Oregon Administrative Rule Revision
Chapter 436, Divisions 009, 010, and 015
November 18, 2025, Stakeholder Rules Advisory Committee Meeting
Meeting Minutes

Location of meeting: 350 Winter St. NE, Salem, OR; Virtual Teams meeting

Stakeholders attending:

Stakeholders (RSVP'd):	
Amanda Barlow	Cascade Health
Adam Fowler	Evernorth
Bryan Null	SAIF Corporation
Connie Barnes	Medata
Connie Whelchel	IMA, Inc.
Misty Bergenstock	Endeavor Psychiatry
Kaylee Bond	CorVel Corporation
Joy Chand	Takacs Clinic
Dee Heinz	SAIF Corporation
Isabel Hernandez	Health e Systems
Lisa Johnson	Majoris Health Systems
Heidi Kaiser	Integrity Medical Evaluations
Andrea Martinez	Enlyte
Monica Rice	Optum
Skylar Hall	SAIF Corporation
Jim Smith	Select Medical
DeAnna Tapia	Professional Interpreters Inc.
Hasina Wittenberg	Government Relations Strategies
Dr. Eric C. Hubbs	MD
Harry Noone	SAIF Corporation
Sydney Montanaro	Thomas, Coon, Newton & Frost
Amanda Waibel	Reinisch Wilson PC
Jeanette Decker	Providence MCO
Laura McAllister	Medata
Stacey Hewitt	Kaiser Permanente
Keith Semple	OTLA
Jovanna Patrick	OTLA
Steven Bennett	APCIA
Gabrielle Haxby	Cascade Health
Ann Klein	Majoris MCO
Ted Heus	QUINN & HEUS, LLC
Thais Lomax	Sedgwick
Daniel Mar	Medata

Kathleen "Kitty" Schrantz	Kaiser Permanente
Jessica Robertson	Concentra Medical
Austin Sheffield	Rehab Without Walls
Craig Stone	Intermountain Claims
Kevin Barrett	SAIF Corporation

State of Oregon staff members attending:

Matt West- WCD Administrator
Rob Andersen – WCD Sanctions and Medical Resolution manager
Kirsten Schrock – WCD resolution section manager
Stan Fields – WCD managed care specialist
Steve Passantino – WCD appellate review unit manager
Tasha Fisher – WCD medical reviewer
Marie Rogers –WCD rules coordinator
Juerg Kunz – WCD medical policy analyst
Mary Mackie –WCD Claim closure policy analyst
Troy Painter- WCD senior auditor
Yesenia Gonzalez – WCD appellate review specialist
Angela Blake – WCD auditor
Daneka Karma – WCD policy manager
Lori Harris – WCD appellate review specialist
Val Mueller – WCD Business Support
Barbra Anderson - Ombuds for Oregon Workers
Caitlin Breitbach - Small Business Ombudsman

Minutes: Marie Rogers welcomed the committee members, asked the members to provide advice about any fiscal impacts of possible rule changes, and also to advise about effects on racial equity in Oregon. Marie called a roll of attendees, including stakeholders and State of Oregon employees.

NOTE: Additional summary minutes are included below each issue.

Issue # 1 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2026)

Issue: The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) publish new CPT® and HCPCS codes, effective January 1, 2026. However, the Workers' Compensation (WCD) does not publish its permanent fee schedule updates until April 1, 2026 (projected effective date). This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if providers use new codes from January 1 through March 31, 2026.

Background:

- In order to allow time for public input, WCD publishes a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), effective April 1 of each year.
- Adopting the new CPT® and HCPCS codes, effective January 1, 2026, would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid, new codes.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD can update appendices B – E, effective Jan. 1, 2026, and assign maximum payment amounts using the 2025 conversion factors/multipliers. One should bear in mind that due to time and staffing restraints, it may not be possible to update all appendices.
- Various organizations will publish updates to standards that WCD adopts in OAR 436-009-0004.
- WCD began issuing temporary rules in January 2016 to allow providers to bill insurers using new codes for dates of service from January 1 through March 31 of each year.
- As in years past, the temporary rules would not delete any codes from any appendix and providers may continue to use all codes valid in 2025.

Options:

- Adopt new CPT® codes and standards (OAR 436-009-0004) through a temporary rule, effective January 1, 2026.
- Update appendices B – E with payment amounts for new codes using the 2025 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

Fiscal Impacts, including cost of compliance for small business: No fiscal impacts are anticipated.

How will adoption of this rule affect racial equity in Oregon? No racial equity impacts are anticipated.

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- No discussion.

*Note that there was poor audio quality and virtual attendees had trouble hearing this issue.

Issue # 2 (Standing)

Rule: OAR 436-009-0004 and Appendices B - E (Permanent rules, effective April 1, 2026)

Issues:

- ORS 656.248(7) requires that WCD update the fee schedules annually.
- The references listed in OAR 436-009-0004 and the fee schedules published in appendices B – E will be outdated when the permanent rules become effective on April 1, 2026.

Background:

- The above listed appendices are based on conversion factors and multipliers developed by DCBS, and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare & Medicaid Services (CMS).
- Every year, there are some CPT® and HCPCS codes that are deleted and some new codes are introduced. Adopting new billing codes and updating Appendices B – E allows us to stay current with valid CPT® and HCPCS codes.
- Every year, DCBS develops updated conversion factors and multipliers taking into account stakeholder input, utilization of medical services, and the new values and fee schedule amounts developed by CMS.
- Various organizations publish updates to standards that WCD adopted in OAR 436-009-0004.

Options:

- Adopt updated standards listed in OAR 436-009-0004 and update Appendices B – E using more current CMS spreadsheets and updated WCD conversion factors/multipliers.

- Other?

Fiscal Impacts, including cost of compliance for small business:
No fiscal impacts are anticipated.

How will adoption of this rule affect racial equity in Oregon?
No racial equity impacts are anticipated.

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- No discussion.

*Note that there was poor audio quality and virtual attendees had trouble hearing this issue.

Issue # 3 (2142)

Rule: OAR 436-009-0004 and Appendix B

Issue: Last year's rules advisory committee recommended that WCD develop a fee schedule amount for CPT® code 0232T (Platelet Rich Plasma Injection).

Background:

- Prior to April 1, 2025, platelet rich plasma (PRP) injections were not a compensable medical services.
- Based on the recommendation by WCD's Medical Advisory Committee, PRP injections became compensable on April 1, 2025.
- Outside the workers' compensation arena, PRP injections are generally not paid by health insurance, i.e., most PRP injections are paid out of pocket by patients.
- Because CMS has not assigned a relative value unit (RVU) to CPT® code 0232T, and the department did not have any billing data for this CPT code, WCD was unable to develop a fee schedule amount for PRP injections.
- In the meantime, WCD has received some billing and payment data through medical EDI. See attachment (at the end of the agenda PDF).

Options:

- Create fee schedule amount for CPT® code 0232T of $500, $550, other?
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Dr. Eric Hubbs noted that this was not in his scope, but $550 seems appropriate.
- Ann Klein noted that she had a question come up when PRP first became compensable; a provider asked how much was bundled (noting there are different systems). She noted Majoris would want clarity regarding what is or is not bundled.
- Juerg Kunz noted that his understanding is that the CPT code includes everything.
- Dr. Eric Hubbs asked if that included the appointment to do the injection.

- Juerg Kunz noted that appointment could potentially be different; that would be something like an office visit.
- Steven Bennett noted that this is not his area of expertise but referenced the attachment (see end of this document): the charged median is $500 and the paid median is $500. Therefore, $500 seems reasonable.
- Skylar Hall noted SAIF supports the fee schedule for PRP injections. She noted that SAIF has, on average, seen a similar range of billings and supports the proposed fee amount of $500 to $550. She referred back to Ann Klein's comment and noted that SAIF, too, would like clarity regarding what is included under the code. She clarified that the CMS description for this billing code provides that it includes the harvest, preparation, and the administration of the injection as well. She added that SAIF has seen providers submit duplicative billings including the "P" code (P9020) which is just for the plasma blood product. SAIF wants to ensure that the division's intention for the zero code is to be inclusive of all services associated with the PRP injection so as to avoid duplicative billings.
- Juerg Kunz noted that, generally, providers must use the CPT code if there is such a code. Only when there is no CPT code adequately describing the service may providers use a HCPCS code.
- Kaylee Bond noted that, without looking at the data, $500 to $550 seems low. What she currently sees is that adjusters will approve these billings and since there isn't a fee, they're often approving them in full. So, they just pay in full because they have to.
- Dee Heinz noted that there is a CPT code—it includes the procedure itself, the harvest, the administration. But there's also another code that is payable at 80%--for the product itself (patient's blood). She described the process: they harvest a certain amount of blood, they put it in a centrifuge, and spin it. One of the layers is the layer that's harvested or extracted and that's the blood product. That's the level under a separate code. Most of the billings SAIF receives include that piece. She wanted to note that there is a separate code that could be billable. So, if we want a combined code, that will need to be addressed.
- Juerg Kunz asked for the code.
- SAIF replied: P9020.

Issue # 4 (2131)

Rule: OAR 436-009-0025

Issue: WCD sees more and more disputes involving reimbursement requests from workers who paid for a medical service or paid a co-pay/co-insurance/deductible on either interim claims, i.e., before claim acceptance/denial, or on denied claims that were later accepted. There is no specific rule addressing a situation where a worker paid for medical services prior to a claim being accepted and subsequently requests reimbursement from the insurer.

Background:

- When a medical provider treats a worker with an accepted workers' compensation claim, the provider must bill the insurer and is not allowed to collect any payments from the worker.
- However, prior to the claim being accepted[1], a worker may have paid a provider for medical services.
- Once a claim gets accepted, a worker may ask for reimbursement from the insurer for medical expenses, copayments and deductibles paid by the injured worker.
- There are three basic scenarios that may need to be addressed by rule:
    - The insurer received bills and chart notes from the provider and paid the provider prior to receiving the worker's reimbursement request;
    - The insurer received bills and chart notes from the provider but hasn't paid the provider yet when the insurer receives the worker's reimbursement request; or
    - The insurer has not received any bills or chart notes from provider when the insurer receives the worker's reimbursement request.

Options:

- Create a new section in OAR 436-009-0025:
  (x) Reimbursement for medical services paid for by the worker prior to claim acceptance.
  When the insurer receives a reimbursement request from a worker for medical services, if the insurer:
  (a) Paid the provider prior to receiving the worker's reimbursement request, then the worker must request a refund from the provider, and the provider must refund the worker within 60 days of receiving the request;
  (b) Has not paid the provider, but has bills or chart notes from provider, then the insurer must reimburse the worker for compensable medical services and pay any balance up to the fee schedule to the provider;
  (c) Has not paid the provider and does not have bills or chart notes from provider, the insurer must inform the worker in writing that they need chart notes from the provider

[1] This could be during the normal course of filing a claim while waiting for the insurer to accept the claim, or it could be prior to a claim denial being overturned.

before they can proceed with reimbursing the worker. [Should the rule state whose responsibility it is to get chart notes, i.e. the worker's or the insurer's?]

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Dr. Eric Hubbs noted that when his practice filed their initial request for workers' compensation, they sent the form with chart notes. He noted that the chart notes in his office always accompanied the insurance billing.
- Juerg Kunz noted that the rule requires the chart notes to accompany the bill. He added that some providers take a long time to bill.
- SAIF confirmed that providers often take a long time to bill.
- Dr. Eric Hubbs sought clarification: certain providers are asking workers to initiate payment despite not knowing if it will be an accepted workers' compensation claim? He noted that, when he was practicing, payments that might be covered by insurance went into escrow. They did not go into his income until/unless there was no claim. If there was no claim, the patient was ahead on his bill. But, if there was a claim, the money was returned to the worker. He noted that could be an option in rule.
- Steven Bennett noted the proposed language could use more "guardrails." Specifically, he noted that the language should include that payment is only required if it is related to the workplace injury, if it's reasonable and necessary, and is otherwise acceptable under the workers' compensation rules.
- Thais Lomax expressed concerns from the processor's standpoint—or even the standpoint of an examiner. She often sees injured workers simply paying medical bills rather than giving workers' compensation information to have the bill sent to Sedgwick. She has concerns about workers paying out of pocket rather than keeping their claim processor in the loop regarding treatment. She noted that there are CPT codes and procedure codes to determine compensability; it is difficult to make sure the treatment plan makes sense and payments are made according to the fee schedule when workers are paying out of pocket. She noted that adding language in rule regarding reimbursement is going to cause confusion. Outside of an instance in which a worker is reimbursed for a prescription, Sedgwick has serious concerns about this as a concept.
- DeAnna Tapia noted that there are some primary care physicians or clinics that don't only deal with workers compensation matters; they require payment upfront because they don't

immediately know if it's actually a work-related injury. She expressed concern for individuals going to a clinic without insurance who may be charged $150.00 to be seen and pay it out of pocket. She noted that they might not know how to handle reimbursement—especially if English is not their first language. She wondered if this would discourage injured workers from going to such places for care. She added that some providers will bill Pacific Source or other such private insurers until the workers' compensation matter is accepted. She noted that Pacific Source could have opinions about that practice.

- Jovanna Patrick expressed support for the idea of having an avenue for workers to be reimbursed directly for medical services that they pay for. She sees it happen often that workers receive care but don't have insurance or a claim, and pay out of pocket for their care (e.g. ambulance to ER). She often sees imaging bills directed to the workers. The workers believe they are doing the right thing by paying the bills. She noted that every worker believes they will be reimbursed by workers' compensation eventually—but they aren't. Jovanna noted that she interprets the statute to require reimbursement to the worker. She then noted that there are two areas where this happens and she believes the rule should be clearer and address both: (1) there is the initial 60-day deferral period in which the insurer is making decisions and they're not covering medical costs and private health is also not covering the cost. Workers have no choice but to pay the cost if they want to be seen by a provider. They do not understand that workers' compensation will not just pay them back. (2) There is also an issue when either the whole claim or a condition is not accepted and the entire claim is denied. Then, private insurance is paying if it is available. Or, the worker is paying. Eventually, the claim is litigated and accepted—however, the worker then needs to have the provider re-bill for services in order for the worker to be paid back. There is no incentive for the provider to re-bill when they are already paid. She has a matter like this ongoing. She noted that this happens with surgeries—the worker has the surgery, goes back to work, and the matter is still being litigated. In such instances, if the worker wins, they should have a mechanism to be reimbursed the thousands of dollars paid for surgery without needing to track down and convince the doctor to re-bill for the service. Jovanna noted that she understands health insurance is often reimbursed, so it makes little sense that the worker is not. So, she thinks this should be expanded, it should be made easy for workers, and doctors should be left out of it.
- Skylar Hall noted that SAIF does not see a need for additional rules in this area. OAR 436-009-0025 already outlines how workers can be reimbursed for costs incurred before claim acceptance. Similarly, there are already mechanisms for insurers to solicit billings from providers when there is a disputed claim that is later accepted. The bills are received and paid in accordance to the schedule. She suggested it would be incumbent on the provider's office to refund money to the worker. She noted that SAIF would like clarity on WCD's intent: is the intent to instruct insurers when to pay the worker or to instruct the insurers when to pay the provider and then have the workers seek reimbursement from the insurer? Or tell provider when they have to refund the worker? SAIF noted concerns regarding potential inefficiencies. She suggested additional education for providers serving injured workers could be helpful. Finally, she asked the division about

the fee disputes being addressed by the proposed change; she asked if the division is seeing a consistent issue.

- Ted Heus noted that he has encountered this issue in practice; his understanding is that under the current law, the insurer has to directly repay workers for copays. He noted that this is the second context in which this takes place—when the claim is denied and eventually goes through litigation. The claim is then accepted and the worker has gone to their private health insurance for deductible, copays, etc. In that context, Ted interprets the law are requiring and ensuring reimbursement to the worker directly for any copays or deductibles. He believes that is correct as it is the worker who is then facing delay in getting money back. He noted that the other aspect is that the workers' compensation rules try to govern all things between employers, claimants, and insurers. Trying to go after the provider is not really an option in the rules currently (vs. the insurer). He noted that something needs to clarified; there have been issues with this since 2015 when interim medical services were removed from statute. The current process leaves the worker to fight with the provider. Ted believes it would be more streamlined and easy to treat it like a service request by asking if it was paid, noting that it can be denied if it isn't thought to be related or if more information is needed. There is already a process for denying that type of service request. Or, if more information is needed, the insurer has the ability to request documentation. But, something needs to be added to clarify that the insurer should reimburse the worker. And if the provider is overpaid, the provider can pay back the insurer.

Issue # 5 (2150)

Rule: OAR 436-009-0030, -0110, and 436-010-0270

Issue: Some insurers and service companies are located in different time zone and may make return phone calls to providers as early as 5:00 am Pacific time.

Background:

- Above listed rules require insurers or their representatives to respond to certain questions by providers within two days, excluding Saturdays, Sundays, and legal holidays.
- This issue was brought to WCD's attention by a provider who opines that insurers should return phone calls during Oregon business hours, not during business hours that are based on Central or Eastern U.S. time zones.

Options:

- Amend OAR 436-009-0005, 436-009-0030, 436-009-0110, and 436-010-0270 as follows:
    - OAR 436-009-0005: Create a new section (36): "**Regular Oregon business hours"** means from 8:00 am to 5:00 pm pacific time zone.
    - OAR 436-009-0030(3)(c)(C): "An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within two days **during regular Oregon business hours**, excluding Saturdays, Sundays, and legal holidays;"
    - OAR 436-009-0110(7)(j): "The insurer or its representative must respond to an interpreter's inquiry about payment within two days **during Oregon regular business hours**, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer."
    - OAR 436-010-0270(4)(a): "The insurer or its representative must respond to a medical provider's inquiry about claim status, accepted conditions, or MCO enrollment within two days **during regular Oregon business hours**, excluding Saturdays, Sundays, and legal holidays listed in ORS 187.010 and 187.020. The insurer or its representative may not refer the medical provider to another entity to obtain an answer. For the purpose of this rule, "regular Oregon business hours" means from 8:00 am to 5:00 pm pacific time zone.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Dr. Eric Hubbs noted that he has received calls at 5 a.m. in the past.
- DeAnna Tapia noted that can be difficult to connect with workers, but she noted that they check the time zones before calling. She noted it would be nice to have someone in the Oregon time zone, but not everyone has that.
- Juerg Kunz noted as an example that DeAnna as an interpreter could call the insurer company and leave a message; the insurer is to call back within two days. The division feels that if you do business in Oregon, the call back should be during Oregon business hours.
- DeAnna Tapia agreed.
- Jovanna Patrick noted that she appreciates this rule; she noted that communications with adjusters have consistently been recognized as problematic at MLAC meetings and in general. She hears it often—several times a week—that workers and doctors are not receiving calls back from adjusters. She noted that, while the rule is open, she would like to see more teeth, more incentive for adjusters to communicate. There's currently no penalty or consequence, and nowhere for providers to report attempted communications—she thinks there should be.
- Sydney Montanaro reaffirmed Jovonna's points. She noted that she, too, hears repeatedly that workers and providers are not getting calls back from adjusters.
- Keith Semple noted that we should receive adjuster's emails in order to leave a paper trail of non-response—some way to document that these communications are being made to set an appeal process in motion. He encouraged the division to make it a requirement that adjusters provide contact information.
- Stacey Hewitt in the chat: "yes! we cannot get a hold of adjusters on a regular basis. We need communication from our insurers to process our work." And "Adjusters routinely say they cannot or will not open our encrypted emails. We cannot send information any other way."
- Joy Chand noted that adjusters do not reply to emails, either.
- Misty Bergenstock noted that currently the rules require the provider to go to the division when the insurer fails to respond; she agreed that this rule should have more teeth to incentivize insurers to respond, and the burden should not be on the worker and provider when the adjuster fails to respond.
- Keith Semple noted that there should be a minimum standard to do business in Oregon; he noted that it is extremely problematic to hear so many providers state that insurers are not communicating with them. Something more should be done. He noted that some companies might benefit from an improvement plan and suggested they should be barred from doing business in the state if they can't perform better.

- Kaylee Bond noted that, sometimes, they receive voicemails that don't have sufficient information to return calls. When they do, they do call back. If they call on a Saturday, it is merely because they are trying to catch up on calls.

Issue # 6 (2105)

Rule: OAR 436-009-0060 Oregon Specific Codes

Issue: There is no billing code for treat and release.

Background:

- A stakeholder requests that WCD create two new Oregon Specific Codes (OSCs). The stakeholder noted:

  > "Due to the unique niche of our services, we do not have a OSC or HCPCS that accurately represents what we do. We are an Oregon non-profit organization and my department, Mobile Health, serves the community by responding to on-the-job injuries on-site to assess, treat and transport, if necessary. We are not an ambulance service but are licensed EMTs and Paramedics. We work under the control of a dually-licensed physician. Our calls fall into 3 categories, 1) on-site treat and release, 2) transport from job site to an appropriate level of care, 3) provide medical service on-site at an hourly rate (such as a blood draw for an exposure where we can get both source and exposed together). We are 24/7/365 and charge an extra fee for after hours and holidays. Treat and release situations are typically billed to the employer since a claim is not opened but occasionally, a treat and release will seek a higher level of care at a later date if new symptoms arise or their injury is not improving. If they end up coming into our clinic for a higher level of care, we would then bill our service to workers comp as well. An injury that we know will open a claim is sent to workers comp."
- The stakeholder requests OSCs for the following services:
  - Basic Life Support (BLS) non-emergent response and treatment. No transport. (non-ambulance)
  - BLS non-emergent response. Treatment and transport. (non-ambulance)
- If two new OSCs are created:
  - Should they have a fee schedule amount?
  - If so, how would the department assign an appropriate fee?
  - If there is no fee schedule amount it would be payable at 80% of billed.

Options:

- Create two new OSCs for:
  - BLS non-emergent response and treatment. No transport. (non-ambulance);
  - BLS non-emergent response. Treatment and transport. (non-ambulance).

- Assign a fee schedule amount to the new codes.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz introduced the issue – see above – and asked Gabrielle Haxby to provide additional information.
- Gabrielle Haxby described in greater detail their current business model (see excerpt from stakeholder above). She noted the code they were using previously (A0130) is a non-emergency transportation wheelchair van, which doesn't represent what they do.
- DeAnna Tapia sought clarification regarding "treat and release" and asked if this would be for isolated, small injuries that don't require follow up.
- Gabrielle Haxby noted that yes, that is an example of treat and release. She noted that they are conducting an assessment to determine if an injury requires a higher level of care. She noted it could be a wound and determining whether stitches are required. She noted there is a benefit to these workers being seen right away rather than waiting for hours to be seen in the emergency room.
- Steven Bennett sought clarification regarding the contract or agreement to bring the mobile health provider to the scene.
- Gabrielle Haxby clarified that they are a nonprofit healthcare organization and have connections with local employers. They are then available to the employees of those employers. They are an alternate to calling 9-1-1 when there is a non-emergent injury. She further clarified that they are not affiliated with the employers—they are merely providing a service to the employers and billing them accordingly. She added that employees of those employers can reach out to them when they are injured—it doesn't need to be the supervisor.
- DeAnna Tapia asked if that would be billed as an initial consult.
- Juerg Kunz noted that the code for an initial consult is an office visit does not cover visits/evaluations in the field—and these treatments are taking place in the field.

Issue # 7 (2117)

Rule: OAR 436-009-0060 Oregon Specific Codes

Issue: The billing code (W0001) for a worker requested medical exam (WRME) includes the charges for the exam, time spent reviewing the record, and the report. However, the code does not include charges for authoring an addendum to a report.

Background:

- OAR 436-009-0060(2) provides the following descriptor for W0001: "WRME (worker requested medical exam): Exam, report, or time spent reviewing the records associated with the scheduled exam."
- Under OAR 436-060-0147:
    - The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the WRME physician at the exam to the physician at least 14 days before the scheduled date of the exam.
    - Upon completion of the exam, the WRME physician must address the original independent medical examination (IME) questions and the questions from the worker or the worker's attorney and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.
- Since the worker or the worker's attorney must submit questions to the physician 14 days prior to the exam, there should generally not be a need for an addendum report.
- However, there may be times when the WRME physician is asked to respond to an addendum report from the IME physician. The division believes that in such a case, the WRME physician should be reimbursed for authoring an addendum report.

Options:

- Add "addendum to a report when authored in response to an IME addendum report" to the descriptor of billing code W0001.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

<u>Minutes</u>:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Skylar Hall noted that SAIF is concerned that the proposed language oversteps the current statute: ORS 656.325(1)(e). That statute specifically provides the worker can request an examination and it directs the insurer or self-insured employer to pay the costs associated with the examination and the examination report. It does not provide for an addendum report. As such, SAIF would be concerned that this proposed rule change goes beyond what the statute allows. Additionally, if the need arose for a WRME addendum report, that cost would be incurred by the worker's attorney in the first instance and, should they prevail, that would become a reimbursable cost depending on the type of matter that the WRME was obtained for.
- Ted Heus disagreed. He expressed that he did not believe the proposed rule oversteps statutory authority. He noted the statute entitles a worker to an examination basically each time a report or reports is uploaded to the record. He noted the proposed rule language doesn't track the statutory language exactly, but he believes the proposed rule language is sufficient. It could be efficient and help to avoid needing an entire new WRME exam. In terms of reimbursement costs, if worker's attorneys were able to pick the WRME doctor and get exactly the reports that they want, Ted supposed that SAIF's point regarding reimbursement could be true. But, sometimes the WRME does not help the worker and sometimes the doctors change their opinion. He noted that the WRME process is supposed to be neutral, and that is not always the case—it can be advantageous for the insurer.
- Thais Lomax noted that the WRME process is reliant on an IME that the attending physician has either disagreed with or not commented on. So, she reasoned that the addendum to a WRME report would also rely on that same process if the insurer is going to pay for it in the first instance. Where there's a WRME report, then an IME addendum, potentially that IME addendum would then need to go to the attending physician, and if the attending physician disagrees with that addendum, then a WRME addendum would be allowed.

Issue # 8 (1949)

Rule: OAR 436-009-0080(7) Durable Medical Equipment (DME) Rental Rates

Issue: Some of the rental rates for DME, published in OAR 436-009-0080(7), may be outdated.

Background:

- On January 1, 2012, WCD started using CMS' DMEPOS fee schedule as the basis for the new workers' compensation DMEPOS fee schedule.
- Many items covered by the DMEPOS fee schedule are being rented, not purchased. The monthly rental rate is 10% of the fee schedule amount (purchase price), published in appendix E.
- Analysis of WCD's billing and payment data showed that for some items, the calculated rental rate was significantly below the going rental rate, and providers pointed out that they would not be able to provide these items at the calculated rental rate. Therefore, certain DME codes were carved out, and WCD publishes a rental rate in OAR 439-009-0080(7) for these DME codes independent from the purchase price.
- The rental rates for some DME codes published in OAR 436-009-0080(7) may now be lower than 10% of the purchase price.
- It is reasonable to remove those codes whose rental rates are below 10% of the purchase price from OAR 436-009-0080(7), i.e., their rental rates would become 10% of the purchase price published in Appendix E.
- WCD intends to compare the rental rates listed in OAR 436-009-0080(7) to the proposed 2026 DMEPOS fee schedule and remove any codes from OAR 436-009-0080(7) that are below 10% of the fee schedule amount

Options:

- Remove codes whose rental fees published in OAR 436-009-0080(7) are below 10% of the fee schedule amount from OAR 436-009-0080(7).

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

<u>Minutes</u>:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- No discussion.

Issue # 9 (2112)

Rule: OAR 436-009-0110 Interpreters

Issue: A stakeholder noted that OAR 436-009-0110(2)(b) as worded violates Title VI of the Civil Rights Act.

Background:

- OAR 436-009-0110(2)(b) provides, in relevant part, that, "if the insurer denies the claim, interpreters may bill the worker."
- According to the stakeholder, "[i]t is illegal to pass the cost of interpreting services onto the worker."
- Title VI of the Civil Rights Act provides that no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.
- The obligations under Title VI regulations apply broadly to any program or activity that receives federal funding, either directly or indirectly (through a contract or subcontract, for example), and without regard to the amount of funds received.
- In the workers' compensation setting, workers may choose their own interpreters, rather than use an interpreter arranged for by the provider. OAR 436-009-0110(2)(b) is intended for interpreters chosen by the worker, not the provider. In such a case, neither any program nor any activity is involved that receives any federal funding.

Options:

- Amend OAR 436-009-0110(2)(b) as follows:

  "Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if **the interpreter is chosen by the worker and** the insurer denies the claim, **the** interpreter~~s~~ may bill the worker."

  Or

  "Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). ~~However, if the insurer denies the claim, interpreters may bill the worker.~~"

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- DeAnna Tapia noted that her interpreter company does not bill the worker as it would violate Title VI. She noted that this could be an issue for an interpreter who does not work for a company and may not have a contract with the providers. DeAnna's company contracts with providers, and if the workers' compensation claim is denied, they bill the provider. If they don't have a contract with the provider, they are not paid for that service. For interpreters without such provider contracts, their income could be impacted greatly if they can't bill to providers upon a claim denial. DeAnna expressed a preference for the first option above, in which the rule specifies that the situation is different if the worker chooses the interpreter (e.g. a family member or friend who is not trained or certified). However, DeAnna added that she recommended having some type of notice for the workers so they know that they will be responsible to pay the interpreter in the event the claim is denied.
- Dr. Eric Hubbs noted that he only needed an interpreter one time, and that cost came out of his pocket. He noted that it is the cost of doing business. He noted that it is important to have an interpreter available—for the worker and the provider. So, he supposed the rule does need some clarification, but the proposed language could be enough.
- Steven Bennett sought clarification: if the workers' compensation claim is denied, one cannot bill the insurer.
- Juerg Kunz noted that was correct.
- Steven Bennett wanted to confirm that would still be the case under the proposed change.
- Juerg Kunz noted that it would still be the case.
- DeAnna Tapia noted that interpreters can bill the insurer if the claim is denied—only if the adjuster is the one who requested the interpreter.

Issue # 10 (2145)

Rule: OAR 436-010 and 436-015

Issue: There is no standardized process for submitting requests for pre-authorization of medical services.

Background:

- This issue was raised by a stakeholder on behalf of the Oregon Trial Lawyers Association (OTLA). OTLA opines that a standardized process is needed for submitting requests for pre-authorization of medical services in order to streamline the process for providers and provide enforceable deadlines for insurer responses.
- ORS 656.245(1)(a) provides that for every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires.
- In the Oregon workers' compensation system, unless the claim is enrolled in an MCO, providers are generally not required to request pre-authorization. However there are providers who insist on receiving some form of pre-authorization from insurers before they are willing to provide medical services to a workers' compensation patient. In such cases an insurer may have to pre-authorize a medical service in order to cause the medical service to be provided.
- There is a provision in OAR 436-010-0270(4) that requires insurers to respond to a provider's pre-authorization request for diagnostic imaging studies: "Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized."
- The stakeholder noted that "[w]orkers and their medical providers often face difficulty and delay in getting responses from insurers so that treatment can proceed or denials can be appealed. This was discussed during the MLAC Access to Care Subcommittee over the summer. It is a common issue cited by providers in terms of added administrative burden."
- The MLAC access to care subcommittee recommended that OTLA move forward with requesting WCD rulemaking to consider a standard procedure for submitting requests for preauthorization with a deadline for response, after which the worker could treat the lack of response as a denial and file an appeal.
- All three certified MCOs require pre-certification of many medical services, and each MCO has their own pre-certification form.
- The stakeholder proposed that WCD "[c]reate a standardized form that providers are encouraged to use for any type of medical service whether or not an MCO is involved. The form would be deemed received after being faxed or emailed, and the insurer would have a set time for response, after which the worker could treat the failure to respond as a denial and file an appeal."

- If WCD created a form for preauthorization of medical services, would MCOs have to accept this form rather than mandate use of their own form?

Options:

- Create a new form that providers must use if they wish to request preauthorization of medical services.

- Amend OAR 436-010-0270 as follows:
  (3)**(a)** Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request **on Form XXX** for preauthorization of ~~diagnostic imaging studies, other than plain film X-rays~~ **medical services**. The response must include whether the service is pre-authorized or not pre-authorized. Preauthorization is not a guarantee of payment.
  (b) If the insurer fails to respond within 14 days of receiving Form XXX:
  (A) The medical service is considered denied; and
  (B) The insurer is barred from challenging the medical appropriateness.

- Delete OAR 436-010-0230(12).
  (Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not preauthorized within 14 days of receipt of the request.)

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Jovanna Patrick noted that this has been a discussion at MLAC—doctors reiterate over and over that they do not receive timely communications from insurers when they need authorization to proceed with treatment. She named one doctor, who is well-versed in

workers' compensation, who needs to "trick" insurers into allowing post-surgery rehab to prevent additional injury. Providers less familiar with workers' compensation rules have a hard time figuring out what they can and cannot do. She noted that the system is completely different for MCOs and non-MCOs. They even have a hard time determining whether a worker is associated with an MCO or not—often because insurers won't get back to them to provide information. Jovanna noted that a standardized method for preauthorization would be so much simpler. She added that stakeholders and MLAC agreed that a more streamlined approach would be better than the current system. Additionally, she added that the MCO preauthorization forms are extensive and difficult to navigate. She suggested a standard, simple form that could be faxed and, if not returned in a certain number of days, considered denied. She added that the current system is riddled with verbal non-denials that cannot be appealed. She's had providers call her and tell her that the adjuster had said that the adjuster wouldn't pay for a treatment, for example. She noted that when the insurers direct care, the recourse is not timely and is ineffective—and the worker then doesn't get the necessary treatment. By creating a form, there would be a concrete decision that could be appealed. Finally, she noted that many providers expect a preauthorization and won't move forward without one.

- Steven Bennett noted that preauthorization could be helpful for specialized, more expensive treatments. He noted that the current proposed language "all medical services" could create a burden on the system. He suggested looking at the methods of other states: requiring preauthorization for certain surgeries, diagnostics, certain rehab or physical therapy.
- Juerg Kunz noted that the proposed language would not require a preauthorization for all medical treatments—it would only create the option to have the preauthorization form, if the provider would like one.
- Steven Bennett appreciated the clarification but noted there would still be a possibility that providers ask for preauthorization for treatments other states consider routine. If that were to happen, the system would be burdened with preauthorization requests.
- Juerg Kunz asked if Steven had certain treatments that should be included?
- Steven Bennett noted that other states include major surgeries, diagnostics or for alternative treatments. He noted that New York includes treatments that are inconsistent with the treatment guidelines.
- Thais Lomax stated that Sedgwick supports streamlining the process and a universal form. She added that insurers are barred from directing care, and a form could help providers understand what insurers are and are not allowed to do in the workers' compensation process. She suggested the form include the name of the attending physician, the claim status, whether there is an MCO. She noted that it would be great to have such a form as adjusters are not able to say they are authorizing treatment. Instead, they can only say they've accepted certain conditions and will pay for the treatment plan with the attending physician. She asked how we would restructure the rule to ensure the form is being reviewed and utilized consistently across the state, and whether or not an MCO is involved.

- Isabel Hernandez echoed Steven Bennett's comments and noted there is room for misinterpretation with the proposed language. As written, the proposed rule could be interpreted to mean a preauthorization is needed for all medical treatments.
- Skylar Hall first sought clarification and asked that this proposed language would not change the fact that preauthorization is not necessarily guaranteed.
- Juerg Kunz confirmed.
- Skylar Hall noted that SAIF is concerned with the use of "all medical treatments" as the term is defined very broadly. She noted SAIF's concerns with a quick turnaround of 14 days—particularly if the matter is complex or if the requested service is unusual. Second, she suggested this could create inefficiencies and administrative burden on adjusters and providers. SAIF suggested that, should this move forward, the rule be more selective with respect to the treatments for which preauthorization would be available and that the division track outcomes. She expressed a concern that this change would increase litigation as 14 days is potentially too short for insurers to properly review and make a decision. Instead, SAIF proposes a reasonableness standard for insurers to use when reviewing preauthorization requests. She added again that the outcomes be tracked to determine if the changes result in the desired outcome. SAIF does not support that a failure to respond in 14 days results in a denial. She noted that such a change would increase litigation and costs, and would not help workers receive treatment faster. Instead, SAIF suggests a civil penalty be put in place. SAIF also does not support insurers forfeiting their ability to challenge appropriateness upon failure to respond.
- Misty Bergenstock noted that they generally send out preauthorization requests because despite certain treatments for an accepted claim are reasonable, insurers do not always reimburse for the treatment. The provider is then at a loss for how to treat the patient. She noted that, while adding a preauthorization form may be more burdensome for insurers, it would likely help and protect workers and get them back to work sooner—which is, after all, the whole goal of the system. And, it would give the provider peace of mind when proceeding with treatment.
- Ann Klein stated that Majoris does not support standardizing a single form for MCOs and non-MCOs. She emphasized that these are two different entities with different lanes and roles. The MCO is put in place to address medical necessity and appropriateness specific to the treatment that is directed towards the condition. MCOs do not touch on compensability. She added that, as was raised by others, the insurer is much more limited in what they can say about what is medically necessary and appropriate—it is very different than what the MCO can say. For the MCO forms, they are designed specifically to solicit the information necessary to help make an informed medical decision by her physician reviewers. The types of questions asked in the form depend on the type of care being provided; they do not have one single form. She noted that these curated forms boost efficiency in review and helps ensure consistency of information shared between the provider and MCO. She noted that trying to standardize a form for MCOs and non-MCOs may introduce more confusion. She added that the more we can do to provide clarity between MCO and insurer, and what each can comment on, the better the outcome will be.

Issue # 11 (2146)

Rule: OAR 436-010-0270(1)

Issue: When a worker becomes medically stationary, OAR 436-010-0270(1) requires the insurer to "immediately" send a notice to the worker, whereas OAR 436-060-0015(8) requires a notice to be sent within seven days.

Background:

- OAR 436-010-0270(1)(c) provides that in disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).
- Further, subsection (1)(d) of rule 0270 states that when the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.
- OAR 436-060-0015(8) provides that an insurer must mail or deliver a written notice to a worker and the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.
- This issue was raised by a stakeholder[2] who noted that insurers may send out multiple notices to injured workers informing them of their medically stationary status. This increases costs for insurers, results in duplicative documents. The stakeholder pointed out that representatives of injured workers have consistently reported that workers receive too much paperwork during the course of their claim.
- The stakeholder is proposing that aligning the time period to send the medically stationary notice under OAR 436-010-0270(1)(c) with OAR 436-060-0015(8). If adopted, an insurer would have to the send the medically stationary notice within 7 days of the worker being declared medically stationary under both rules. This would simplify the timeline and avoid duplicative mailings or delivery of the same or similar notices.
- WCD has noticed that oftentimes ancillary care providers and specialist physicians are not made aware of the worker's medically stationary status and, therefore, are not aware that medical services for a worker are limited to those listed in ORS 656.245(1)(c).

Options:

- Amend OAR 436-010-0270(1)(c) as follows:

[2] This issue was raised previously by a stakeholder, however, at that time, WCD did not make a rule change.

In disabling and nondisabling claims, ~~immediately following~~ **within seven days of** notice or knowledge that the worker is medically stationary, the insurer must notify the worker and ~~the attending physician or authorized nurse practitioner~~ **all medical service providers** in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245-(1)(c).

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Skylar Hall noted that SAIF supports the alignment of the time periods. However, SAIF has concerns about the requirement to send notice to all medical providers. She noted that "all medical providers" could include emergency room physicians, etc. that are not actively treating the worker. SAIF believes sending the notice to the attending physician or authorized nurse practitioner is sufficient.
- Juerg Kunz noted that OAR 436-010-0270(1)(d)—which states that if insurer establishes a medically stationary date that is not based on the finding of the attending physician or authorized nurse practitioner, the insurer needs to send notice to all medical providers.
- Skylar Hal noted that yes, in those situations, the attending physician would know that the worker was medically stationary and there would likely be adequate communication between the actively-treating providers. The concern with the proposed language is that it does not limit notice to go to only those who are actively treating the worker.
- Juerg Kunz suggested the division add "actively-treating" to the proposed language.
- Skylar Hall noted that would be an improvement, but the term "actively-treating medical service providers" would require a definition.
- Kevin Anderson noted that he brought this issue forward and supports simplifying the notice process. He agreed with SAIF's points. He noted that his understanding was that "all medical providers" is for when there's a preponderance of medical evidence for the closure–not the standard attending physician or combined condition cases. He voiced that the notice should go to the attending physician, as all treatment goes through the provider. He added that the number of cases being closed under the other rule (OAR 436-010-0270(1)(d)) is fairly low. Finally, he added that he often tells his clients that they can add providers to the list to receive notice. But, requiring the notice be sent to all medical providers or even all active providers could cause confusion.

- DeAnna Tapia noted that interpreter services should also get that notice. They don't currently receive them and sometimes go to appointments that are not covered. She noted that interpreters are not medical providers but contribute to continuity of care—it would be nice if they received all of the information, too.

Issue # 12 (2137)

Rule: OAR 436-010-0280

Issue: MCOs are allowed to grant full length attending physician (AP) status to physician associates (PAs), i.e., permit them to be AP for the life of the claim. Similarly, MCOs may allow authorized nurse practitioners (ANPs) to treat workers for the life of the claim. However, under OAR 436-010-0280(1) MCOs may not allow PAs and ANPs to make findings of impairment.

Background:

- ORS 656.245(2)(b) provides that a medical service provider who is not a member of a managed care organization is subject to the following provisions:

  (C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

  (D)(iii) When an injured worker treating with a nurse practitioner or physician assistant authorized to provide compensable services under this section becomes medically stationary within the 180-day period in which the nurse practitioner or physician assistant is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability.
- OAR 436-010-0280(1) provides, in relevant part, that when a worker becomes medically stationary and there is a reasonable expectation of permanent disability, and the worker is under the care of an authorized nurse practitioner, physician associate, or a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam.
- ORS 656.245(2)(b)(C) and (D)(iii) apply to providers who are not members of an MCO. However, OAR 436-010-0280(1) as currently worded applies to all ANPs, PAs, and naturopathic physicians, regardless of whether they are members of an MCO.

Options:

- Amend OAR 436-010-0280(1) as follows: "When a worker becomes medically stationary and there is a reasonable expectation of permanent disability, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. **Unless otherwise provided by an MCO,** ~~If~~ **if** the worker is under the care of an authorized nurse practitioner, physician associate, or a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam."

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Ann Klein noted that Majoris is supportive of having that clarity.
- Thais Lomax noted that Sedgwick would support allowing physician assistants and nurse practitioners to act as the attending physicians for the 180 days, including rating and commenting on impairments. For rural workers, it can be extremely difficult to get closing exams by a doctor.
- Juerg Kunz noted that, unfortunately, that limitation is outlined in statute. So, we can't change that in rule.

Issue # 13 (2148)

Rule: OAR 436-015-0037(3)

Issue: A stakeholder stated that workers report that it becomes increasing difficult to schedule an appointment with an MCO panel provider within the timeframe required by OAR 436-015-0037(3)(e)(A).

Background:

- OAR 436-015-0037(3)(e)(A) allows a worker, upon being enrolled in an MCO, to continue to treat with the current medical service providers for at least 14 days after the mailing date of the notice of enrollment.
- This issue was raised by a stakeholder who noted:

  > Injured workers have only 14 days from the date of mailing a letter informing them they are subject to an MCO to find providers within the MCO. These letters are mailed, often from out of state, and workers don't receive them until days later. Then they only have 10 days or less to find a new doctor. As you can imagine, calling any medical clinic and being seen in that timeframe is impossible. If the worker can't be seen within 14 days of the letter, they will lose their time loss. The rule should be changed to reflect the reality of how hard it is to find a doctor within that timeframe. 30 or even 45 days seem more reasonable.

Options:

- Amend OAR 436-009-0037(3)(e)(A) to allow workers, upon being enrolled in an MCO, to continue to treat with the current medical service providers for at least 30 (or 45?) days after the mailing date of the notice of enrollment, rather than the current 14 days.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

<u>Minutes</u>:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Ann Klein noted that Majoris interprets the rule as not requiring an injured worker to be seen in 14 days, but rather that the 14 days is a buffer in which a worker can get non network care. She noted that enrollment is not tied to the timing of the last office visit. Enrollment can happen at any point in the individual 's course of care as well as any phase in their recovery journey. The 14 days allows the worker, if they haven't been seen

recently, or if authorized time loss is coming up due, etc., to have this last, final window in which to have non-network care from their attending physician while they look for a new, in-network attending physician. She noted that they typically see most attending physicians in a monthly cadence of work release information, treatment plans, etc. So, if the worker was just seen, their next office visit will likely be closer to 30 days out. In instances like this, there is a buffer. The 14 days is not the deadline to find a new attending physician and be seen by that new provider. She noted, too, that time loss does not expire 14 days from enrollment (it isn't tied to that). So, to Majoris, the 14 days provides a good target to help ensure they're identifying the transition over to network, establishing network care, or issuing a come along offer for the existing provider and establishing how they will work together. Doing all of these things promptly is important. She added that there are other ways to continue the out-of-network care for more than the 14 days, if necessary. For example, the worker can reach out to the MCO.

- Sydney Montanaro supported extending the deadline. She noted that the letters go out and the mail can often delay them 10 or so days, which gives the worker only four days to find and see a new attending physician. There is a lack of providers, which makes this nearly impossible. She emphasized that there is a subcommittee dedicated to Access to Care—certain clinics have stopped taking workers' compensation patients, etc.—it is extremely hard for workers to find providers, particularly in tight timelines. She added that it can depend on when the worker becomes enrolled in the MCO, as enrollment can happen at any time. Typically, they see the providers wanting to connect with the adjuster to learn what is accepted on the claim, they want the whole claim file before they decide whether or not to take the claim. So, the worker can be trying to find a provider and a provider can just refuse to take their case. Overall, 14 days is too short. And, she noted that she was not aware that the 14 days was viewed as a buffer, as expressed by Majoris.
- Kevin Anderson reiterated that this was brought up in the Access to Care subcommittee. One alternative to pushing out the deadline would be to allow electronic service of the enrollment notice. He doesn't think there is anything currently prohibiting his clients from sending out the enrollment form via email, but there is no real incentive to do so when it needs to be sent by mail, too. But, if there is a way to get the worker the notice by email right away, the mail delay becomes less of an issue. Another item recently discussed—in lieu of pushing out the 14 days— was allowing providers to retroactively authorize time loss up to 45 days. He noted that is a little bit of the buffer described by Majoris. He does have concerns about pushing the 14 days to 30 or 45 days as it starts cutting into the 60 days to investigate the claim. That could leave the insurer in a position of trying to determine compensability with inadequate records.
- Skylar Hall stated that SAIF supports the current rule and opposes extending the 14 days. She noted that the data suggests workers are able to connect with MCO providers to schedule—but maybe not attend—the appointment in the 14-day period. SAIF believes the 14-day time period is important to ensure a timely connection between the worker and the MCO provider. She noted that they supported extending the time period to 45 days for an attending physician to retroactively authorize for 45 days to ensure benefits are not interrupted. She expressed agreement with the comments of Ann Klein and Kevin Anderson.

- Jovanna Patrick agreed with Sydney Montanaro: the worker has less than 14 days after mailing delays. She noted that there is a significant difference between a matter that is accepted in which the worker can seek an MCO doctor in 60 days and those matters that go to litigation and the worker is left looking for an MCO doctor after 60 days. Many MCO doctors will not take a worker after 60 days/a year/litigation. The midstream changes are difficult for workers. Jovanna noted that there has been a big change over time with respect to providers treating a worker. Often, the provider wants to connect with the adjuster and be paid to review an entire file before maybe deciding to treat the worker. Also, workers are often ready to go back to work but they are forbidden from doing so until they get the release from an MCO doctor—which causes huge delays. If providers are not going to be more willing to take on treatments mid-claim, the workers need more time to find providers.

Issue # 14 (2158)

Rule: OAR 436-015-0110 and 436-015-0008

Issue: The timeframes for MCO dispute resolution and administrative review by the director may delay necessary treatment substantially.

Background:

- OAR 436-015-0110(6) provides that the time frame for resolution of the dispute by the MCO may be up to 60 days from the date the MCO receives the dispute to the date it issues its final decision.
- An aggrieved party may then request administrative review by the director within 60 days of the date the MCO issues a final decision. OAR 436-015-0008(1)(b).
- Reducing the timeframes listed in OAR 436-015-0008(1)(b) and OAR 436-015-0110(6) from 60 to 30 days could reduce treatment delay by up to 60 days.

Options:

- Amend OAR 436-015-0008(1)(b) and -0110(6) as follows:
    - OAR 436-015-0008(1)(b):
      Within ~~60~~ **30** days of the date the MCO issues a final decision under the MCO's dispute resolution process, the aggrieved party must file a written request for administrative review with the division. The request must specify the grounds upon which the action is contested.
      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 must request administrative review within ~~60~~ **30** days of the failure of the MCO to issue a decision.
      When the aggrieved party is a represented worker, and the worker's attorney had given written notice of representation to the insurer at the time the MCO issued its decision, the ~~60~~**30**-day time frame begins when the MCO issues its final decision to the attorney.
    - OAR 436-015-0110(6):
      The time frame for resolution of the dispute by the MCO may not exceed ~~60~~ **30** days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260(15), the MCO must notify all parties to the dispute in writing with an explanation of the reasons for the decision. If the worker's attorney has notified the insurer in writing of representation, the MCO must also send a copy of the explanation of the reasons for the decision to the attorney. This notice must inform the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

How will adoption of this rule affect racial equity in Oregon?

Recommendations:

Minutes:

- Juerg Kunz described the issue – see above – and asked the committee for advice.
- Keith Semple noted that it would speed up the process if MCOs did not need to review a decision they're already made. He would like to see the statistics regarding how often MCOs reverse their decisions. He is not sure why a second review is necessary—but he supports shortening the timeframe. He is not supportive, however, of shortening the timeframe for workers to recognize and respond to appeal a decision. If getting the worker timely treatment is the system's priority, he doesn't believe they should have a shorter time period to make a decision. He expressed general frustration with MCOs and the rules and barriers that he believes accompany MCOs.
- Lisa Johnson noted that 60 days does give the worker more time to get in with their provider. And, Majoris wants to leave the MCO turnaround time at 60 days. She noted that the point of the appeal is to have the medical dispute reviewed by medical professionals and to be informed of the most relevant, current information. Majoris believes it is important to balance the desire for speed and the desire for a quality review and decision. She noted that the reasoning for the decision is circulated to all parties, and it is important that the review and decision making is thorough. When Majoris gets an appeal, they reach out to make sure they have current information. They may have a consultation with the medical provider and review new literature. Then, they need to gather a committee which requires picking the right specialists and finding time that works for everyone. It takes time, and shortening the timeframe could cause rushed, incomplete decision making. And, if a matter does go to the division's Medical Resolutions Team (MRT), Majoris wants MRT to have all relevant information.
- Ted Heus asked Lisa about the original timeframe for the MCO to review medical treatment, i.e., to make a pre-certification decision.
- Lisa Johnson noted that there is no timeframe. For those, the provider sends all information that the provider believes should go to the single reviewer (not a panel).
- Ted Heus noted that there is no time period for the director to make decisions, either. Sometimes those reviews are quick and sometimes they are not. He suggested that time period could be compressed to speed up the process.

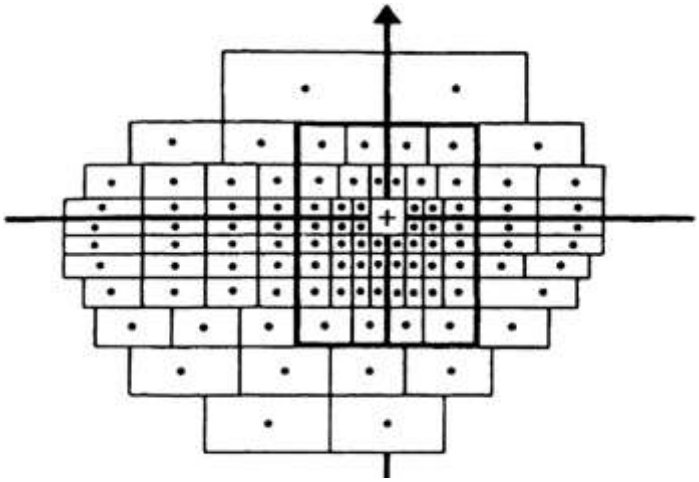
Issue #15

Rule: OAR 436-035-0260(3)

Issue:
OAR 436-035-0260(3) specifies that a Goldmann perimeter must be used to measure visual field loss. Because this device is now outdated, there are a limited number of ophthalmologists available to conduct closing and arbiter exams requiring visual field testing.

Background:
For permanent partial disability (PPD), a worker's level of impairment must be determined based on objective medical findings. ORS 656.726(4)(f)(B), OAR 436-035-0013(1). Findings vary based on body part and are outlined in OAR 436-035. One component of visual loss impairment is visual field loss, or the loss of peripheral vision to a certain extent due to a compensable injury. The impairment ratings for visual field loss are based on "measurements of each eye separately using the Goldmann perimeter with a III/4e stimulus." OAR 436-035-0260(3). The rule provides two methods for scoring the results of these measurements in order to determine the percentage of loss.

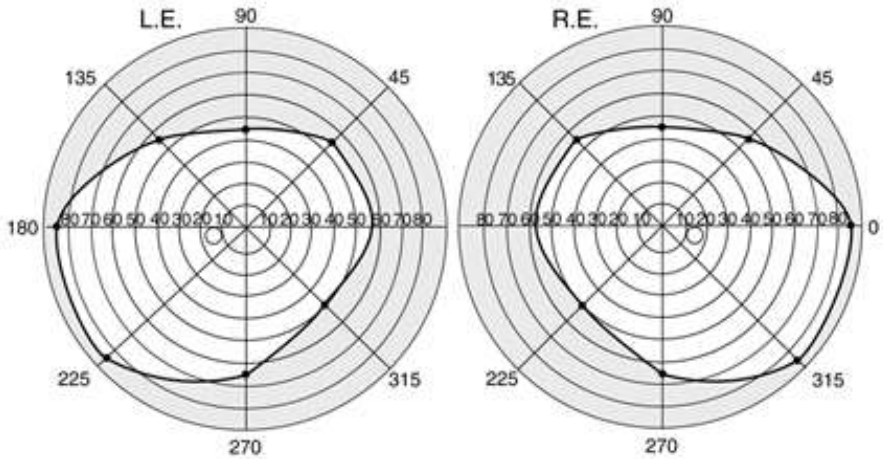
The first method uses the Esterman Grid, which is a set of 100 test points used to systematically map the visual field and identify areas of loss. The operator draws a line around the outermost points that the worker can see to determine the extent of their visual field. The rule provides that the number of points counted outside or on this line is the percentage of loss. OAR 436-035-0260(3)(a). The Esterman Grid is shown below:



Source: Esterman B: Grid for scoring visual fields. Archives of Ophthalmology, 1968.

The second method uses a perimetric chart, which is a map of the visual field split into eight sections. The operator measures the worker's peripheral view in each direction of gaze to trace the outer boundary of their vision. The rule requires that the measurements are added together

and provides a chart to convert the total degrees retained into a percentage of loss. OAR 436-035-0260(3)(b). A perimetric chart is shown below:



Source: Workers Compensation Division (WCD) Form 2312

OAR 436-035-0260(3) was added to the division's disability rating standards in 1992 and has not been updated since then. The rule specifically requires use of the Goldmann perimeter, a manual device that is now outdated. The manufacturer of the device discontinued its production in 2007 and repair parts for existing machines are unavailable. There is currently only one clinic in the state with a Goldmann perimeter and available arbiter ophthalmologists. Due to the limited number of ophthalmologists able to comply with the rule, the division faces challenges in scheduling arbiter exams and recruiting new arbiter ophthalmologists. Additionally, this may pose challenges for insurers to schedule closing exams, possibly requiring some workers to travel across the state to reach this one clinic.

The Goldmann perimeter uses a method referred to as kinetic perimetry, where the operator manually moves a test stimulus inside of a bowl. Since the Goldmann perimeter was discontinued, the field has moved towards automated devices that use a different technique called static perimetry. With this technique, the test stimulus is placed in a few locations while its size and intensity are changed. The Humphrey Field Analyzer and the Octopus, which each come in a variety of models, are now more commonly used by ophthalmologists to measure the visual field. These devices are typically used in their automatic mode, which is limited to assessing central portions of the visual field, out to about 30 degrees. However, certain models of these devices are capable of performing kinetic perimetry. This type of testing is able to provide reliable measurements of the full peripheral visual field and is preferred when rating impairment for visual field loss.

In order to allow more devices to be used to conduct closing and arbiter exams requiring visual field testing, the division is considering updating OAR 436-035-0260(3) to remove required use of a Goldmann perimeter, instead requiring the use of kinetic perimetry on a device that is

capable of producing the findings required for completion of either of the two reporting methods allowed under the rule. The division invites stakeholder input on the following options:

Options:

1) Amend OAR 436-035-0260 as follows:

OAR 436-035-0260 Visual Loss

(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using kinetic perimetry ~~the Goldmann perimeter with~~ and a III/4e stimulus on a device that is capable of producing the findings required for completion of either one of the two reporting methods below. The results may be scored in either one of the two following methods:

(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or

(b) Using a~~A~~ perimetric chart, ~~may be used which~~ indicate~~s~~ the extent of retained vision for each of the eight standard 45° meridians out to 90°. The directions and normal extent of each meridian are as follows:

Minimal normal extent of peripheral visual field

Direction	**Degrees**
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
TOTAL	500

(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.

(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of

each meridian included within the retained field. This results in a figure which may be applied in the chart below.

(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

2) Other?

Fiscal impacts, including cost of compliance for small business:
No significant impacts are expected, though there could be some cost reduction. Currently, insurers may need to reimburse workers who require a visual field loss exam for travel to reach the one available clinic. Costs could be reduced by allowing additional clinics for these exams in more locations throughout the state. The division invites input from advisory committee members about costs, including costs to be borne by small businesses.

How adoption of this rule could affect racial equity in this state:
The division does not collect data about race or ethnicity related to workplace injuries and illness in Oregon, but the United States Bureau of Labor Statistics publishes lists of occupations and numbers of Americans employed broken down by race. Black/African Americans and Hispanic/Latino workers are represented in some of the more dangerous occupations in higher numbers than their respective shares of the U.S. workforce. To the extent Oregon workers in these racial groups suffer more on-the-job injuries and illnesses, changes to exam scheduling may impact these racial groups more than others. The agency does not have sufficient data needed to estimate specific effects on racial equity in Oregon, but invites public input.

Minutes:

- Mary MacKie described the issue – see above – and asked the committee for advice.
- Skylar Hall noted that SAIF supports the update with a potential concern: SAIF is unsure whether physicians are able to provide the same measurements with kinetic perimetry. The kinetic perimeter should be able to measure at least 85 degrees temporally. If not, there is potential for awards in the absence of actual impairment. Otherwise, SAIF supports updating the rule to move away from an outdated machine.

Minutes:

Marie Rogers thanked attendees for joining and ended the meeting. She invited people to provide feedback regarding the issues via email to marie.a.rogers@dcbs.oregon.gov. She noted that comments must be received by the end of the day on November 26, 2025.

Re: Issue #3 (Platelet Rich Plasma Injection)

Billings for PRP Injections (CPT code 0232T) With DOS 4/1/25 - 10/13/25

DOS	Charge	Paid
7/8/2025	$400.00	$0.00
7/8/2025	$400.00	$0.00
7/8/2025	$400.00	$0.00
7/8/2025	$400.00	$0.00
5/6/2025	$500.00	$0.00
8/12/2025	$500.00	$0.00
6/3/2025	$500.00	$0.00
8/4/2025	$500.00	$400.00
6/24/2025	$500.00	$400.00
8/4/2025	$500.00	$400.00
5/13/2025	$500.00	$400.00
4/29/2025	$500.00	$500.00
4/29/2025	$500.00	$500.00
4/29/2025	$500.00	$500.00
6/17/2025	$550.00	$413.60
6/27/2025	$550.00	$440.00
6/19/2025	$800.00	$640.00
7/14/2025	$850.00	$0.00
8/6/2025	$850.00	$680.00
4/7/2025	$895.00	$0.00
5/12/2025	$895.00	$0.00
5/7/2025	$995.00	$0.00
5/7/2025	$995.00	$796.00
5/8/2025	$1,200.00	$960.00

Summery:

Total Charged	Count	24
	Min	$400.00
	Median	$500.00
	Mean	$632.50
	Max	$1,200.00
Total Paid	Count	13
	Min	$400.00
	Median	$500.00
	Mean	$540.74
	Max	$960.00