



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

August 20, 2007

Proposed Changes to Workers' Compensation Rules

The 2007 Oregon Legislature passed a number of bills affecting workers' compensation laws. The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436 to make these rules consistent with the revised laws. In addition, the department proposes changes to make the rules easier to understand, to streamline regulations, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

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

When is the hearing? September 24, 2007, 2:00 p.m.

Where is the hearing? Labor & Industries Building
350 Winter Street NE, Room 260 (2nd Floor),
Salem, Oregon 97301

How can I make a comment? Come to the hearing and speak, send written comments, or do both. Send written comments to:

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

The closing date for written comments is September 27, 2007.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –
<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>

Or call (503) 947-7627 to get free paper copies

Questions? Contact Fred Bruyns, (503) 947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

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

OAD CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns	PO Box 14480, Salem, OR 97309-0405;	(503) 947- 7717
Rules Coordinator	350 Winter Street NE, Rm 27, Salem, OR 97301-3879	Fax (503) 947-7581
	Address	Telephone

RULE CAPTION

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

September 24, 2007	2:00 p.m.*	Room 260 (2 nd Floor, Labor & Industries Building)	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

***NOTE: The hearing will begin at 2:00 p.m. and end when all present who wish to testify have done so. Written testimony will be accepted through September 27, 2007.**

**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 436-105-0511; 436-105-0512; 436-160-0400; 436-160-0410; 436-160-0420; 436-160-0430

AMEND: OAR 436-040; 436-105; 436-110; 436-120; and

436-009-0005	436-015-0005	436-030-0175	436-050-0100	436-060-0008	436-160-0004
436-009-0010	436-015-0030	436-030-0185	436-050-0175	436-060-0010	436-160-0005
436-009-0020	436-015-0040	436-035-0005	436-050-0200	436-060-0015	436-160-0006
436-009-0030	436-015-0120	436-035-0110	436-050-0400	436-060-0018	436-160-0010
436-009-0040	436-030-0007	436-035-0350	436-050-0410	436-060-0055	436-160-0020
436-010-0005	436-030-0020	436-035-0390	436-050-0420	436-060-0060	436-160-0030
436-010-0210	436-030-0035	436-035-0420	436-050-0440	436-060-0140	436-160-0040
436-010-0220	436-030-0115	436-035-0500	436-050-0450	436-060-0147	436-160-0050
436-010-0230	436-030-0135	436-045-0008	436-050-0455	436-060-0150	436-160-0060
436-010-0240	436-030-0145	436-045-0030	436-050-0460	436-160-0001	436-160-0070
436-010-0265	436-030-0155	436-050-0003	436-050-0470	436-160-0002	436-160-0080
436-010-0280	436-030-0165	436-050-0005	436-050-0480	436-160-0003	436-160-0090

REPEAL: 436-030-0440; 436-030-0450; 436-030-0460; 436-030-0550; 436-030-0570;
436-110-0326; 436-110-0327; 436-110-0380; 436-120-0730

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656;
HB 2943 - OL 2007, ch. 300

Stats. Implemented

RULE SUMMARY

Amendments to implement changes in the Workers' Compensation Law, including:

- Replacing the term "Handicapped Workers" with "Workers with Disabilities" (SB 83);
- Updating name of Board of Medical Examiners for the State of Oregon to "Oregon Medical Board" (SB 147);

- Including “administrative law judge” as a person who may approve or disapprove a claims disposition agreement (SB 253);
- Describing restrictions affecting emergency room physicians’ rights to be attending physicians and authorize temporary disability benefits (SB 504);
- Deleting requirement that managed care organizations send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval; deleting related definitions (SB 563);
- Explaining how DCBS will publish the maximum reimbursable amount for medical services for non-disabling claims (SB 762);
- Amending penalty provisions affecting managed care organizations; deleting procedures for temporary rule promulgation to address disability in individual claims (when medical conditions are not addressed by current standards), and addressing such conditions in the director’s order on reconsideration, and providing that penalties will not be assessed if an increase in compensation results from such an order; describing how insurers must process requests for a lump sum payments of permanent partial disability awards (HB 2218);
- Describing the authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians (HB 2756);
- Referring to ORS 656.427 regarding time frames for termination of guaranty contracts; defining “premium” (HB 2783);
- Adopting standards of professional conduct for health care providers who perform independent medical examinations, which apply if the provider’s professional regulatory board has not adopted standards for performing such examinations (HB 2943);

General amendments to OAR chapter 436, including:

- Using plain language to add clarity to a number of rules;
- Shortening some rules by removing unnecessary descriptions of DCBS procedures;

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI), to improve the quality of medical billing data for use by DCBS and its customers, including:

- Requiring hospitals and other health care providers to include sufficient data on their billings so insurers and DCBS can identify the providers;
- Requiring insurers to report medical billing data to DCBS using standards for electronic data interchange adopted by the International Association of Industrial Accident Boards and Commissions;
- Listing the data elements reportable to DCBS; testing procedures for EDI; phase-in dates for EDI and when insurers and self-insured employers are subject; procedures for requesting deferral of EDI reporting;

Amendment to OAR 436-010, “Medical Services,” to remove obsolete medical utilization guideline:

- Regarding frequency of treatment in OAR 436-010-0230;

Amendments to OAR 436-030, “Claim Closure and Reconsideration,” to eliminate conflicts between statute and rules, streamline processing, delete obsolete rules, and reduce litigation, including:

- Restricting reconsideration of claim closure to issues raised by the parties plus requirements under ORS 656.268(1);
- Requiring insurers to submit documents related to reconsideration of claim closure in chronological order;
- Removing the limitation on attorney fees from OAR 436-030-0175(4);
- Deleting obsolete rules OAR 436-030-0440, 0450; 0460, 0550, and 0570; the relevant subject matter from these rules has been addressed in other rules in OAR 436-030 and 436-035 (since approximately 1988), but the rules have remained in the Oregon Administrative Rules published by the Secretary of State;

Amendments to OAR 436-035, “Disability Rating Standards,” to clarify or correct certain provisions, and to provide for rating disability for a medical condition not currently addressed by the standards, including:

- Clarifying the definition of “direct medical sequela”;
- Correcting the description of impairment involving angulation or malalignment of the humerus;
- Clarifying how to rate impairment for surgery involving one or more discs or vertebrae;
- Eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed;
- Provide standards for rating impairment for vaginal prolapse;

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility,” to clarify certain provisions and ensure appropriate oversight of worker leasing company licensing and practices, including:

- Clarifying time frames and process for cancellation of self-insurance;
- Revising regulations affecting worker leasing companies, including:
 - Relevant definitions;
 - The application and license renewal process;
 - Reporting and record-keeping;
 - Grounds for disqualification, suspension of license, and revocation of license by the director;
 - Appeal rights for persons refused approval or renewal of a worker leasing license;
 - Reapplication following disqualification for, or revocation of, license;
 - Continuation of a disqualification, suspension, or revocation of a worker leasing license applicable to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person or controlling person;
 - Penalties under ORS 656.990;

Amendments to OAR 436-060, “Claims Administration,” to eliminate inconsistencies in DCBS rules and clarify or streamline certain provisions, including:

- Revising time frame for employers’ first aid record-keeping (to be consistent with Oregon OSHA requirements);
- Reducing the documentation a worker must submit when appealing an insurer’s refusal to reclassify a claim;
- Clarifying conditions under which the insurer must notify health care providers when a workers’ compensation claim is denied or partially denied;

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP), to promote increased use of the EAIP and therefore earlier return to work of injured workers with their employers at injury, by streamlining program administration, setting an appropriate fee payable to insurers for administration of the program, and expanding some incentives, including:

- Providing that a medical release remains in effect until another medical release is issued by the worker’s medical service provider;
- Providing that a worker is eligible for EAIP services while the claim is “deferred” (prior to acceptance or denial);
- Providing insurers greater discretion to determine appropriate EAIP worksite modifications and EAIP purchases;
- Providing insurers greater discretion to determine what is appropriate training; eliminating the requirement that EAIP purchases for training are limited to “accredited” or “licensed” training or courses;
- Increasing maximum reimbursable amount for EAIP purchases for tools and equipment;
- Allowing insurers to submit more than one reimbursement request per EAIP;
- Stating the administrative fee payable to the insurer for its administration of EAIP services (formerly not prescribed by rule);

Amendments to OAR 436-110, “Preferred Worker Program” (PWP) to promote increased use of the PWP and therefore facilitate the return to work of injured workers and improve return-to-work outcomes (wages, tenure, etc.), by streamlining program administration, creating new PWP incentives, and expanding some existing incentives, including:

- Redefining and simplifying “date of hire” and “reimbursable wages”;
- Shortening and simplifying the wording that must appear on notices to workers about potential PWP benefits;
- Issuing PWP identification cards with no expiration date - workers could offer the initial and any subsequent employers three full years of premium exemption and claim cost reimbursement;
- Eliminating the requirement that a modification of regular work be “substantial” in order for a worker to be eligible for PWP benefits other than Worksite Modification;
- Removing the restriction that Wage Subsidies may not be combined with subsidies from other sources, with the exception of subsidies under OAR 436-120;
- Revising the name of “Obtained Employment Purchases” to “Employment Purchases”;
- Allowing Employment Purchases while a worker is receiving vocational assistance under OAR 436-120;
- Allowing replacement of Employment Purchases;

- Increasing the maximum expenditure for an Employment Purchase for tools and equipment;
- Providing Employment Purchases needed to create a new worksite;
- Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment;
- Allowing a second use of Wage Subsidy and a second use of each category of Employment Purchase for a different job with the same employer (formerly two wage subsidies could not be used with the same employer);
- Eliminating forms currently required for Worksite Modifications costing \$2,500 or less;
- Eliminating the general requirement for competitive bids for Worksite Modification;

Amendments to OAR 436-120, “Vocational Assistance to Injured Workers,” to improve sufficiency of certain notices, clarify time frames for submitting information to DCBS, streamline return-to-work plan development process, clarify or define certain provisions, and delete obsolete provisions, including:

- Describing how the Workers’ Compensation Division will determine the timeliness of any document that must be sent to the division in vocational matters;
- Requiring that notices of eligibility for vocational assistance, training, or direct employment services explain the rights of the worker to request a return-to-work plan conference;
- Requiring that notice must be *in writing* when an insurer notifies a worker that an eligibility determination is postponed while awaiting information about permanent restrictions;
- Requiring that if an insurer ends a worker’s eligibility because lack of suitable employment is not due to the limitations caused by the injury, the insurer must have obtained new information that did not exist or that the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility;
- Including among the reasons a worker would be ineligible for vocational assistance or for which eligibility would end, that the worker is unavailable for vocational assistance due to short-term incarceration;
- Eliminating all time frames related to return-to-work plan development except that a plan must be approved within 45 days (direct employment) or 90 days (training) under OAR 436-120-0500(1) & (2);
- Updating the vocational fee schedule (consistent with changes in state average weekly wage and Bulletin 124);
- Eliminating the requirement that insurers request administrative approval for vocational services when the insurer is entitled to claims cost reimbursement under OAR 436-110;
- Repealing the rule: “Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries”; and
- Defining “show-cause hearing” for the purposes of OAR 436-120-0915(3).

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.

September 27, 2007
Last Day for Public Comment

John L. Shilts
Authorized Signer and Date

8-14-07

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.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

Department of Consumer and Business Services,
Workers' Compensation Division
Agency and Division

OAR CHAPTER 436

Administrative Rules Chapter

Number

In the Matter of

The Amendment of OAR:

436-009, Oregon Medical Fee and Payment Rules
436-010, Medical Services
436-015, Managed Care Organizations
436-030, Claim Closure and Reconsideration
436-035, Disability Rating Standards
436-040, Workers with Disabilities Program
436-045, Reopened Claims Program
436-050, Employer/Insurer Coverage Responsibility
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

Rule Caption:

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

Need for the Rule(s): Chapter 436 must be amended to be consistent with the Workers' Compensation Law, as amended by legislation passed by the 2007 Oregon Legislature. Some of that legislation required the director to make rules to implement revised laws. The department is proposing additional changes to make the rules easier to understand, to streamline regulations affecting stakeholders, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Documents Relied Upon, and where they are available: "Issues" documents as presented to advisory committees; advisory committee meeting minutes; written advice from advisory committee members.

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: The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by proposed rule amendments:

Amendments to implement changes in the Workers' Compensation Law

- Senate Bill 504 restricts emergency room physicians' rights to be attending physicians and authorize temporary disability benefits. Overall emergency-room treatment charges can be substantially higher than charges for visits to primary care physicians. In addition, early referral to primary care physicians should improve insurers' ability to keep track of authorization of temporary disability benefits and to promote return-to-work. The agency estimates that these changes should result in a small reduction in insurers' claims costs.

- Senate Bill 563 eliminates the requirement that managed care organizations (MCOs) send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval. In the “Statement of Need and Fiscal Impact” filed with the Secretary of State on 8/14/06, DCBS estimated reporting costs for such reporting based on advice from MCOs. The low-high range of estimated reporting costs was then \$100 per year to \$50,000 per year per MCO, potentially \$400/year to \$200,000/year for the four active MCOs. The agency projects elimination of these reporting costs for MCOs.
- House Bill 2756 provides authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians. Because we cannot project how many injured workers will choose these providers as their attending physicians, we cannot now project the fiscal impacts. However, DCBS will monitor the effects of HB 2756 to identify impacts over time.
- House Bill 2783 requires insurers to notify the employer of termination of a guaranty contract 45 days in advance instead of the 30 days currently required. In addition, HB 2783 allows for a shorter notice requirement of only 10 days if the termination is based on nonpayment of premium. The agency projects some reductions in costs for insurers, because they can shorten their liability under the 10-day notice provision. The agency projects that these savings will be greater than any increased costs due to the 45-day notice provision, because insurers can adjust notice procedures in order to end liability, in most cases, by a date certain. The agency projects a small positive impact for employers subject to the 45-day notice, as it will give them more time to shop for cost-effective workers’ compensation insurance coverage.

In addition to changes to implement changes in the Workers’ Compensation Law:

Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI)

- The agency projects that proposed rule changes will not have a significant fiscal impact on Oregon health care providers, as providers already send sufficient data to insurers on standard billing forms. The agency projects some fiscal impacts for insurers and self-insured employers, smaller for those companies already using EDI in other states and greater for Oregon-only reporters. The advisory committee did not express concerns about implementation costs. However, the agency projects significant costs for some insurers and self-insured employers in order to prepare for EDI, and also projects that these costs will eventually be exceeded by savings due to efficiencies inherent in electronic communication.

Amendments to OAR 436-035, “Disability Rating Standards”

- The agency projects that eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed, will have a positive economic impact on affected workers and an equal increased cost to affected insurers. However, this combination of medical conditions is very rare and the impact is not expected to be significant overall.

Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility”

- The agency projects that proposed rules affecting worker leasing companies will add a small cost to submit additional information with the application for initial license or renewal of license.
- Conversely, the purpose of these rule changes is to create a level playing field for leasing companies by preventing or removing unfair competition by companies that cannot or will not comply with worker leasing laws and rules. Successfully preventing unfair competition would have a positive economic effect on leasing companies that do comply with the laws and rules. Relative to taking no action, the agency projects a small positive economic impact on worker leasing companies.

Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP) and OAR 436-110, “Preferred Worker Program” (PWP)

- The agency projects that expanded benefits and administrative fees for the EAIP will cost the Workers’ Benefit Fund (maximum/annual):
 - Reimbursement of EAIP costs before the claim is accepted or denied (if ultimately denied)..... \$700,000.00
 - Increased reimbursable amount for EAIP purchases for tools and equipment \$300,000.00
 - Proposed fee payable to insurers for administration of the EAIP..... \$480,000.00
 - Total \$1,480,000.00

- The agency projects that expanded benefits for the PWP will cost the Workers' Benefit Fund (maximum/annual):
 - Providing Employment Purchases needed to create a new worksite..... \$100,000.00
 - Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment \$100,000.00Total \$200,000.00
- The agency projects that issuing PWP identification cards with no expiration date will increase use of premium exemption and thus increase costs to the Workers' Benefit Fund. However, the impact would be very minor in the near term and increase gradually over time. The agency does not have a basis to project how many workers will use their cards for future employment, but will monitor this closely.
- Additional proposed changes that expand access to reemployment incentives will have lesser impacts on the Workers' Benefit Fund; however, the agency does not have a basis to project how extensively these incentives will be used.
- All moneys paid out of the Workers' Benefit Fund would have a positive economic impact on Oregon employers and insurers. In addition to the direct dollar transfer, by promoting early return to work, the proposed rules may reduce claims costs. In addition, the proposed changes should positively affect injured workers by promoting early return to work, which produces better long-term employment outcomes.
- The Workers' Benefit Fund has adequate reserves to cover any increased costs resulting from proposed rule changes.

Regarding: Additional proposed changes:

- The agency estimates that additional changes will not have any significant negative economic impacts on any persons or businesses, including small businesses. Because a number of the proposed rule changes streamline processes, the agency projects a small overall positive economic impact of proposed rule changes not otherwise described.

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

Representatives from small businesses participated in the stakeholder advisory committees.

Cost of compliance effect on small businesses:

Estimated number of small businesses subject to the proposed rule:

One managed care organization. (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.)

Identify the types of businesses and industries with small businesses subject to the proposed rule:

The proposed rule amendments will affect managed care organizations.

Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services:

Reporting: Proposed rule changes would require less reporting by managed care organizations, who will no longer have to send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval.

Record-keeping: Proposed rule changes may substantially reduce record keeping by a managed care organization only if organization keeps a running record of updated treatment standards, protocols, and guidelines for the purpose of reporting the updates to the director.

Other administrative activities and costs of professional services: For managed care organizations that contract with companies that specialize in provision of guidelines and protocols, there is the potential for reduced professional services costs.

Extent of economic impact: The agency projects a substantial reduction in reporting costs for MCOs.

Identify equipment, supplies, labor and increased administration required for compliance with the proposed

rule:

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

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

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

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

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

Administrative Rule Advisory Committee consulted:

Yes. Advisory committees met on 6/21/07, 7/10/07, 7/16/07, 7/17/07, 7/19/07, 7/20/07, 7/23/07, 7/26/07, 7/31/07

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

John L. Shilts

8-14-07

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

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



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

Summer/Fall 2007

TABLE OF CONTENTS

Rule	Page
436-015-0005 Definitions.....	1
436-015-0030 Applying for Certification.....	1
436-015-0040 Reporting Requirements For an MCO.....	6
436-015-0120 Sanctions and Civil Penalties.....	8

Revisions are marked as follows:

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

HISTORY LINES: These rules include only the most recent "History" lines. The history line shows when the rule was last revised (or "filed" if the rule has never been revised) and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: http://www.wcd.oregon.gov/policy/rules/full_set.html

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

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

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.~~

~~(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: Amended 10/19/06 as Admin. Order 06-059, eff. 11/28/06

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.

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

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

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

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

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

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

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

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

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

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

(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

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

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, protocols, and guidelines adopted by the MCO, including protocols and guidelines from any companies from whom the MCO may have purchased them, for the director 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 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

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

provide for adequate notice and hearing rights for any physician.

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

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

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

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

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

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

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

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

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

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

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

(C) A standardized claimant medical 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.

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

(9) The MCO plan must include a summary of the process used by the MCO to develop and review treatment standards, protocols, and 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 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.

(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.

(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.

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

(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.

(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.

(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.

(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.

(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.

(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.

(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.

(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: Amended 10/19/06 as Admin. Order 06-059, eff. 11/28/06

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

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

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, ~~including changes to the MCO summary of the process used by the MCO to develop and review treatment standards, protocols, or guidelines under OAR 436-015-0030(9),~~ 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.

(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 either all treatment protocols and guidelines, or any new and any revised treatment protocols and guidelines, adopted 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 protocols and guidelines 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 ensure the online protocols and guidelines are complete and not in an abbreviated version. If the MCO did not adopt any new or any revised treatment protocols and guidelines during the previous calendar year, the MCO must provide a written statement to this effect.~~

(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
Hist: Amended 10/19/06 as Admin. Order 06-059, eff. 11/28/06

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

436-015-0120 Sanctions and Civil Penalties

(1) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against any MCO:

(a) Reprimand by the director;

(b) Civil penalty **as provided under ORS 656.745(2) and (3)**, of up to \$5000 for failure to comply with ~~ORS 656.001 to 656.990. Each day a violation continues shall constitute a separate violation.~~ All penalties collected under this section shall be paid into the Department of Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker, insurer, or medical provider;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violation.

(c) Suspension or revocation of the MCO's certification pursuant to OAR 436-015-0080.

(2) If the director determines that an insurer has entered into a contract with an MCO which violates OAR 436-015 or the MCO's certified plan, the insurer shall be subject to civil penalties as provided in ORS 656.745.

Stat. Auth.: ORS 656.726(4); **Stats. Implemented:** ORS 656.260
Hist: Amended 2/25/02 as Admin. Order 02-053, eff. 4/1/02