians involved;**

**(b) A description regarding what the protocols and guidelines are based on;**

**(c) The criteria used by the MCO in selecting the conditions for which the MCO implements treatment protocols and guidelines;**

**(d) A description of the criteria used by the MCO to determine when it needs to review or revise its treatment standards, protocols and guidelines;**

**(e) How the MCO makes the standards, protocols and guidelines available to its panel providers and how it notifies them of any changes;**

**(f) Sufficient flexibility to allow treatment outside the standards, protocols and guidelines if such treatment is supported by persuasive professional medical judgment and**

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**reasoning; and****(g) A description of how the MCO will ensure the worker continues to receive appropriate care in a timely, effective and convenient manner throughout the dispute resolution process.**

~~(9)~~ **(10)** The MCO plan shall provide other programs that meet the requirements of ORS 656.260(4) including:

(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled injured workers; and

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

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

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

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

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

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

~~(40)~~ **(11)** 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.

~~(44)~~ **(12)** 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 436-009.

~~(42)~~ **(13)** 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.

~~(43)~~ **(14)** The MCO must provide satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.

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~~(14)~~ **(15)** 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)~~ **(16)** 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)~~ **(17)** 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)~~ **(18)** 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)~~ **(19)** The application for certification for an MCO shall not be approved if the MCO fails to meet the requirements of these rules.

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

**Stats. Implemented:** ORS 656.260

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

Amended 12/12/90, as Admin. Order 31-1990, eff. 12/26/90

Amended 1/10/92, as Admin. Order 4-1992, eff. 2/1/92

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Amended 12/16/98, as Admin. Order 98-061, eff. 1/1/99

Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02

Amended 12/12/03 as Admin. Order 03-070, eff. 1/1/04 (Temporary)

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

Amended 12/1/05 as Admin. Order 05-072, eff. 1/1/06

Amended 5/11/06 as Admin. Order 06-053 eff. 6/1/06 (Temporary)

**Amended xx/xx/xx as Admin. Order 06-xxx eff. xx/xx/xx**

#### **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).

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(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; **and**

**(d) Copies of any new or revised treatment protocols and guidelines developed or used by the MCO during the previous calendar year. The MCO must provide these copies at no cost to the director. The MCO may meet the requirements of this subsection if the new or revised protocols and guidelines purchased or adopted by the MCO are available online through the MCO or through a company from whom the MCO has purchased them. If the MCO chooses this option, the MCO must notify the director and ensure the director has access to them at no cost to the director. The MCO must specifically identify which protocols and guidelines are new or revised and ensure the online protocols and guidelines are complete and not in an abbreviated version. If the MCO did not develop or use any new or revised treatment protocols and guidelines during the previous calendar year, the MCO must provide a written statement to this effect. MCO treatment standard plan amendments under OAR 436-015-0030(9) must be submitted, prior to implementation, in accordance with section (3) of this rule.**

(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.

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

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