WORKERS' COMPENSATION
MANAGEMENT-LABOR ADVISORY COMMITTEE
Access To Care Subcommittee Committee Meeting
August 22, 2025
9:00 a.m.– 11:00 a.m.

Committee members present via zoom:
Emily Cronan, Oregon Nurses Association
Kim Schlessinger, Samaritan Health Services

Staff:
Teri Watson, MLAC Committee Administrator
Baaba Ampah, MLAC Assistant

Agenda Item	Discussion
Opening	
(00:00:07)	Co-chair Emily Cronan called the meeting to order.
	Provider Feedback **Ron Bowman, MD Northwest Extremity Specialist**
(00:01:20)	Dr. Ron Bowman introduced himself, explaining that he has been practicing orthopedic surgery since 1991, and has focused heavily on workers' compensation since 2003.
(00:02:20)	Barriers to Care: - Workers' are often hesitant to file a claim because of stigma from peers and employers. - Claim adjusters fail to respond or are frequently switched slowing the claim progress. - Legal involvement, although necessary, slows claims process. - Heavy administrative paperwork burden discourages some providers from joining workers' compensation, as it raises overhead cost. - Insurer and MCO (Management Care Organization) processes add complexity. - The ODG (Occupational Disability Guidelines) is insurance-industry biased, and limits treatments like physical therapy or surgeries. This further deters surgeons.
(00:07:11)	Co-chair Emily Cronan asked what specifically in administrative documentation in workers' compensation is more burdensome compared to other payers. Dr. Bowman explained that workers' compensation requires more correspondence, adding 20% higher administrative cost for workers 'compensation compared to commercial insurance.

Barriers to Care continued:

(00:10:14)

- Many urgent and first line providers are not knowledgeable about workers' compensation leading to coding errors and significant delays.
- Early diagnostics are often delayed, though timely MRIs are critical for certain injuries
- MCO panels can be restrictive when trying to refer patients to specialized providers, and can be overrun by TCP (temporary credential provider).
- Difficulty identifying attending physician and accepted conditions causes confusion for both patients and doctors.
- Small town providers may avoid workers' compensation cases because of patient proximity, which can hurt their practice

(00:16:53) Collaboration with other physicians: meets with other providers through Medical Advisory Committee (MAC) meetings 2-4 times per year, and regularly interacts with occupational medicine physicians at Northwest Occupational Medical Center at Providence.

(00:17:45) Staff: has great staff support, including an assistant with prior adjuster experience who helps navigate claim requirements. Also is in contact with WCD policy analyst, Juerg Kunz, who is a reliable resource.

(00:19:00) Dr. Bowman suggested incentivizing orthopedics group to take on some aspects of workers' compensation claims. When patients need surgical treatment for a workers' compensation claim, surgeons should not be required to be the attending physician, and suggested occupational physicians would provide better as the attending physician.

(00:20:23) Kirsten Adams, AGC, asked how to incentivize other doctors, particularly surgeons, to be more interested in workers' compensation. Dr. Bowman noted that the payment is not bad, and suggested that reimbursement should not be reduced to commercial insurance levels. He also suggested streamlining the process and removing speed bumps, especially around surgery approval, so that handling workers' compensation cases is less burdensome.

(00:22:24) To Keith Semple's , OTLA, questions, Dr. Bowman answered:

- MCO generally adds another level to authorizations, which makes the process less streamlined, though they bring in medical expertise that adjusters lack.
- Conflicts arise when MCO deny care but insures approve it late, causing delays.
- He did not think MCOs increase providers willingness to participate, but rather help check abuse by outlier physicians.
- Confirmed that ODG guidelines are used to deny treatment, driving the treatment plan away from physicians.

(00:26:43) Thais Lomax, Sedgwick, clarified that MCOs only address if treatment is medically reasonable and necessary, while insurers decide if it is compensable related to the injury. She later asked what can be done for the system to be streamlined. Dr. Bowman although unsure, suggested creating a subcommittee of experienced providers to help adjusters review complex medical necessity cases.

(00:30:35) Jovanna Patrick, OTLA, asked if a standardized portal with set approval timelines could help improve access. Dr. Bowman response that a streamlined process could help, but caution is needed to prevent approval of pre-existing conditions. He suggested fast-tracked obvious cases, but mitigating factors should be different. Dr. Bowman continued to answer additional questions from Jovana Patrick about post-surgical physical therapy, urging eliminating monthly re-requesting ongoing physical therapy as it leads to delays and can be harmful to patients.

(00:35:58) To Jovanna Patrick's question, Dr. Bowman agreed that constant back and forth between claims adjusters and providers can deter providers from joining the system. He mentioned that it can lead to unnecessary delays as it is difficult for uninitiated providers to figure out where to look.

(00:37:09) Dr. Bowman agreed to Co-chair Cronan's question that insurers' required authorizations of post-surgical physical therapy are slowing recovery despite common best-practices timelines. He continued to agree that physical therapy clinics already send progress notes, so constant reapprovals feel arbitrary. He explained that if approval lapses, clinics pause treatment because they would not be paid without authorization. It was also noted that gaps in physical therapy reduces progress hindering recovery and time loss payment.

(00:40:37) Dr. Bowman agreed that four-week physical therapy approval is usually MCO related, but recently there has not been any issues.

(00:41:09) Thais Lomax, Sedgwick, explained that workers who are not enrolled in an MCO do not need insurer approval. Insurers pays for physical therapy and similar treatment as directed by the attending physician. She continued that authorization issues mainly occurs inside MCOs, where the MCO reviews treatment under its contract and treatment modalities.

(00:42:39) Thais Lomax clarified Co-chair Cronan's question that technically treatment plans and time loss must be authorized by the attending physician. In practice, claims adjusters follow the surgeon's plan and might go to the attending physician for technical clarifications. Dr. Bowman added that in his practice, post-operation, he typically directs treatment and short-term work releases, and the attending physician "rubber stamps" his plan.

(00:46:31) Dr. Bowman suggested a posted status of the attending physician and the accepted condition for streamlining, noting patients typically do not know the accepted condition. Although it appears on standard referral forms, it might not be accurate and complicates request and planning.

(00:48:06) Keith Semple stated that insurers can approve and pay for a service without accepting the condition that is found during the service. If additional conditions are revealed after the surgery, the worker has to request adding specific conditions to the claim. Then the insurer has 60 days to accept or deny the condition. Keith noted that he advises workers to submit the treatment request first; if it's denied, then address accepted-condition scope rather than prompting pre-surgery denials. He also clarified that the attending physician is a question of fact based on who is primarily responsible of the worker's care, which can shift during surgical times. Because of status changes, a database of the attending provider would be hard to maintain. Dr. Bowman commented that pre-operation diagnoses are tentative based on MRI, which can be fallible. It's helpful to delay finalizing accepted conditions until after surgery because surgery trumps anything.

(00:52:48) Keith Semple noted that the worker has to ultimately prove any claimed condition actually exists, MRI findings can be misleading. Nobody knows after the surgery if the scope of the claim have been redefined. It is frustrating after a claim is closed after surgery because the obligation is placed on the worker to ask for conditions to be added. Insurers are supposed to update the notice of acceptance as new information arises, but they do not always ask the surgeon or order an IMR (Independent Medical Review), leading to surprises when procedures are later denied.

(00:56:05) Dr. Bowman ended his feedback presentation. Co-chairs showed their appreciation.

SAIF Update, Ivo Trummer

(00:56:50) Ivo Trummer, SAIF, updated that no language has been drafted yet, but SAIF is planning to reintroduce a version of the -2 amendment of HB 3374 in the 2026 session. The base bill would have allowed SAIF to partner with or own an MCO, allow the City of Portland (fire and police) to use such MCO, and grant full attending provider privileges to nurse practitioners(NPs) and physician assistants (PAs). Ivo Trummer continued that the changes of the new bill will include strengthening the accountability measures to ensure separation between a SAIF insurer and a potential SAIF MCO, streamline MCO process for workers' insures, statutorily explicit mention non-exclusivity where SAIF-affiliated MCO must be open to all insurers, and SAIF would contract with multiple MCOs not just its own. He continued that he is seeking feedback on statutory provisions for an MCO to conduct provider outreach and education and billing assistance. Ivo Trummer noted that the goal is to ensure resiliency Oregon's MCO model by addressing access to care issues.

(01:02:40) To Kim's Schlessinger's question, Ivo Trummer noted that the bill will give SAIF the ability to start addressing some of the issues to access to care. The goal of stakeholder's is to reduce the complexity in the system. Outdated rules that rely on mailing vs delivery could be updated, but that would requires a bigger push.

What we have heard……

(01:05:38) Co-chair Schlessinger suggested examining rules on whether and how employers can direct injured workers to care, noting there seems to be confusion. Also suggested educating and certifying clinic support staff to handle workers' compensation processes. She acknowledged that some issues are broader healthcare access challenges. Co-chair Cronan agreed, mentioning to review OAR and ORS language to improve "low-hanging fruit" processes to get information to injured workers and streamline routine requests and referrals. She suggested following clinical best practices such as allowing physical therapy orders as a routine and not a fixed calendar date to avoid lapses, reduce repeated short authorization, and improving accountability and response timeliness from claim handlers.

(01:10:36) Keith Semple mentioned that a common thread was heavy administrative burden (about 20% higher in workers' compensation) and slow insurer responses, which hurts workers, providers and employers. He proposed a standardized portal with timestamps and response deadlines; if the insurer misses the deadline, the service is automatically paid for. This would educate providers on a single streamlined process.

(01:14:05) Lon Holston mentioned that there has been past discussions regarding employer-directed care, with testimony and data that the department has. He mentioned that the referral lists varies by employers to injuries to different settings. He recommended reviewing the prior work before considering new directed-care proposals.

(01:15:58) Co-chair Schlessinger noted that there is an aging workforce with more pre-existing conditions that could be adding to the complexity of workers' compensation care. Co-chair Cronan agreed, mentioning that such problem will not have a clear solution.

(01:18:24) Chris Frost, OTLA, showed appreciation to Lon Holsten's comment, mentioning that in 2011 there was a lot of work done. She mentioned that some employers violated restrictions for directing care, and it is not helpful to workers. Employer-directed care was been proving to be fraught. Co-chair Cronan appreciated the comment, but noted that the intent is to clarify statue language to provide additional resources to worker so that they are making educated choices. Co-chair Schlessinger agreed.

	Public Comment - Stakeholder Feedback*
	Steve Bennett, APCI
(01:21:25)	Steve Bennett showed appreciation to the subcommittee and expressed that all stakeholders, including insurers, have the interest to help injured workers get the appropriate care. He opposed allowing SAIF to operate as an MCO, arguing SAIF already has many competitive advantages in the insurer industry and such change would give them an unfair advantage in the market. He mentioned that he supports reforms that would not further advantage SAIF over private insurers.
(01:26:34)	Teri Watson noted that the next meeting is September 12 at 9:00 a.m. The Co-chairs showed their appreciation to the participants of the subcommittee and its mission.
(01:28:30)	Co-chair Cronan adjourned the meeting at 10:28 a.m.

*These minutes include time stamps from the meeting video found here: https://www.youtube.com/watch?v=cPy_r379eH8
**Referenced documents can be found on the MLAC Meeting Information page here: https://www.oregon.gov/DCBS/mlac/Pages/access-to-care-subcommittee.aspx