February 25, 2021

To: Management-Labor Advisory Committee

From: Sally Coen, Administrator

Subject: Follow-up information regarding Managed Care Organizations (MCOs)

At your February 5 meeting, you asked for more information about:

- The enrollment process and criteria for enrolling workers in MCOs
- Attorney fees related to MCO disputes

Enrollment process

Insurers and self-insured employers ("insurers") determine when and in which MCO to enroll a worker. When an insurer contracts with one or more MCOs, the insurer may enroll a worker as soon as the insurer is notified of a potential injury or anytime thereafter. The exact timing of worker enrollment may be addressed in the contract between the insurer and the MCO.

The MCO is required under OAR 436-015-0040 to provide the director a copy of each MCO-insurer contract within 30 days of execution, as well as any amendments or cancellation of the contracts within 30 days of execution. Although the statute requires the director approve an MCO's overall plan, individual MCO-insurer contracts are not specifically subject to director approval. Once the contract is reported to the director, it is reviewed to ensure it is consistent with the statute and administrative rules. If there is a conflict, the MCO is notified and it is up to the MCO and insurer to adjust the contract accordingly.

A worker is subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the MCO or on the third day after the notice was sent by regular mail by the insurer (whichever occurs first). In order to provide continuity of care, workers are allowed to continue to treat with their current medical service providers for at least 14 days after the mailing date of the notice of enrollment.

When an insurer enrolls a worker in an MCO, the insurer must provide the worker's name and other relevant information to the MCO, and simultaneously provide written notice of enrollment to the worker, the worker's representative, the worker's medical providers, and the MCO. To be considered complete, the notice must:

- Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area and provide a Web address or contact information to access the list of eligible attending physicians.

- Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers.
- Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes information about changing attending physicians or how to continue treating with their current attending physician ("come-along" provider).
- Advise the worker of the right to choose the MCO if more than one MCO contract covers the worker's employer.
- Notify the worker of the right to appeal MCO decisions and the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must pay for certain medical services even if the claim is denied. The insurer must pay necessary and reasonable medical services that are not otherwise covered by health insurance until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

If a worker who is not yet medically stationary must change medical providers because of MCO enrollment, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental. If the MCO determines that the change in provider would be medically detrimental to the worker, the worker is not subject to the contract until the worker is found to be medically stationary, the worker changes physicians or nurse practitioners, or the MCO determines that the change in provider is no longer medically detrimental (whichever event first occurs). A worker is also not subject to a contract if the worker's primary residence is more than 100 miles outside the MCO's geographical service area.

Attorney fees
Co-Chair Winther asked about attorney fees in MCO disputes, specifically this paragraph on page 5 of the January 29, 2021, memorandum regarding MCO enrollment disputes:

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

We wanted to clarify that paragraph covers two separate topics, and the prohibition on fees before an MCO is unrelated to the fees that are available in a managed care dispute before MRT or the director.

The prohibition against attorney fees for representation of a worker before an MCO is in ORS 656.388(1):

> "No claim or payment for legal services by an attorney representing the worker or for any other services rendered before an Administrative Law Judge or the Workers' Compensation Board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the Administrative Law Judge or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the Administrative Law Judge, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307 (5), 656.308 (2), 656.382 or 656.386. *No attorney fees shall be approved or allowed for representation of the claimant before the managed care organization*."

(Emphasis added.) The last sentence of ORS 656.388(1) was added in 1995 by Senate Bill 369 (Oregon Laws 1995, chapter 332, section 44).[1]

The criteria for fees to be awarded by MRT or the director in a managed care dispute are in ORS 656.385(1), which reads in full:

> "In all cases *involving a dispute over compensation benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340*, where a claimant finally prevails after a proceeding has commenced, the Director of the Department of Consumer and Business Services, the Administrative Law Judge or the court shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, an Administrative Law Judge or the court, the director, Administrative Law Judge or court shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department or court. The attorney fee assessed under this section must be proportionate to the benefit to the injured worker. The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this subsection shall be

[1] The entire sentence that was added stated: "No attorney fees shall be approved or allowed for representation of the claimant before the managed care organization or director except for representation at the contested case hearing." The last portion of the sentence was removed in 2015 (Oregon Laws 2015, chapter 521, section 8; HB 2764).

> adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any."

(Emphasis added.) The attorney fee under ORS 656.385 was originally adopted in 1995 by Senate Bill 369 (Oregon Laws 1995, chapter 332, section 42d), though it has been adjusted several times since then.

The proponents of SB 369 testified that the intent of adopting ORS 656.385 was not to create new rights to attorney fees. SB 369 created new hearings procedures before the department for disputes that were previously heard by the Hearings Division. The intent of the attorney fee provision was to allow the same fees that were awardable by the Hearings Division to be awardable by the department.[2]

---

[2] January 30, 1995, joint meeting of the Senate Labor and Government Operations committee and the House Labor committee.