DCBS | Consumer and Business Services
Workers' Compensation Division

M E M O R A N D U M

January 29, 2021

To: Management-Labor Advisory Committee

From: Robert Andersen
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Subject: MCO enrollment disputes

At your Jan. 8, 2021, meeting the committee received public testimony regarding managed care organizations (MCOs). To assist with understanding the comments, we are providing a background memo on MCOs and their processes (attached). This document was previously provided to the committee as part of an educational session in 2019. We have updated it with current data. More detailed information about these areas can be provided at a later date if it would be helpful to the committee.

The following is an overview of the process when a worker disputes being enrolled in an MCO. The overview touches on three specific areas raised in the public testimony:

1. The worker's enrollment in an MCO.
2. The review and appeal process if the worker disputes enrollment.
3. Attorney representation and attorney fees in an enrollment dispute.

The information below is a general description of the process. Please note that we are not able to comment on the specifics of the worker's case discussed in the public testimony, due to the matter being in litigation.

The worker's enrollment in an MCO

The insurer or self-insured employer, if they have a contract with an MCO, makes the decision whether and when to enroll a worker in the MCO. If enrolled, the worker must treat with an MCO panel provider (there are some exceptions). A worker may continue to treat with a non-panel provider if certain criteria are met (the "come-along" provisions).

Reasons why a worker may not become subject to an MCO contract include: if proper notice of enrollment was not given; if the contract expires or terminates without renewal; if the worker's primary residence is more than 100 miles outside the MCO's geographic service area; or if changing providers as a result of the enrollment would be medically detrimental to the worker.

If the MCO determines that changing providers would be medically detrimental to the worker, the worker does not become subject to the contract until the worker is medically stationary, the worker changes providers, or the MCO determines that the change in provider is no longer medically detrimental.[1]

If the worker believes that changing providers would be medically detrimental, and the worker is not yet medically stationary, the worker may request review by the MCO.[2] "Medically detrimental" is not defined in statute or rule.

The review and appeal process if the worker disputes enrollment.

There are several levels of review when medical care by an MCO is at issue.

1. MCO dispute resolution process.

At the time the worker is enrolled in the MCO, the insurer is required to notify the worker of the right to appeal MCO decisions, and to provide the worker with contact information.[3] If the worker is not medically stationary, the insurer is also required to notify the worker of the right to request review by the MCO if the worker believes the change in medical providers as a result of enrollment would be medically detrimental.[4]

If the worker requests review by the MCO, the MCO's dispute resolution process is followed. The procedure for the MCO's dispute resolution process is part of the MCO's certified plan.[5] An MCO is required to provide a written summary of its dispute resolution process to anyone who requests it, as well as to the parties to a dispute.[6]

At the conclusion of the MCO's dispute resolution process, the MCO will issue a final decision. (There may be some issues that an MCO does not address in its dispute resolution process, such as compensability issues or billing disputes. If that is the case, the MCO will notify the parties.)

[1] ORS 656.245(4)(a).
[2] OAR 436-010-0270(4)(f).
[3] OAR 436-010-0270(4)(d)(F).
[4] OAR 436-010-0270(4)(f).
[5] OAR 436-015-0030(9).
[6] OAR 436-015-0110(2).

2. Administrative review before the Medical Resolution Team (MRT).

If a party is dissatisfied with the MCO's final decision, or if the issue is not one that the MCO addresses in its dispute resolution process, the party has 60 days to request administrative review by the Workers' Compensation Division's Medical Resolution Team (MRT).[7]

When MRT review is requested, the insurer is required to provide MRT and the other parties a complete copy of the worker's medical record and other documents that are related to the dispute.[8] MRT gives the other parties the opportunity to submit additional input and information, including medical evidence, payment records, written factual information, sworn affidavits, legal argument, and rebuttal evidence.[9]

The statute requires MRT to create a "documentary record sufficient for judicial review."[10] The record created before MRT becomes the record that is reviewed at the next levels of appeal.

At the conclusion of its review, MRT issues an Administrative Order.

3. Hearing before Administrative Law Judge.

If a party disagrees with MRT's administrative order, the party has 30 days to file a request for hearing with the Workers' Compensation Division.[11] The division refers the request to the Hearings Division of the Workers' Compensation Board, and a hearing is scheduled before an Administrative Law Judge.[12] Before the hearing, the board sends the parties a "Notice of Rights and Procedures in Workers' Compensation Division Hearings [ORS 183.413(2)]."

Under the statute, the administrative law judge's review of MRT's order is limited. MRT's order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law; no new medical evidence or issues may be considered.[13] The statute defines "substantial evidence" as follows: "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."[14]

The courts have interpreted "substantial evidence" review to require the reviewer "to look at the whole record with respect to the issue being decided, rather than at one piece of evidence in isolation. If an agency's finding is reasonable, keeping in mind the evidence against the finding

[7] ORS 656.260(15); OAR 436-010-0008(2)(a)(B), 436-015-0008(1)(b).
[8] OAR 436-010-0008(3)(c).
[9] OAR 436-010-0008(3)(b).
[10] ORS 656.260(16); OAR 436-015-0008(1)(c).
[11] ORS 656.260(16); OAR 436-010-0007(a).
[12] ORS 656.704(2)(a); OAR 436-001-0019.
[13] ORS 656.260(17); OAR 436-001-0225(2), 436-010-0008(7)(b), 436-015-0008(4).
[14] ORS 183.482(8)(c).

as well as the evidence supporting it, there is substantial evidence."[15] The case law is clear that in a substantial evidence review, no additional evidence is admissible.[16]

The statute provides that this standard applies in all hearings on an order issued by MRT regarding medical services or treatment, regardless of whether the worker is enrolled in an MCO.[17]

The party who requested the hearing has the burden to show that MRT's order should be modified.[18]

The administrative law judges review many of these types of cases "on the record," where the parties submit written arguments to the judge but do not appear before the judge. The judge can hold a hearing, usually by phone, at which the parties present their positions orally. After the judge has reviewed the record and considered the parties' arguments, the judge issues a Proposed and Final Order, which becomes final unless a party files exceptions with the Workers' Compensation Division within 30 days.[19]

4. Director review.

If exceptions are filed, the case comes back to the Workers' Compensation Division for what is referred to as "director review."[20] The parties have the opportunity to submit written arguments explaining why they think the judge's order is wrong. The same limitations that apply at hearing are followed at director review; no new issues or evidence may be considered. After the parties submit their arguments, the hearing record is reviewed and a Final Order is issued, signed by the division administrator or the director.

5. Judicial review.

A party that disagrees with the director's final order has 60 days to file a petition for judicial review with the Court of Appeals.[21] The process for appellate review is specified in the Administrative Procedures Act (ORS chapter 183) and the Oregon Rules of Appellate Procedure.

If a party disagrees with the Court of Appeals' opinion, the party has 35 days to file a petition for review with the Supreme Court.[22] Review by the Supreme Court is discretionary.

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[15] *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206 (1988).
[16] *Liberty Northwest Ins. Corp. v. Kraft*, 205 Or App 59, 62-63 (2006); *Liberty Northwest Ins. Corp. v. Mundell*, 219 Or App 358, 363 (2008).
[17] ORS 656.245(6), 656.327(2).
[18] ORS 183.450(2).
[19] OAR 436-001-0246(8).
[20] ORS 656.704(2); OAR 436-001-0246.
[21] ORS 183.482(1).
[22] Oregon Rule of Appellate Procedure (ORAP) 9.05.

Attorney representation and attorney fees in an enrollment dispute.

A worker can be represented by an attorney at any stage of a workers' compensation claim. The attorney, however, may only be paid fees as provided in the statute. The statute specifies the circumstances in which fees may be paid and sets caps on those fees.[23] Generally the worker must prevail on the specific issue for an attorney fee to be awarded for work on that issue.

The statute does specifically prohibit attorney fees for representation of a worker before a managed care organization.[24] If a dispute regarding managed care proceeds to review before MRT or the director, an attorney fee is only available if the worker prevails in a "dispute over compensation benefits," [25] which includes medical services.

[23] A cap of $1500 was specifically mentioned in the public testimony at the Jan. 8, 2021 meeting. That cap applies to reasonable expenses and costs for records, expert opinions, and witness fees, which may be awarded if the worker finally prevails against a claim denial. ORS 656.386(2).
[24] ORS 656.388(1).
[25] ORS 656.385(1).

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Managed Care Organizations in Oregon Workers' Compensation
Background

What is an MCO?

A managed care organization (MCO) contracts with insurers or self-insured employers to provide managed health care services to workers enrolled in the MCO. MCOs focus specifically on treating injured workers. These health care services are provided through participating panel providers.

The director of the Department of Consumer and Business Services must certify MCOs. The director cannot certify an organization that is formed, owned, or operated by an insurer or employer. MCOs were created during the 1990s Mahonia Hall workers' compensation reforms. The director has certified many MCOs since then. However, today only four remain: CareMark Comp/Managed Healthcare Northwest (MHN); Kaiser On-the-Job; Majoris Health Systems Oregon, Inc.; and Providence MCO.

Why were MCOs created?

The 1990 legislative reforms created MCOs. The reasons cited for creating managed care, as outlined in the MLAC Mahonia Hall report, were:

- For workers: [to provide] "managed medical care system to deliver high quality and consistent standard of medical service to all workers."
- For employers, "managed medical care system controls costs while delivering high quality and consistent standard of medical care, with unnecessary care eliminated."

How do MCOs work?

Workers may be enrolled in an MCO if they have filed a workers' compensation claim and the worker's employer is covered by an insurer that has a contract with an MCO. If enrolled, a worker must treat with an MCO panel provider, although there are some exceptions. MCOs may only provide services in those geographic service areas that are authorized by the director. MCOs have the authority to designate any medical service provider or category of providers as attending physicians.

MCOs recruit medical providers for their panels and perform peer review of panel members. The MCOs require precertification of many services to ensure quality of medical services. They also provide dispute resolution services for workers, providers, and insurers.

What are MCO enrollment requirements?

Insurers and self-insured employers determine whether and when to enroll workers into a contracted MCO. Many insurers enroll workers at the time of claim acceptance. Others automatically enroll workers upon notice or knowledge of the claim. Overall, just under half of workers with accepted disabling claims are enrolled in an MCO.

The insurer or the self-insured employer must send a written enrollment notice to the worker, as well as provide copies to the worker's attorney (if represented); all the worker's medical service providers; and to the MCO. Enrollment notices generally direct workers to the MCO website, where they can find a list of available MCO panel providers. MCOs must help workers who have questions about the process; difficulty getting a new attending physician; or treatment disputes.

Enrollment figures for recent years are on the last page of this overview.

Who may provide treatment to enrolled workers?
Medical providers contract with MCOs to be members of their provider panel. Each MCO sets criteria for who may be a panel provider. Enrolled workers are required to treat with an MCO panel provider. However, if the worker has been treating with a provider they may be able to continue treatment with the non-MCO provider if certain criteria are met.

What medical services are allowed?
MCOs may require precertification, or pre-approval, for certain medical services. This may include elective surgeries, physical medicine services, and diagnostic services. Specific requirements for precertification vary among the four certified MCOs.

How are disputes resolved?
If the MCO does not grant approval of a medical service, the worker or provider may request review, usually through the MCO's internal dispute resolution process. If there is still disagreement, the decision can be appealed to the Workers' Compensation Division. An insurer also has the right to request review of an MCO decision approving a precertification request.

Workers' Compensation Division - disputes related to Managed Care Organizations

	2018 Total	Affirmed*	% affirmed	2019 Total	Affirmed*	% affirmed
CareMark Comp / MHN	70	32	46%	71	35	49%
Providence	7	3	43%	12	7	58%
Majoris	62	19	31%	35	12	34%
Kaiser OTJ	1	0	0%	1	0	0%
TOTAL	**140**	**54**	39%	**119**	**54**	45%

*affirmed means the decision was upheld

Number of Accepted Disabling Claims Enrolled in Managed Care

Claims Data by Insurer and MCO as of 1/20/21

2020	Accepted Disabling Claims	Total MCO Enrolled Claims	CareMark Comp/MHN	Providence	Majoris	Kaiser OTJ
SAIF	11,256	7,086	878	0	5,471	737
Private Insurers	5,223	402	3	290	109	0
Self-Insured Employers	3,611	1,409	217	532	336	324
NCE	34	0	0	0	0	0
Total	20,124	8,897	1,098	822	5,916	1,061
		44.21%				

2019	Accepted Disabling Claims	Total MCO Enrolled Claims	CareMark Comp/MHN	Providence	Majoris	Kaiser OTJ
SAIF	11,732	7,226	1,286	0	5,212	728
Private Insurers	6,399	647	0	451	195	1
Self-Insured Employers	4,133	1,878	239	763	410	466
NCE	44	0	0	0	0	0
Total	22,308	9,751	1,525	1,214	5,817	1,195
		43.71%				

2018	Accepted Disabling Claims	Total MCO Enrolled Claims	CareMark Comp/MHN	Providence	Majoris	Kaiser OTJ
SAIF	11,378	7,073	1,583	0	4,730	760
Private Insurers	5,531	617	4	423	190	0
Self-Insured Employers	3,944	1,750	225	789	282	454
NCE	47	0	0	0	0	0
Total	20,900	9,440	1,812	1,212	5,202	1,214
		45.17%				