Top MRT Disputes

Nicholas Ring

Medical Resolution Team

Department of Consumer
and Business Services

Jurisdiction

Statutes

Common disputes

Jurisdiction for medical disputes

Workers' Compensation Board (WCB)

Medical Resolution Team (MRT)

Medical dispute jurisdiction

Workers' Compensation Board (WCB)

ORS 656.704(3)(b)(A) and (C)

WCB addresses matters concerning a claim or compensability of a claim or medical service.

MRT involvement is delayed until the issue of causation/compensability is resolved by WCB.

Medical dispute jurisdiction

Medical Resolution Team (MRT)

ORS 656.704(3)(b)(B)

Medical service disputes that are matters not concerning a claim are reviewed by MRT.

Appropriateness

Violations of medical service rules

Entitlement to medical services for medically stationary workers

Statutes and associated dispute types

Statute	Dispute type
• ORS 656.245	Medical service rules and entitlement
• ORS 656.247	Interim medical services
• ORS 656.248	Medical fee disputes
• ORS 656.260	MCO disputes
• ORS 656.325	Worker-requested medical examination
• ORS 656.327	Appropriateness disputes

Common dispute issues

- Recent trends
- Lack of communication
- Treatment and medical services
- Documentation for managed care organizations
- Pharmacy benefit managers
- Post-medically stationary
- Attorney fees

Common dispute issues

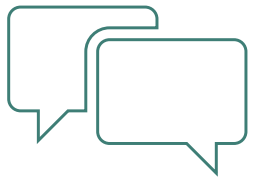
Recent trends

- Arbiter panel examinations including more than one physician
- Surgical implants being bundled with the surgery fee

  OAR 436-009-0023(3)(c) states that implants costing more than $100 must be paid at 110 percent of actual cost. If there are multiple implants such as surgical screws, the implants must be calculated in aggregate.
- Insurers or third-party administrators (TPAs) are automatically enrolling providers into “virtual” payment systems
- Interpreter services are being incorrectly paid or denied due to billing style

Common dispute issues

Lack of communication

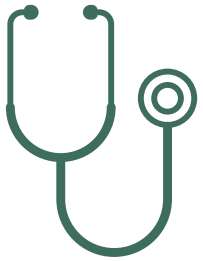


- Insurer or TPA doesn't respond to treatment or reimbursement requests
- Medical services do not have to be authorized, <u>however</u> …

  Some providers prefer to have written or verbal authorization before rendering care
- Insurer or TPA doesn't communicate when there are denials or reasons for denials

Common dispute issues

Treatment disputes – ORS 656.327



- Appropriateness of proposed medical treatments
- Overutilization of ancillary treatments
- Inappropriate surgery or pain management services
- Overuse of opioids
- Imaging requests

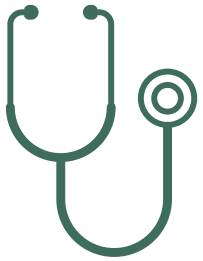
Important factors:

Submission of a complete medical record

Sufficient and well-reasoned arguments

Common dispute issues

Treatment disputes – appropriateness



- **OAR 436-010-0230(1)**

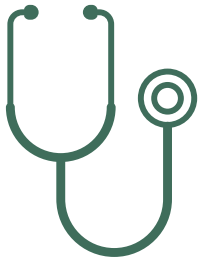
  Medical services … "must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable."

- **"Accepted professional standards"**

  Has been interpreted to include various standards by either professional associations and simply by the individual rendering physician.

Common dispute issues

Treatment disputes – medical guidelines

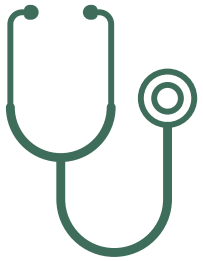


- WCD has not adopted any external guidelines such as the Official Disability Guidelines (ODG).
- Managed care organizations (MCOs) commonly cite their own proprietary internal guidelines or the ODG, <u>however</u> …

MRT is not held to these guidelines and will often include outside information that can easily override those cited by the MCO.

Common dispute issues

Treatment disputes – other factors



- ORS 656.012(2)(c) “To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.”
- Considers the worker’s ability to perform self-care, recreation, work duties, etc.

Common dispute issues

Medical service rule violations

Medical documentation

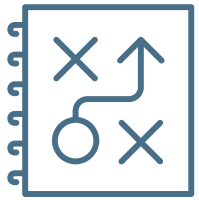
- Clear and concise treatment notes
- Timely submission

Treatment plans

- Must be submitted within seven days of beginning services, such as PT or chiropractic
- Objective clinical findings, treatment duration, diagnoses, treatment modalities, and frequency

Common dispute issues

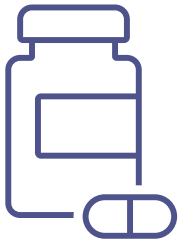
Documentation for MCOs



- MCOs have their own processes, unique to each company
  - Be aware of the MCO requirements and processes.
  - Review the MCO provider manual.
  - Provide clear and concise information.
  - Submit chart notes that support the need for medical services.

Common dispute issues

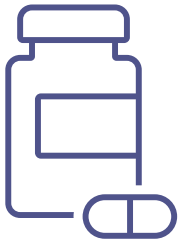
Pharmacy benefit managers (PBM)



- Ideally, PBMs streamline the process and eliminate delays and worker out-of-pocket expenses; however, it doesn't always work out that way.
- Disputes involving PBMs can be complex
  - Four or more entities may be involved: worker, pharmacy, PBM, insurance adjuster
  - Can be difficult to find where the error occurred
- Point-of-sale denials may happen and can result in:
  - Worker unable to pay and unable to obtain medications
  - The need for worker reimbursement

Common dispute issues

Pharmacy benefit managers (PBM)

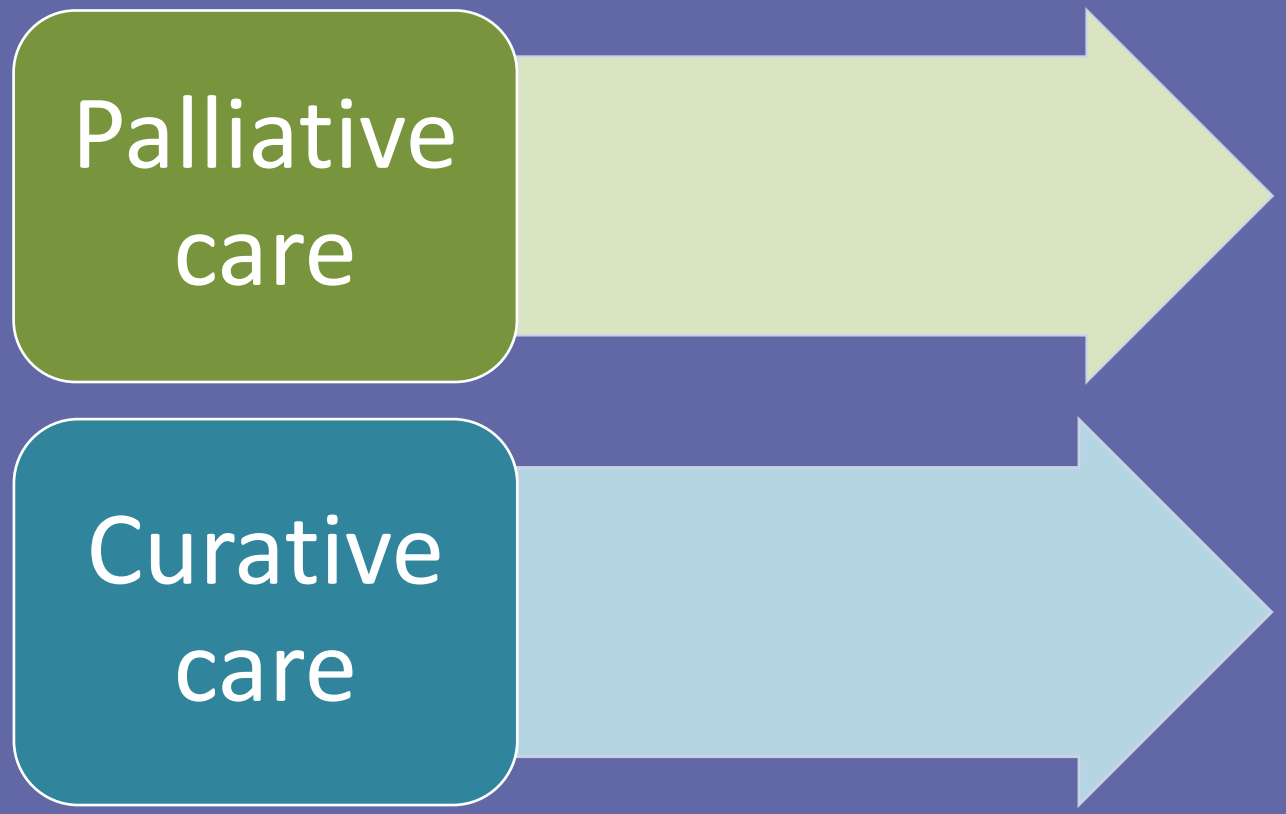


- The responsibility can be placed on the insurer to remove any hindrance of care to the worker.
- Disputes regarding PBMs are handled on a case-by-case basis.

ORS 656.245(1)(a)
" … 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 …"

Common dispute issues

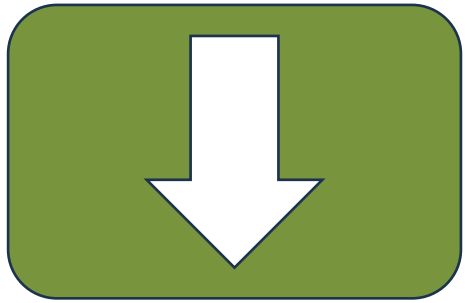
ORS 656.245(1)(c) Post-medically stationary



Common dispute issues

Palliative care considerations

Participation in employment or vocational program



Reduce or temporarily moderate the intensity of an otherwise, stable medical condition

Does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition.

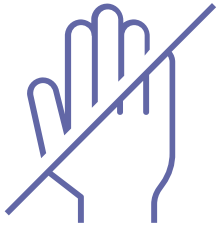
Common dispute issues

Palliative care considerations

- Palliative care requests must include
  - Objective findings
  - Appropriate diagnosis code(s)
  - A complete treatment plan
  - Explain how the requested care is related to the compensable condition
  - Describe how the medical care will allow the worker to continue current employment or a current vocational training program
  - Include possible adverse effects if the care is not provided
- Dispute examples

Common dispute issues

Curative care – ORS 656.245(1)(c)



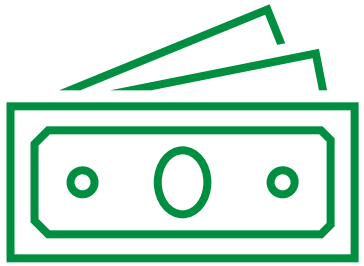
"… to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition."

The statute, by its own terms, addresses *symptoms,* not conditions.

Common dispute issues

Attorney fees – ORS 656.385(1)

- Claimant attorneys only get paid when the insurer is found liable, or in settlements.
- Attorneys do not get paid in medical payment disputes that fall under ORS 656.248, even if the claimant prevails.
- Examples.



Questions?

Contact SMRT
Phone: 503-947-7606
Fax: 503-947-7629
Email: Nicholas.G.Ring@dcbs.Oregon.gov

How To Avoid Common Civil Penalties

Lin Allen, sanctions representative

Sanctions and Medical Resolution Team

Statute for authority to assess

ORS 656.745(2)(a)(B) provides the director may assess a civil penalty against an employer, self-insured employer, insurer, managed care organization or service company that fails to comply with statutes, rules, or orders of the director regarding reports or other requirements necessary to carry out the purposes of this chapter.

ORS 656.745(2)(b) provides, in part, the director may not assess under this subsection a civil penalty against a self-insured employer, insurer, or service company that exceeds $4,000 for each violation or $180,000 in the aggregate for violations during a calendar year.

Civil penalties and amounts assessed are always at the discretion of the director.

Most common civil penalty assessed

Failure to appropriately respond to an order of the director (demand letter)

Response is either:

a) Untimely
b) Inadequate
c) Not submitted; or
d) Duplicate (Appellate Review Unit reconsiderations)

How to identify a demand letter

Demand letters will contain:

a) A specific time frame to respond.

b) Warning language about a potential civil penalty.

c) Identify the specific documentation that is to be submitted.

The most common civil penalty assessment is for failure to appropriately respond to an order of the director (demand letter).

Name three out of four of the **types of responses that can result in penalties**.

1. Untimely
2. Inadequate
3. Not submitted
4. Duplicate

Common demand letter

Appellate Review Unit – acknowledgement letter

Notice/demand letter is issued by an appellate reviewer.

+

A complete record, without duplication, must be submitted for the reconsideration proceeding.

+

The record is required to be submitted within 14 days from the date of the letter.

INSURER RESPONSE REQUIRED

RECONSIDERATION ACKNOWLEDGMENT LETTER

January 31, 2024

WORKER'S NAME WORKER'S ADDRESS	INSURER'S NAME INSURER'S ADDRESS
Worker: Worker's Attorney: Date of Injury: WCD File No:	Insurer: Claim No.: Insurer's Attorney:

Dispute of Notice of Closure dated: 11/30/2023 Request Received: 01/29/2024

The Workers' Compensation Division (WCD) has received a request for reconsideration of the Notice of Closure listed above. Any information the parties wish to have considered during this proceeding should be submitted to the division no later than February 14, 2024. Evidence received after this date may not be considered if the final review process has begun.[1]

The division will issue either an Order on Reconsideration or a Notice of Postponement on or before February 23, 2024. Reasons for postponing the reconsideration proceeding include a referral for a medical arbiter review or a request for additional information.

If the division fails to issue an Order on Reconsideration or a Notice of Postponement by February 23, 2024, the request for reconsideration is automatically denied and the closure is affirmed.[2]

NOTICE TO INSURER: You must provide a copy of all documents pertaining to the claim, which include, but are not limited to the complete medical record and all official actions and notices on the claim (in chronological order by date) to the division and the worker or the worker's attorney no later than February 14, 2024.[3] Attach a cover letter identifying the documents as the record for the reconsideration proceeding of the Notice of Closure dated 11/30/2023, including the insurer's name and contact person. If some or all of the record has previously been submitted to the division, send a letter stating this and provide only those documents not previously sent to the division. Failure to provide these documents timely may result in civil penalties.[4]

If you have any questions regarding this process, please contact this office (503) 947-7816 and ask to speak to an Appellate Review Specialist. Please reference WCD File No. ECD5043 on all correspondence to the division.

Penalty assessment

Appellate Review Unit – reconsideration proceeding

No response

And the order requires the previously requested response be submitted within seven days from the date of the order.

Inadequate response

And the order requires the previously requested response be submitted within seven days from the date of the order.

Untimely response

Duplicates

Best practices

Thoroughly read the notice to identify all documents requested.

Contact the appellate reviewer for any questions or clarification needed for an accurate and timely response to be provided.

How many days do you have to respond to a civil penalty order with missing or inadequate documentation?

How much is the penalty amount for no response or inadequate response?

Penalties and amounts assessed are always at the discretion of who?

Common demand letter

Medical Resolution Team – Notice of Required Action (NORA) letter

- A notice issued by a medical reviewer ordering specific documentation be provided (necessary for review) to resolve a medical dispute.
- Must complete the Specification of Disputed Medical Issues form (SPEC).
- A response is required within 14 days from the date of the notice.

INSURER RESPONSE REQUIRED
Notice of Required Action on a Medical Dispute

January 30, 2024

Sent Via Fax

Insurer Name and Address	

RE:	Injured Worker:		Insurer:	
	RT File No:		Insurer Claim No:	
	WCD File No:		Date of Injury:	

This letter is to notify you of a request for administrative review regarding a medical treatment dispute. The treatment in dispute is left shoulder subacromial decompression rotator cuff repair surgery requested by Hava Goodday, MD.

Notice to Parties: An incomplete response to the request for information will not be considered a response. Failure to submit a complete response in the prescribed format in OAR 436-010-0008(3) within 14 days of receipt of this letter may result in the issuance of penalties under ORS 656.254, 656.745, and OAR 436-010-0340.

The insurer must complete the enclosed Specification of Disputed Medical Issues and copy all parties. The insurer must provide all medical information according to OAR 436-010-008(3). The record must be certified complete and copied to all parties. The insurer must certify that there is no issue of causation or compensability of the underlying claim or condition. Please be aware that failure to submit the requested information to the Medical Resolution Team in the required format may result in the issuance of penalties.

The response must include all medical records to this dispute without error or omission including the following:

- Completed **Specification of Disputed Medical Issues** form. If you check "yes" that the service is not causally related to the accepted condition, you do not need to send a copy of the record at this time.
- All medical records without error or omission
- Notice of injury (801/827)
- MCO enrollment

Date: January 30, 2024

Workers' Compensation Board
Workers' Compensation Division

To: Insurer

Specification of Disputed Medical Issues

Worker's Name: CareBear	Party Requesting Review: Worker's Attorney
Date of Injury: November 7, 2022	Subject of Dispute: Right knee total knee arthroplasty requested by Hava Goodday MD
Insurer's Claim Number: 12341234	MRT File Number: 1234
WCD File Number: EEEEK0	WCB Number:

The jurisdictional roles of the Workers' Compensation Division (WCD) and the Workers' Compensation Board (WCB) are defined in ORS 656.704. Any dispute that requires a determination of:

1. The compensability of the medical condition for which medical services are proposed is a matter concerning a claim and is subject to review by WCB.

2. Whether medical services are excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services is not a matter concerning a claim and is subject to review by WCD.

3. Whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245(1)(c) is not a matter concerning a claim and is subject to review by WCD.

4. Whether a sufficient causal relationship exists between medical services and accepted claim to establish compensability is a matter concerning a claim and is subject to review by WCB.

When a dispute involves multiple issues, WCB must first decide the causal relation and compensability issues. Failure to specify an issue before WCD may preclude review at a later date.

Answer all questions listed below:

Yes	No	The disputed medical service is disapproved because:
☐	☐	The underlying condition has been formally denied.
☐	☐	The service is not causally related to the accepted condition.
☐	☐	The service is excessive, inappropriate, ineffectual.
☐	☐	The service is not a compensable medical service under ORS 656.245(1)(c).
☐	☐	The service is in violation of the medical service rules (specify rule) _____
☐	☐	The service is for a new/omitted condition which:
		☐ the worker has not asked for acceptance **or**
		☐ the worker has asked for acceptance and a decision is pending.

What is the name or acronym of the form that is required to be completed as part of the NORA?

Specification of Disputed Medical Issues (SPEC)

Penalty assessment

Medical Resolution Team – medical disputes

No response
And the order requires the previously requested response be submitted within seven days from the date of the order.

Inadequate response
And the order requires the previously requested response be submitted within seven days from the date of the order.

Untimely response

Best practices

Thoroughly read the notice to identify all documents requested.

Contact the medical reviewer for any questions or clarification needed for an accurate and timely response to be provided.

Delinquency penalties

Reporting required notices and forms

OAR 436-060-0011(10) Failure to report

The director may issue a civil penalty against any insurer that does not file required notices and forms within the time frames of these rules.

- Form 801 (First Report of Injury)
- Form 1502 (Insurer’s Report)
- Form 1503 (Notice of Closure summary)

Re: Insurer Delinquency Report for Companies Listed as attached on following page(s):

A WRITTEN RESPONSE IS REQUIRED WITHIN 30 DAYS OF THE DATE OF THIS LETTER

Enclosed is the quarterly Insurer Delinquency Report for your company. The report identifies missing claims data, forms, and related documents that have not yet been reported to the Workers' Compensation Division.

ORS 656.264 and OAR Chapter 436 require insurers and self-insured employers to report certain claims information to the division. Timely and accurate reporting is essential for ensuring the division has accurate and complete claims data to monitor industry performance, respond to inquiries, perform dispute resolution and assist with return-to-work.

The report identifies the information that needs to be submitted for items listed. You must submit the required documentation requested within 30 days of the date of this letter. Items remaining unresolved after 30 days will subject you to penalties under ORS 656.745(2)(a)(B).

Contact Garilee Brown, Quality Control Specialist at (971) 283-0221 for any questions regarding the individual items on the report. **Please send all written responses to:**

Workers' Compensation Division
Operations Section, **Attn: Garilee Brown**
PO Box 14480
Salem OR 97309-040
Fax: 503-947-7632

What are the three forms that need to be reported?

1. Form 801
2. Form 1502
3. Form 1503

Assessment of penalties

- $750 penalty with a $150 per additional missing document and order requiring all missing documents must be submitted within seven days from the date of the order.
- $4,000 is the maximum penalty.
- Penalties and assessed amounts are always at the discretion of the director.

Questions

Delinquency report questions?

Garilee Brown, lead quality control specialist

971-283-0221

Sanctions questions?

Tasha Fisher, lead reviewer, Sanctions and Medical Resolution Team

971-701-3842
or

Lin Allen, sanctions representative, Sanctions and Medical Resolution Team
971-245-0676