

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
 WORKERS' COMPENSATION DIVISION
 MEDICAL SERVICES

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[Bracketed 8 point text is deleted] ; **bold/underlined text is added**

EFFECTIVE NOVEMBER 1, 2002

OREGON ADMINISTRATIVE RULES
 CHAPTER 436, DIVISION 010

NOTE: Only adopted, amended, and repealed rules are included in this document:

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436-010-0005 Definitions

For the purpose of these rules, OAR 436-009, and OAR 436-015, unless the context otherwise requires:

(1) "Administrative Review" means any decision making process of the director requested by a party aggrieved with an action taken pursuant to these rules except the contested case process described in OAR 436-001.

(2) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

(a) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral surgeon licensed by the Oregon Board of Dentistry;

(b) A medical doctor, doctor of osteopathy, or oral surgeon practicing in and licensed under the laws of another state;

(c) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits, during that 30 day period, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon;

(d) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician of chiropractic practicing and licensed under the laws of another state; or

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(e) Any medical service provider authorized to be an attending physician in accordance with a managed care organization contract.

(3) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(4) "Contested Case" means a proceeding as defined in ORS 183.310(2) pursuant to OAR 436-001.

(5) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied.

(6) "Current Procedural Terminology" or "CPT" means the Current Procedural Terminology codes and terminology most recently published by the American Medical Association unless otherwise specified in these rules.

(7) "Customary Fee" means a fee that falls within the range of fees normally charged for a given service.

(8) "Days" means calendar days.

(9) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

(10) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(11) "Eligible" means an injured worker who has filed a claim and is employed by an employer who is located in an MCO's authorized geographical service area, covered by an insurer who has a contract with that MCO. "Eligible" also includes a worker with an accepted claim having a date of injury prior to contract when that worker's employer later becomes covered by an MCO contract.

(12) "Enrolled" means an eligible injured worker has received notification from the insurer that the worker is being required to treat under the auspices of the MCO. However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

(13) "First Chiropractic Visit" means a worker's first visit to a chiropractic physician on the initial claim.

(14) "Health Care Practitioner" has the same meaning as a "medical service provider."

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- (15) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.
- (16) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.
- (17) "Home Health Care" means medically necessary medical and medically related services provided in the injured worker's home environment. These services might include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.
- (18) "Hospital" means an institution licensed by the State of Oregon as a hospital.
- (19) "Initial Claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.
- (20) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.
- (21) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.
- (22) "Interim Medical Benefits" means those services provided pursuant to [section 14, chapter 865, Oregon Laws 2001] **ORS 656.247** on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer's notice of the claim.
- (23) "Mailed or Mailing Date," **for the purposes of determining timeliness pursuant to these rules,** means the date a document is postmarked or, **pursuant to ORS 84.043, the date** an electronic record is sent [pursuant to section 15 (1), chapter 535, Oregon Laws 2001, for the purposes of determining timeliness pursuant to these rules].
- (24) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.
- (25) "Medical Evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, x-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material utilized, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

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(26) "Medical Service" means any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(27) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(28) "Medical Provider" means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(29) "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(30) "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician pursuant to ORS 656.005 and subsections (2)(c) and (2)(d) of this rule.

(31) "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also outpatient services.

(32) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(33) "Physical Capacity Evaluation" or "PCE" means an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, and Functional Capacity Assessment shall be considered to have the same meaning as Physical Capacity Evaluation.

(34) "Physical Restorative Services" means those services prescribed by the attending physician to address permanent loss of physical function due to hemiplegia, a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the highest functional ability consistent with the worker's condition. Physical restorative services are not services to replace medical services usually prescribed during the course of recovery.

(35) "Report" means medical information transmitted in written form containing relevant subjective and/or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(36) "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting,

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kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

(37) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensable injury.

(38) "Usual Fee" means the fee charged the general public for a given service.

(39) "Work Capacity Evaluation" or "WCE" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening shall be considered to have the same meaning as Work Capacity Evaluation.

(40) "Work Hardening" means an individualized, medically prescribed and monitored, work oriented treatment process. The process involves the worker participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the worker to a specific job.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.000 et seq.; 656.005

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436-010-0008 Administrative Review and Contested Cases

(1) Administrative review before the director:

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(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.247, 656.260, and 656.327[, and section 14, chapter 865, Oregon Laws 2001].

(b) A party need not be represented to participate in the administrative review before the director except as provided in ORS chapter 183 and OAR chapter 436, division 001.

(c) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, a director's order shall be issued.

(2) Administrative review and contested case processes for change of attending physician issues are in OAR 436-010-0220; additional insurer medical examination (IMEs) matters are in OAR 436-010-0265; and fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

(3) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. After the compensability of the underlying claim is finally decided, any party may request director's review of appropriate medical issues within 30 days after the date the decision becomes final by operation of law.

(4) When there is a denial of the causal relationship between the medical service and the accepted condition or the underlying condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.

(5) All issues pertaining to disagreement about medical services within a Managed Care Organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the injured worker, are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter by the director.

(6) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision under the MCO's internal dispute resolution process. If a party has been denied access to an MCO internal dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process.

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(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438 chapter, division 005.

(c) Disputes regarding elective surgery shall be processed in accordance with OAR 436-010-0250.

(d) The director may, on the director's own motion, initiate a medical services review at any time.

(e) Medical provider bills for treatment or services which are subject to director's review shall not be deemed payable pending the outcome of the review.

(7) Parties shall submit requests for administrative review to the director in the form and format provided in Bulletin 293. The requesting party shall simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

- (a) Identify the worker's name, date of injury, insurer, and claim number;
- (b) Specify what issues are in dispute and specify with particularity the relief sought;
- (c) Provide the specific dates of the unpaid disputed treatment.

(8) In addition to medical evidence relating to the medical services dispute, all parties may submit other relevant information, including but not limited to, written factual information, sworn affidavits, and legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain addition evidence consistent with statute.

(9) When a request for administrative review is filed pursuant to ORS 656.247, 656.260, or 656.327[, or section 14, chapter 865, Oregon Laws 2001], the insurer shall provide a record packet, without cost, to the director and all other parties or their representatives as follows:

(a) Except for disputes regarding interim medical benefits, the packet shall include certification that there is no issue of compensability of the underlying claim or condition. If there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet shall include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical service in dispute, arranged in chronological order,

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with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages, and date of the document. The packet shall include the following notice in bold type:

As required by OAR 436-010-0008, we hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order which could affect reimbursement for the disputed medical service(s).

(c) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer shall provide the record within 14 days of the director's request in the form and format described in this rule.

(e) If the insurer fails to submit the record in the time and format specified in this rule, the director may penalize or sanction the insurer under OAR 436-010-0340.

(10) If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review shall be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

(b) When a panel of physicians is selected, at least one panel member shall be a practitioner of the healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

(c) When such an examination of the worker is required, the director shall notify the appropriate parties of the date, time, and location of the examination. The physician or panel shall not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted to the director for screening as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination may include, but is not limited to:

(A) a review of all medical records and diagnostic tests submitted,

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(B) an examination of the worker, and

(C) any necessary and reasonable medical tests.

(11) The director shall review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

(a) If the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order pursuant to ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical services dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(b) When a bona fide dispute exists, the director will issue an administrative order and provide notice of the record used in the review.

(A) The parties will have 30 days from the issuance of an order pursuant to ORS 656.245, 656.260, or 656.327, or 60 days from the issuance of an order pursuant to section 14, chapter 865, Oregon Laws 2001, to request a contested case hearing before the director.

(B) The director may on the director's own motion reconsider any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case order is issued.

(C) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this subsection and may respond to such evidence submitted by others.

(D) Any party requesting reconsideration or responding to a reconsideration request shall simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(12) If the director issues an order declaring an already rendered medical service inappropriate, or otherwise in violation of the statute or medical services rules, the worker is not obligated to pay for such medical service.

(13) Contested cases before the director: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

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(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested, and include a copy of the administrative order being appealed.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of action being appealed.

(c) The hearing shall be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(d) In the review of orders issued pursuant to ORS 656.327(2), ORS 656.260(14) and (16), and section 14, chapter 865, Oregon Laws 2001, no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(e) For claims not enrolled in an MCO, disputes about whether a medical service after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c) and whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review by the director. If appealed, review at contested case hearing is not subject to the "no new medical evidence or issues rule" in subsection (13)(d) of this rule. However, if the disputed medical service is determined compensable under ORS 656.245(1)(c) or 656.245(3) all disputes and assertions about whether the compensable medical services are excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services are subject to the substantial evidence rule at contested case hearing.

(14) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be filed with the division within 60 days after service of the order or notice of assessment.

(c) The Division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

(15) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1)

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through (14) of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within ninety (90) days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (13) of this rule.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704

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436-010-0220 Choosing and Changing Medical Providers

(1) A newly selected attending physician or a specialist physician who becomes primarily responsible for the worker's care, shall notify the insurer not later than five days after the date of change or first treatment, using Form 827. An attending physician:

(a) is primarily responsible for the worker's care,

(b) authorizes time loss,

(c) monitors ancillary care and specialized care, and

(d) is determined by the facts of the case and the actions of the physician, not whether a Form 827 is filed.

(2) The worker may have only one attending physician at a time. Simultaneous or concurrent treatment by other medical service providers shall be based upon a written request of the attending physician, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician to be reimbursable. Fees for treatment by more than one physician at the same time are payable only when treatment is sufficiently different that separate medical skills are needed for proper treatment.

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(3) The worker is allowed to change attending physicians by choice two times after the initial choice. Referral by the attending physician to another attending physician, initiated by the worker, shall count in this calculation. The limitations of the worker's right to choose physicians pursuant to this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes of physician by choice of the worker:

- (a) Emergency services by a physician;
- (b) Examinations at the request of the insurer;
- (c) Consultations or referrals for specialized treatment initiated by the attending physician;
- (d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change physicians to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician;

(f) Changes of attending physician required due to conditions beyond the worker's control. This could include, but not be limited to, when the physician terminates practice or leaves the area, when a physician is no longer willing to treat an injured worker, when the worker moves out of the area requiring more than a 50 mile commute to the physician, and when a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A ^[w]**W**orker ^[r]**R**equested ^[m]**M**edical ^[e]**E**xamination; or

(h) Whether a worker has an attending physician who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines.

(4) When a worker has made an initial choice of attending physician and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer shall inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician, the insurer shall pay for compensable services rendered prior to notice to the worker. If an attending physician begins treatment without being informed that the worker has been given the required notification, the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made and informs the worker of the right to seek approval of the director.

(5)(a) If a worker not enrolled in an MCO wishes to change attending physicians beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of attending physician or a Form 827 indicating the worker is choosing to change attending physicians, the insurer shall notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer shall advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332

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(Worker's Request to Change Attending Physicians) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change attending physicians beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the change of attending physician request, the insurer shall notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer shall provide the reasons and give notification that the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of Form 2332.

(6) Upon receipt of a worker's request for an additional change of attending physician, the director may notify the parties and request additional information. Upon receipt of a written request from the director for additional information, the parties shall have 14 days to respond in writing.

(7) After receipt and review, the director will issue an order advising whether the change is approved. The change of attending physician shall be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

(a) Whether there is medical justification for a change, including whether the attending physician can provide the type of treatment that is appropriate for the worker's condition.

(b) Whether the worker has moved to a new area and wants to establish an attending physician closer to the worker's residence.

(c) Whether such a change will cause unnecessary travel costs and/or lost time from work.

(8) Any party that disagrees with the director's order may request a contested case hearing before the director, pursuant to ORS 183.310(2) and OAR 436-001, as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested and must include a copy of the order appealed.

(b) The appeal must be made within 30 days of the mailing date of the order.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.252, 656.260

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436-010-0250 Elective Surgery

(1) "Elective Surgery" is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

(2) Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician, believes elective surgery is needed to treat a compensable injury or illness, the attending physician or the surgeon shall give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery[, an estimate of the post-surgical recovery period], and the approximate surgical date and place if known.

(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the recommending physician, the worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician. When requested, the consultation shall be completed within 28 days after notice to the attending physician.

(4)(a) Within seven days of the consultation, the insurer shall notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer shall endeavor to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, shall obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

(c) The recommending physician shall provide written notice to the insurer, the worker and the worker's representative when further attempts to resolve the matter would be futile by signing Form 440-3228.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in subsection(4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery was excessive, inappropriate, or ineffectual.

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(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.

(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-0340.

(8) Surgery which must be performed promptly, i.e., before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases the attending physician should endeavor to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)

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436-010-0265 Insurer Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by physicians of their choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. A claim for aggravation, Board's Own Motion, or reopening of a claim where the worker becomes enrolled or actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "insurer medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician. The examination may be conducted by one or more medical providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the medical providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer shall first notify and request authorization from the director. Insurers that fail to first notify and request authorization from the

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director, may be assessed a civil penalty. The process for requesting such authorization shall be as follows:

(a) The insurer shall submit a request for such authorization to the director in a form and format as prescribed by the director in Bulletin 252 including, but not limited to, the reasons for an additional IME, the conditions to be evaluated, dates, times, places, and purposes of previous examinations, copies of previous IME notification letters to the worker, and any other information requested by the director. A copy of the request shall be provided to the worker and the worker's attorney; and

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. Upon receipt of a written request for additional information from the director, the parties shall have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

(3) In determining whether to approve or deny the request for an additional IME, the director may give consideration, but is not limited, to the following:

(a) Whether an IME involving the same discipline(s) and/or review of the same condition has been completed within the past six months.

(b) Whether there has been a significant change in the worker's condition.

(c) Whether there is a new condition or compensable aspect introduced to the claim.

(d) Whether there is a conflict of medical opinion about a worker's treatment, impairment, stationary status, or other issue critical to claim processing/benefits.

(e) Whether the IME is requested to establish a preponderance for medically stationary status.

(f) Whether the IME is medically harmful to the worker.

(g) Whether the IME requested is for a condition for which the worker has sought treatment or the condition has been included in the compensable claim.

(4) Any party aggrieved by the director's order may request a hearing by the Hearings Division of the Workers' Compensation Board pursuant to ORS 656.283 and OAR chapter 438.

(5) For purposes of determining the number of insurer required examinations, any examinations scheduled but not completed are not counted as a statutory IME. The following examinations shall not be considered IMEs and do not require approval as outlined in section (2) of this rule:

(a) An examination conducted by or at the request or direction of the worker's attending physician;

(b) An examination obtained at the request of the director;

(c) A consultation obtained in accordance with OAR 436-010-0250(3);

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(d) An examination of a permanently totally disabled worker required under ORS 656.206(5);
and

(e) An examination by a consulting physician that has been arranged by the worker's attending physician in accordance with OAR 436-010-0280.

(6) Examinations shall be at times and intervals reasonably convenient to the worker and shall not delay or interrupt proper treatment of the worker.

(7) When a worker is required to attend an examination by a physician of the insurer's choice, the insurer shall comply with the notification and reimbursement requirements contained in OAR 436-[060-0070]009-0025 and 436-060-0095.

(8) When scheduling an IME, the insurer shall provide Form 440-3227 (Invasive Medical Procedure Authorization) to the medical service provider.

(9) If a medical service provider intends to perform an invasive procedure as part of an IME, the worker shall sign Form 440-3227 and may refuse the procedure. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

(10) The person conducting the examination shall determine the conditions under which the examination will be conducted. Subject to the physician's approval, the worker may use a video camera or tape recorder to record the examination. Also subject to the physician's approval, the worker may be accompanied by a family member or friend during the examination. If the physician does not approve a worker's request to record an examination or allow the worker to be so accompanied, the physician must document the reasons.

(11) Upon completion of the examination, the examining physician shall send a copy of the report to the insurer and attending physician within seven days.

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