OREGON TRIAL LAWYERS ASSOCIATION
In the Service of Justice

812 SW Washington St.
Suite 900
Portland, OR 97205

tel. 503-223-5587
fax 503-223-4101
www.oregontriallawyers.org

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MLAC Access to Care Subcommittee

Dear Co-Chairs,

Thank you for the work you have done to address the critical issue of provider participation in the Oregon Workers' Compensation system, and thank you to the other stakeholders for engaging in this discussion.

OTLA's position on this topic has always been that we need to start by asking the providers where the problems are and what could be done to address them.

After hearing from providers, we understand that one of their biggest issues is the additional overhead required to hire staff that can perform the additional administrative tasks associated with Workers' Compensation claims. Dr. Bowman estimated that Workers' Compensation insurance adds about 20% to the administrative burden compared to other insurance. Some of the reasons cited for the additional administrative burden (and delays in treatment) were:

Inability to obtain timely responses to preauthorization requests or requests for claim information from the claim processor (this could be with or without an MCO),

Additional process (and delay) to obtain insurer approval after MCO approval,

Having the MCO place its own limitations as to the number and date range for therapy sessions, which are sometimes preauthorized for dates that have passed,

Having the MCOs respond to the doctor with additional questions or proposals about treatment.

To address some of these barriers to participation, we would like to propose 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 with the WCD. A standard form for written requests and responses would minimize the number of calls medical providers have to make, and the number of calls claims processors need to return, regarding approval.

This process should be the same for MCO and non-MCO claims.

OTLA has previously proposed a more formal process for adjudicating medical disputes at the Medical Review Unit with procedures that mirror what is done in litigation at WCB. This would help to ensure that due process is available to both sides in a timely manner.

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Much of this could be accomplished through administrative rulemaking. There is already a standard form for Elective Surgery requests. A more general form could easily be created. Many insurers already have portals. We could explore expanding those to include provider preauthorization requests. This would eliminate the volume of calls/emails/faxes.

An ideal procedure would include a presumption that the request was received with proof of fax or email. The insurer or processor would be required to tell the provider whether they are contesting compensability, reasonableness, or both within a certain period of time. If the response period passes, the worker can appeal. We find that a formal appeal is usually the most effective way to spur resolution, or at least clarification, of the issues that require adjudication.

This should apply to ALL claims. All workers should have the same deadlines and the same procedure process for appeals. Currently, enrollment in an MCO strips the worker of the protections and deadlines that insurers are otherwise subject to by statute and rule. If the MCO denies a service, the worker must complete an initial appeal process through the MCO before they can start the standard appeal process through WCD. This is not fair to the worker or the employer, as it further delays resolution of disputes. It is a hassle for the doctor as well. By the time all of the appeals are completed, the dispute is often a moot point because the window for the service to be effective has passed.

There is no getting around that workers' compensation claims require procedures for contesting and adjudicating responsibility for payment of benefits, including medical services. But it is critical that adjudication of disputes take no longer than absolutely necessary. Streamlining the adjudication process should be a focus of long term discussion for the benefit of all involved.

Providers also raised reimbursement rates as a barrier to treating injured workers. OTLA would also propose finding ways to raise the reimbursement rates for providers. There are a number of ways that could be done, and OTLA would be happy to participate in ongoing discussions on that issue. Perhaps we could start at the Medical Advisory Committee and go from there. It would be nice if we could determine the tipping point for getting the larger health networks to participate as a data point for future discussion.

In recent meetings, there has been discussion of whether greater access can be achieved by allowing employers to provide workers with a list of doctors. We feel that this infringes on one of the core principles in the workers' compensation system: that workers choose their own doctors and employers cannot direct medical services. While it may sound helpful, in practice we see it having negative consequences. So many of our workers already come to us and tell us that they went to "the employer's doctor" or where the employer said they had to go. Workers already have confusion over whether the employer can tell them where they are to seek medical services. Allowing employers to provide a list would increase this overstepping and likely make it harder for the WCD to enforce potential violations of employer directing care.

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Nurse Practitioners and Physicians Assistants comprise a large group of medical providers who could treat injured workers. However, under current law, they can only be the attending physician for 180 days, and they cannot perform their own closing examinations. This requires workers to change providers in the middle or at the end of their claims, when it can be difficult to find a Type A provider willing to step in, especially at closure when all the treatment has been completed. This delays closure and creates administrative burdens for insurers and providers.

OTLA supports the concept of expanding full Type A privileges to NP/PA providers, if it is coupled with protections for workers who are contesting compensability denials. If the insurer denies the entire claim or a new/omitted condition, both parties must obtain medical evidence to present at hearing. The insurer will likely send the worker to a specialist for an IME, even for simple strains. In practice, NP/PA providers are often unwilling or unable to rebut the opinions of a surgeon or another specialist. That leaves workers without the ability to obtain the evidence they need to support their claim, because one of the criteria for evaluating medical evidence is the expertise of the provider.

Currently the worker can only obtain a WRME (Worker Requested Medical Exam) with a provider of equivalent credentials if the insurer bases a compensability denial on an IME and the attending physician does not concur or does not respond for 30 days. If we were to expand Type A privileges to NP/PA providers, we would want workers to be eligible for a WRME any time the insurer relies on an IME for a compensability issue. This would relieve NPs and PAs from having to rebut the opinions of a specialist, and would put workers on an even playing field for purposes of contesting compensability denials.

Expanding access in this way would provide greater access to medical providers, and an easier way for insurer to close claims. It would increase employers' ability to get workers back to work faster without delays in medical treatment due to searching for a Type A provider, and it would do so without hampering the workers' access to justice.

We hope the work of this subcommittee can provide a catalyst for further engagement with the medical community and policy discussion at MLAC. This problem has been a long time in the making, and will not be addressed in a meaningful way without sustained efforts, so we hope this can continue to be a priority.

Thank you for considering our comments and for your commitment to improving the system.

Keith Semple

Co-Chair
OTLA WC Section

Jovanna Patrick

Co-Chair
OTLA WC Section