Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Effective April 1, 2016

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NOTE: Significant revisions are marked with vertical lines in the right margins.

Oregon Administrative rules
OAR chapter 436

436-010-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(2) Authority for Rules.

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.

(3) Purpose.

The purpose of these rules is to establish uniform guidelines for administering the delivery of and payment for medical services to workers within the workers' compensation system.

(4) Applicability of Rules.

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794
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Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) "Administrative review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(3) "Attending physician" has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider Types."

(4) "Authorized nurse practitioner" means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.

(5) "Board" means the Workers' Compensation Board and includes its Hearings Division.

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

(7) "Come-along provider" means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who continues to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)

(8) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(9) "Days" means calendar days.

(10) "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.

(11) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela."

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

(13) "Eligible worker" means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO's authorized geographical service area, covered by an insurer that has a contract with that MCO.

(14) "Enrolled" means an eligible worker has received notification from the insurer that the worker is being required to treat under the provisions of a managed care organization (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.

(15) "Health care practitioner or health care provider" has the same meaning as a "medical service provider."

(16) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(17) "Home health care" means necessary medical and medically related services provided in the patient's home environment. These services may 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 or authorized nurse practitioner. 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 or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(20) "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 that meets the qualifications of a self-insured employer under ORS 656.407.

(21) "Interim medical benefits" means those services provided under 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.

(22) "Mailed or mailing date" means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(23) "Managed care organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(24) "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 used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

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

(26) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, or other related services; drugs, medicine, crutches, 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 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.

(29) "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.

(30) "Patient" means the same as worker as defined in ORS 656.005(30).

(31) "Physical capacity evaluation" 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 Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(32) "Physical restorative services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the patient's highest functional ability consistent with the patient's condition.

(33) "Report" means medical information transmitted in written form containing relevant subjective 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.

(34) "Residual functional capacity" means a patient's remaining ability to perform work-related activities. 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, kneeling, crouching, crawling, and

reaching, and the number of hours per day the patient can perform each activity.

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

(36) "Work capacity evaluation" 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 has the same meaning as Work Capacity Evaluation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.000 et seq.; 656.005
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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0008 Request for Review before the Director

(1) General.

(a) Administrative review before the director:

(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(B) A party does not need to be represented to participate in the administrative review before the director.

(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(b) All issues pertaining to disagreements 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 worker, are subject to 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 before the director.

(c) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

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

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

(2) Time Frames and Conditions.

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

(A) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

(B) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to the MCO dispute resolution 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. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.

(C) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review before the director within 90 days of the date the party knew, or should have known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. 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. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

(b) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

(A) Identify the worker's name, date of injury, insurer, and claim number;

(B) Specify the issues in dispute and the relief sought; and

(C) Provide the specific dates of the unpaid disputed treatment or services.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or 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 additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document 10 must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

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

(C) If the requesting party is not the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

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

(E) Except for disputes regarding interim medical benefits, the packet must include certification stating that there is an issue of compensability of the underlying claim or condition or stating that there is not an issue of compensability of the underlying claim or condition. If the insurer issued a denial that has been reversed by the Hearings Division, the Board, or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

(4) Physician Review (E.g., appropriateness).

If the director determines a review by a physician is indicated to resolve the dispute, the director, under 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 exam as part of the administrative review process, the worker may refuse an invasive test without sanction.

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

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

(c) When such an exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the exam. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel unless it relates to the exam date, time, location, or attendance. If the parties have special questions they want addressed by the physician or panel, the 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 exam may include, but is not limited to:

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

(B) An examination of the worker, and

(C) Any necessary and reasonable medical tests.

(5) Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order. If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical 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.

(6) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw 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 information that 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 must be received by the director before the administrative order becomes final.

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

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

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(7) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245, 656.247, 656.260(15) or (16), or 656.327(2), no new medical evidence or issues will be admitted at 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.

(c) Contested case hearings of sanctions 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 under 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 mailed to the administrator within 60 days after the mailing date of the order or notice of assessment.

(C) The administrator will forward the request and other pertinent information to the Workers' Compensation Board.

(8) Other Proceedings.

(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party not covered under sections (1) through (7) of this rule, may request administrative review before the director.

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

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

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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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0200 Medical Advisory Committee

The Medical Advisory Committee members are appointed by the director of the Department of Consumer and Business Services. The committee must include one insurer representative, one employer representative, one worker representative, one managed care organization representative, and a diverse group of health care providers representative of those providing medical care to injured or ill workers.

The director may appoint other persons as may be determined necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. When appointing members, the director should select health care providers who will consider the perspective of specialty care, primary care, and ancillary care providers and consider the ability of members to represent the interests of the community at large.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.794
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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0210 Attending Physician, Authorized Nurse Practitioner, and Time-Loss Authorization

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes time loss, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

(b) Type A and B attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

(2) Emergency Room Physicians.

Emergency room physicians may authorize time loss for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in his or her private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

(3) Authorized Nurse Practitioners.

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

(4) Unlicensed to Provide Medical Services.

Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(5) Out-of-State Attending Physicians.

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days.

(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

(A) The Oregon medical fee and payment rules, OAR 436-009;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and

(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

(b) If the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:

(A) Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,

(B) Identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, and

(C) Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.

(6) If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:

(a) The reasons for withdrawing the approval,

(b) That any future services provided by that physician will not be paid by the insurer, and

(c) That the worker may be liable for payment of services provided after the date of notification.

(7) If the worker disagrees with the insurer's decision to disapprove an out-of-state attending physician, the worker or worker's representative may request approval from the director under OAR 436-010-0220.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.005(12), 656.245, 656.260
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0220 Choosing and Changing Medical Providers

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment he or she considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:

(a) Emergency services;

(b) Insurer or director requested examinations;

(c) A Worker Requested Medical Examination;

(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and

(e) Diagnostic studies provided by radiologists and pathologists upon referral.

(2) Changing Attending Physician or Authorized Nurse Practitioner.

The worker may choose to change his or her attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;

(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or

(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:

(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;

(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;

(D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");

(E) When the authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;

(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or

(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(3) Insurer Notice to the Worker.

When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to

notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change his or her attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.

(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:

(A) Send the worker a written explanation of the reasons;

(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and

(C) Inform the worker that he or she may request director approval by sending Form 2332 to the director.

(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.

(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:

(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service 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 or authorized nurse practitioner closer to the worker's residence.

(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date

of the order.

(5) Managed Care Organization (MCO) Enrolled Workers.

An MCO enrolled worker must choose:

(a) A panel provider unless the MCO approves a non-panel provider, or

(b) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.252, 656.260
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0225 Choosing a Person to Provide Interpreter Services

A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Adopted 5/27/10, as Admin. Order 10-053, eff. 7/1/10

436-010-0230 Medical Services and Treatment Guidelines

(1) Medical services provided to the worker 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.

(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.

(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize time loss. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.

(4) Consent to Attend a Medical Appointment.

(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.

> **(A)** The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.
>
> **(B)** The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.
>
> **(C)** The insurer must keep a copy of the signed consent form in the claim file.

(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.

(5) Request for Records at a Medical Appointment.

The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.

(6) Requesting a Medical Provider Consultation.

The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.

(7) Ancillary Services – Treatment Plan.

(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.

(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.

(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes.

(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")

(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.

(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants directed by the attending physician do not have to provide a written treatment

plan as prescribed in this section.

(8) Massage Therapy.

Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services provided by a massage therapist licensed by the Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by massage therapists must follow the same requirements as those for ancillary providers in section (7) of this rule.

(9) Therapy Guidelines and Requirements.

(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.

(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:

(A) Subjective status of the patient;

(B) Objective data from tests and measurements conducted;

(C) Functional status of the patient;

(D) Interpretation of above data; and

(E) Any change in the treatment plan.

(10) Physical Capacity Evaluation.

The attending physician or authorized nurse practitioner must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician or authorized nurse practitioner must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.

(11) Prescription Medication.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.

(b) Providers should review and are encouraged to adhere to the workers' compensation division's opioid guidelines. See http://wcd.oregon.gov/medical/Pages/opioid-guidelines.aspx.

(12) Diagnostics.

Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.

(13) Articles.

Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices

are not compensable unless a report by the attending physician or authorized nurse practitioner clearly justifies the need. The report must:

(a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and

(b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.

(14) Physical Restorative Services.

(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:

> **(A)** The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and
>
> **(B)** A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.

(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(15) Lumbar Artificial Disc Replacement Guidelines.

(a) Lumbar artificial disc replacement is always inappropriate for patients with the following conditions (absolute contraindications):

> **(A)** Metabolic bone disease – for example, osteoporosis;
>
> **(B)** Known spondyloarthropathy (seropositive and seronegative);
>
> **(C)** Posttraumatic vertebral body deformity at the level of the proposed surgery;
>
> **(D)** Malignancy of the spine;
>
> **(E)** Implant allergy to the materials involved in the artificial disc;
>
> **(F)** Pregnancy – currently;
>
> **(G)** Active infection, local or systemic;
>
> **(H)** Lumbar spondylolisthesis or lumbar spondylolysis;

(I) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or

(J) Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

(b) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients with the following conditions, depending on severity, location, etc. (relative contraindications):

(A) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(B) Arachnoiditis;

(C) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);

(D) Facet arthropathy – lumbar – moderate to severe, as shown radiographically;

(E) Morbid obesity – BMI greater than 40;

(F) Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;

(G) Osteopenia – based on bone density test;

(H) Prior lumbar fusion at a different level than the proposed artificial disc replacement; or

(I) Psychosocial disorders – diagnosed as significant to severe.

(16) Cervical Artificial Disc Replacement Guidelines.

(a) Cervical artificial disc replacement is always inappropriate for patients with any of the following conditions (absolute contraindications):

(A) Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;

(B) Significantly abnormal facets;

(C) Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g., -2.7);

(D) Allergy to metal implant;

(E) Bone disorders (any disease that affects the density of the bone);

(F) Uncontrolled diabetes mellitus;

(G) Active infection, local or systemic;

(H) Active malignancy, primary or metastatic;

(I) Bridging osteophytes (severe degenerative disease);

(J) A loss of disc height greater than 75 percent relative to the normal disc above;

(K) Chronic indefinite corticosteroid use;

(L) Prior cervical fusion at two or more levels; or

(M) Pseudo-arthrosis at the level of the proposed artificial disc replacement.

(b) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) may be inappropriate for patients with any of the following conditions, depending on severity, location, etc. (relative contraindications):

(A) A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(B) Multilevel degenerative disc disease – cervical – moderate to severe, as shown radiographically;

(C) Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;

(D) Prior cervical fusion at one level;

(E) A loss of disc height of 50 percent to 75 percent relative to the normal disc above; or

(F) Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

(1) Medical Records and Reports.

(a) Medical providers must maintain records necessary to document the extent of medical services provided.

(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).

(2) Diagnostic Studies.

When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs.

When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

> **(A)** Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and
>
> **(B)** HIV-related information protected by ORS 433.045.

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

> **(A)** Psychotherapy notes;
>
> **(B)** Information compiled for use in a civil, criminal, or administrative action or

proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or his or her representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of his or her medical records because of inability to pay.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

(6) Time Loss and Medically Stationary.

(a) When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

(A) The anticipated date of release to work;

(B) The anticipated date the patient will become medically stationary;

(C) The next appointment date; and

(D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

(7) Consultations.

When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0241 Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims

(1) First Visit.

(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit (Saturdays, Sundays, and holidays are not counted in the 72-hour period).

(b) Form 3283 ("A Guide for Workers Recently Hurt on the Job") is included with Form 827. All medical service providers must give a copy of Form 3283 and Form 827 to the patient.

(2) New or Omitted Medical Condition.

A patient may use Form 827 to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.

(3) Change of Attending Physician.

When the patient changes attending physician or authorized nurse practitioner, the patient and the new medical service provider must complete and sign Form 827. The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician or authorized nurse practitioner. The new attending physician or authorized nurse practitioner is responsible for requesting all available medical records from the previous attending physician, authorized nurse practitioner, or insurer. Anyone failing to forward the requested information to the new attending physician or authorized nurse practitioner within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.

(4) Aggravation.

After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign Form 827. The physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:

(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and

(b) Whether the patient is unable to work as a result of the compensable worsening.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273
Hist: Adopted 8/20/15 as Admin. Order 15-060, eff. 10/1/15

436-010-0250 Elective Surgery

(1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health.

(2) Except as otherwise provided by the MCO, the attending physician, authorized nurse practitioner, or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.

(3) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

(4) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery:

(a) Is approved;

(b) Is not approved and a consultation is requested by using Form 3228 (Elective Surgery Notification); or

(c) Is disapproved by using Form 3228.

(5) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(6) If the insurer requests a consultation, it must be completed within 28 days after sending Form 3228 to the physician.

(7) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.

(8) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.

(9) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must either send the signed and dated Form 3228 or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(10) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

(11) Surgery that must be performed 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 or authorized nurse practitioner should try to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327
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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0265 Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs)

(1) General.

(a) Except as provided in section (12) of this rule, "independent medical exam" (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325. A "worker-requested medical exam" (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker's attending physician or authorized nurse practitioner. The insurer may obtain three IMEs for each opening of the claim. These exams may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as a statutory IME. A claim for aggravation, Board's Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 allows a new series of three IMEs. A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a physician of the insurer's choice. The insurer must choose the medical service providers from the director's list of authorized IME providers under ORS 656.328. The IME may be conducted by one or more providers of different specialties, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the IME must be completed within a 72-hour period and at locations reasonably convenient to the worker.

(b) The provider will determine the conditions under which the exam will be conducted.

(c) IMEs must be at times and intervals reasonably convenient to the worker and must not delay or interrupt treatment of the worker.

(d) When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(e) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.

(f) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the Workers' Compensation Division's website. If the worker does not have access to the Internet, the worker may call the Workers'

Compensation Division at 503-947-7606.

(2) IME/WRME Authorization.

(a) Medical service providers can perform IMEs, WRMEs, or both once they complete a director-approved training and are placed on the director's list of authorized IME providers.

(A) To be on the director's list to perform IMEs or WRMEs, a medical service provider must complete the online application at www.oregonwcdoc.info, hold a current license, be in good standing with the provider's regulatory board, and must have:

(i) Reviewed IME training materials provided or approved by the director found at www.oregonwcdoc.info; or

(ii) Completed a director-approved training course regarding IMEs. The training curriculum must include all topics listed in Appendix B.

(B) By submitting the application to the director, the medical service provider agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or standards published in Appendix C if the provider's regulatory board does not have standards; and

(ii) All relevant workers' compensation laws and rules.

(C) A provider may be sanctioned or removed from the director's list of authorized IME providers after the director finds that the provider:

(i) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C;

(ii) Has a current restriction on his or her license or is under a current disciplinary action from their professional regulatory board;

(iii) Has entered into a voluntary agreement with his or her regulatory board that the director determines is detrimental to performing IMEs;

(iv) Violated workers' compensation laws or rules; or

(v) Has failed to complete training required by the director.

(D) A provider may appeal the director's decision to exclude or remove the provider from the director's list within 60 days under ORS 656.704(2) and OAR 436-001-0019.

(b) If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

(3) IME Training.

(a) The IME provider training curriculum must be approved by the director before the training is given. Any party may submit a curriculum to the director for approval. The curriculum must include:

(A) A training outline,

(B) Goals,

(C) Objectives,

(D) The method of training, and

(E) All topics addressed in Appendix B.

(b) Within 21 days of the IME training, the training vendor must send the director the date of the training and a list of all medical providers who completed the training, including names and license numbers.

(c) Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

(4) IME Related Forms.

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

(A) Form 3923, "Important Information about Independent Medical Exams**,"** available to the worker before the exam; and

(B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.

(5) IME Observer.

(a) A worker may choose to have an observer present during the IME, however, an observer may not participate in or obstruct the IME. An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must sign Form 3923A, "IME Observer Form," acknowledging that the worker understands the IME provider may ask sensitive questions during the exam in the presence of the observer. An observer must not participate in or obstruct the exam. If the worker does not sign Form 3923A, the provider may exclude the observer. The IME provider must verify that the worker signed the "IME Observer Form" acknowledging that the worker understands:

(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;

(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and

(C) The observer must not be paid to attend the exam.

(c) A person receiving any compensation for attending the exam may not be a worker's observer. The worker's attorney or any representative of the worker's attorney may not be an observer.

(6) Invasive Procedure.

For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form.

(7) Record the Exam.

With the IME provider's approval, the worker may use a video camera or other recorder to record the exam.

(8) Objection to the IME Location.

When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, fax, email, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if travel is medically contraindicated or unreasonable because:

(A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;

(B) Alternative methods of travel will not overcome the limitations; or

(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

(9) Failure to Attend an IME.

If the worker fails to attend an IME and does not notify the insurer before the date of the exam or does not have sufficient reason for not attending the exam, the director may impose a monetary penalty against the worker for failure to attend.

(10) IME Report.

(a) Upon completion of the exam, the IME provider must:

(A) Send the insurer a copy of the report and, if applicable, the observer Form 3923A, the invasive procedure Form 3227, or both.

(B) Sign a statement at the end of the report acknowledging that any false statements may result in sanctions by the director and verifying:

(i) Who performed the exam;

(ii) Who dictated the report; and

(iii) The accuracy of the report content.

(b) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within three days, excluding weekends and legal holidays, of the insurer's receipt of the report.

(11) Request for Additional Exams.

(a) When the insurer has obtained the three IMEs allowed under this rule and wants to require the worker to attend an additional IME, the insurer must first request authorization from the director. Insurers that fail to request authorization from the director may be assessed a civil penalty. The process for requesting authorization is:

(A) The insurer must submit a request for authorization to the director by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if any; and

(B) The director will review the request and determine if additional information from the insurer or the worker is necessary. Upon receiving a written request for additional information from the director, the parties 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.

(b) To determine whether to approve or deny the request for an additional IME, the director may consider, but is not limited to, whether:

(A) An IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(B) There has been a significant change in the worker's condition.

(C) There is a new condition or compensable aspect introduced to the claim.

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits.

(E) The IME is requested to establish preponderance for medically stationary status.

(F) The IME is medically harmful to the worker.

(G) The IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(c) Any party who disagrees with the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.283 and OAR chapter 438.

(12) Other Exams – Not Considered IMEs.

The following exams are not considered IMEs and do not require approval as outlined in section (11) of this rule:

(a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;

(b) An exam requested by the director;

(c) An elective surgery consultation requested under OAR 436-010-0250(3);

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

(e) A closing exam that has been arranged by the insurer at the attending physician's or authorized nurse practitioner's request; and

(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0270 Insurer's Rights and Duties

(1) Notifications.

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) Pre-authorization.

Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

(4) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);

(B) How workers can receive compensable medical services within the MCO;

(C) How workers can receive compensable medical services by non-panel providers; and

(D) The geographical service area governed by the MCO.

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

(i) Provide a telephone number the worker may call to ask for a written list; and

(ii) Tell the worker that he or she has seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or

(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing 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 workers with health care benefits even if a workers' compensation claim is denied; and

(F) Notify the worker of his or her right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

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

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, 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.

(g) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0035(4).

(h) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(i) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) Any changes to the worker's or worker's attorney's name, address, or telephone number;

(B) Any requests for medical services from the worker or the worker's medical provider; or

(C) Any request by the worker to continue treating with a "come-along" provider.

(j) Insurers under contract with MCOs must maintain records including, but not limited to:

(A) A listing of all employers covered by MCO contracts;

(B) The employers' WCD employer numbers;

(C) The estimated number of employees governed by each MCO contract;

(D) A list of all workers enrolled in the MCO; and

(E) The effective dates of such enrollments.

(k) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(l) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0280 Determination of Impairment / Closing Exams

(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)

(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.

(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.

(5) The attending physician must specify the worker's residual functional capacity if:

(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and

(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.

(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:

(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or

(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.

(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:

(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or

(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician for a closing exam.

(8) The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Findings documenting permanent work restrictions.

(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.

(c) A statement regarding the validity of an impairment finding is required in the following circumstances:

(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the

determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252
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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0290 Medical Care After Medically Stationary

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:

(a) Palliative care under section (2) of this rule;

(b) Curative care under sections (3) and (4) of this rule;

(c) Provided to a worker who has been determined permanently and totally disabled;

(d) Prescription medications;

(e) Necessary to administer or monitor administration of prescription medications;

(f) Prosthetic devices, braces, or supports;

(g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;

(h) Provided under an accepted claim for aggravation;

(i) Provided under Board's Own Motion;

(j) Necessary to diagnose the worker's condition; or

(k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

(2) Palliative Care.

(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those

medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

(A) Describe any objective findings;

(B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;

(C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;

(D) Explain how the requested care is related to the compensable condition; and

(E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice to the attending physician, worker, and worker's attorney approving or disapproving the request.

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

(A) The palliative care services are not related to the accepted condition(s);

(B) The palliative care services are excessive, inappropriate, or ineffectual; or

(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

(A) A copy of the original request to the insurer; and

(B) A copy of the insurer's response.

(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.

(g) Subsequent requests for palliative care are subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

(3) Curative Care.

Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(4) Advances in Medical Science.

The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

(a) Describe any objective findings;

(b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);

(c) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;

(d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and

(e) Describe why the care is otherwise justified by the circumstances of the claim.

Stat. Auth: ORS 656.726
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See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0300 Requesting Exclusion of Medical Treatment from Compensability

If a worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. The director will request advice from the licensing boards of practitioners that might be affected and the Medical Advisory Committee. The director will issue an order and may adopt a rule declaring the treatment to be noncompensable. The decision of the director is appealable under ORS 656.704. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process. Excluded treatments are listed in OAR 436-009-0010.

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See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0330 Medical Arbiters and Physician Reviewers

(1) The director will establish and maintain a list of arbiters. The director will appoint a medical arbiter or a panel of medical arbiters from this list under ORS 656.268.

(2) The director will establish and maintain a list of physician reviewers. The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245 and 656.327.

(3) When a worker is required to attend an examination under this rule, the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location, and purpose of the examination. Examinations will be at a place reasonably convenient to the worker, if possible.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.268, 656.325, 656.327
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0335 Monitoring and Auditing Medical Providers

(1) The director may monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and chapter 436 of the administrative rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended and renumbered from OAR 436-010-0260 8/20/15 as Admin. Order 15-060, eff. 10/1/15
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0340 Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), or 656.325, or OAR 436-009 or 436-010, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Non-payment, reduction, or recovery of fees in part or whole for medical services provided;

(c) Referral to the appropriate licensing board;

(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations; or

(e) A penalty of $100 for each violation of ORS 656.325(1)(c)(C).

(2) If the medical provider fails to provide information under OAR 436-010-0240 within fourteen days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.

(3) The director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence on any medical service provider who, under ORS 656.254, and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(b) Provide medical services that are excessive, inappropriate, or ineffectual; or

(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a

worker.

(4) If the conduct as described in section (3) of this rule is found to be repeated and willful, the director may declare the medical provider ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years.

(5) A medical provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

(6) If a financial penalty is imposed on the medical provider for violation of these rules, the provider may not seek recovery of the penalty fees from the worker.

(7) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are appropriate, either may submit a complaint in writing to the director.

(8) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical providers for services provided until the insurer complies with the notification requirement. Any penalty will be limited to the amounts listed in section (9) of this rule.

(9) If the director finds any insurer in violation of statute, OAR 436-009, OAR 436-010, or an order of the director, the insurer may be subject to penalties under ORS 656.745 of not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separate violation.

(10) The director may subject a worker who fails to meet the requirements in OAR 436-010-0265(9) to a $100 penalty per occurrence under ORS 656.325, to be deducted from future benefits.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15
Amended 3/7/16 as Admin. Order 16-051, eff. 4/1/16
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Appendix A - Matrix for health care provider types *

See OAR 436-010-0005

	Attending physician status (primarily responsible for treatment of a patient's injury)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathy Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician Physician assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan. (Note: physician assistants are not required to have a written treatment plan)	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No Unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No if patient referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No Unless authorized by the attending physician
Other health care providers e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any other health care providers. Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

Appendix B

Independent Medical Examination (IME)

Medical Service Provider
Training Curriculum Requirements

A. Overview
WCD will provide the overview portion of the curriculum to vendors for use in their approved training program.

1. Why the IME training is required.
   a) The Workers' Compensation Management-Labor Advisory Committee requested a study after hearing anecdotal injured worker complaints.
   b) The Workers' Compensation Division (WCD) study found there was perceived bias in the IME system.
   c) There was no process to handle complaints about IMEs.
   d) There was concern about IME report quality.
   e) The 2005 Legislature passed Senate Bill 311 unanimously.

2. Workers' compensation system:
   a) Public policy: workers' compensation law [ORS 656.012 (2)] identifies four objectives:
      1) Provide, regardless of fault, sure, prompt and complete medical treatment for injured workers, and fair, adequate, and reasonable income benefits to injured workers and their dependents.
      2) Provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent possible, while providing for access to adequate representation for injured workers.
      3) Restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.
      4) Encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents.

      Additional items to discuss:
      - Exclusive remedy.
      - The Legislature found that common law is expensive without proportionate benefit.
      - No fault versus tort.
      - The economy and the costs of injuries.

   b) Causation of work related injuries.
      - Is the injury work related?
      - What are pre-existing conditions?
      - What is major contributing cause?

- What is material contributing cause?

c) The IME provider role
- Unbiased, neutral third-party
- Independent

d) The difference between IMEs and
- Worker Requested Medical Exams (Causation)
- Arbiter Exams (Reconsideration)
- Physician Reviews (Medical disputes)

B. Provider Code of Professional Conduct
IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:
1. The guidelines adopted by the appropriate health professional regulatory board, OR
2. The "Guidelines of Conduct" published in Appendix C, if the appropriate regulatory board hasn't adopted standards for professional conduct regarding IMEs.

C. Report writing
1. The statement of accuracy must be in compliance with OAR 436-010-0265.
2. Report content: what comprises a good IME report?

D. Communication
What is appropriate communication between claims examiners and medical providers?

E. Training specific to the requirements of ORS 656.325, OAR 436-010, and 436-060 concerning:
1. Observers
2. Recording of exams
3. Invasive procedures
4. Sanctions and civil penalties
5. Worker penalties and suspension
6. Exam location disputes
7. Forms
8. Complaints.

F. Sanctions of providers, up to and including removal from the list:
1. Provider has restrictions on its license or current disciplinary actions from its health professional regulatory board.
2. Provider has entered into a voluntary agreement with the licensing board that the director has determined to be detrimental to performing IMEs.
3. Provider has violated the standards of professional conduct for IMEs.
4. Provider has violated workers' compensation laws or rules.
5. Provider has failed to attend training required by the director.

G. If the director removes a provider's name from the director's list, providers may appeal.

H. Workers' Compensation Division's complaint process:
1. Use of injured workers surveys about IMEs
2. Complaints received by the Workers' Compensation Division.

I. Impairment findings: The purpose of measuring impairment is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job at injury being performed, etc.

J. Other necessary information as determined by the director.

OAR 436-010-0265

Appendix C

Independent Medical Examination Standards

As developed by the Independent Medical Examination Association

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
   a. Remind the examinee of the party who requested the examination.
   b. Explain to the examinee that a physician-patient relationship will not be sought or established.
   c. Tell the examinee the information provided during the examination will be documented in a report.
   d. Review the procedures that will be used during the examination.
   e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
   f. Answer the examinee's questions about the examination process.
6. During the examination:
   a. Ensure the examinee has privacy to disrobe.
   b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
   c. Examine the condition being evaluated sufficient to answer the requesting party's questions.
   d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

BEFORE THE DIRECTOR
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

In the Matter of the Amendment of Oregon Administrative Rules (OAR): 436-010, Medical Services	))))	**ORDER OF ADOPTION No. 16-051**

The Director of the Department of Consumer and Business Services, under the general rulemaking authority in ORS 656.726(4), and in accordance with the procedures in ORS 183.335, amends OAR chapter 436, division 010.
On Jan. 12, 2016, the Workers' Compensation Division filed with the Secretary of State a *Notice of Proposed Rulemaking Hearing* and *Statement of Need and Fiscal Impact*. The division mailed copies of the *Notice* and *Statement* to interested persons and legislators in accordance with ORS 183.335 and OAR 436-001-0009, and posted copies to its website. The Secretary of State included notice of the public hearing in its February 2016 *Oregon Bulletin*. On Feb. 22, 2016, a public hearing was held as announced. The record remained open for written testimony through Feb. 25, 2016.

SUMMARY OF RULE AMENDMENTS

OAR 436-010, Medical Services, has been amended to:

- Require that requests for reconsideration of administrative orders be ***received by*** the director before the order becomes final;
- Replace the requirement for an insurer to forward a copy of an independent medical exam report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report with a requirement to do so within three days; and
- Clarify in the matrix for health care provider types that a physician assistant who is not, or is no longer, eligible to provide treatment as a Type B attending physician is not required to have a written treatment plan if the physician assistant provides care that is authorized by an attending physician.

FINDINGS

Having reviewed and considered the record and being fully informed, I make the following findings:

a) The applicable rulemaking procedures have been followed.

b) These rules are within the director's authority.

c) The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

IT IS THEREFORE ORDERED THAT

1) Amendments to OAR chapter 436, division 010 are adopted as administrative order No. 16-051 on this **7th day of March, 2016, to be effective April 1, 2016.**
2) A certified copy of the adopted rules will be filed with the Secretary of State.
3) A copy of the adopted rules with revision marks will be filed with the Legislative Counsel under ORS 183.715 within ten days after filing with the Secretary of State.

DATED this 7th day of March, 2016.

/s/ Louis Savage
Louis Savage, Administrator
Workers' Compensation Division

Under the Americans with Disabilities Act guidelines, alternative format copies of the rules will be made available to qualified individuals upon request.

If you have questions about these rules or need them in an alternate format, contact the Workers' Compensation Division, 503-947-7810.

Distribution: Workers' Compensation Division e-mail distribution lists, including advisory committee members and testifiers

Secretary of State
Certificate and Order for Filing

PERMANENT ADMINISTRATIVE RULES

FILED
3-7-16 2:21 PM
ARCHIVES DIVISION
SECRETARY OF STATE

I certify that the attached copies are true, full and correct copies of the PERMANENT Rule(s) adopted on Upon filing, by the

Department of Consumer and Business Services, Workers' Compensation Division — 436
Agency and Division — Administrative Rules Chapter Number

Fred Bruyns — (503) 947-7717
Rules Coordinator — Telephone

PO Box 14480, Salem, OR 97309-0405
Address

To become effective 04/01/2016 Rulemaking Notice was published in the February 2016 Oregon Bulletin.

RULE CAPTION

Amendment of rules governing workers' compensation medical services and medical billing and payment

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
436-009-0001, 436-009-0004, 436-009-0005, 436-009-0008, 436-009-0010, 436-009-0020, 436-009-0025, 436-009-0030, 436-009-0040, 436-009-0060, 436-009-0080, 436-009-0090, 436-009-0110, 436-010-0001, 436-010-0005, 436-010-0008, 436-010-0240, 436-010-0265, 436-010-0270, 436-010-0330, 436-010-0340

REPEAL: 436-009-0004(T), 436-009-0010(T) 3/8/16

RENUMBER:

AMEND AND RENUMBER:

Statutory Authority:
656.248, 656.726(4)

Other Authority:

Statutes Implemented:
656.245, 656.248; 656.252; 656.327; 656.704

RULE SUMMARY

The agency has amended OAR 436-009, "Oregon Medical Fee and Payment Rules," to:

-Adopt updated medical fee schedules (Appendices B, C, D, and E) and resources for the payment of health care providers;
-Increase maximum allowable payment rates by three percent for physician services except for physical therapy services;
-Remove two laboratory HCPCS codes, G0431 and G0434, from the physician fee schedule. Add fee schedule amounts to the physician fee schedule for HCPCS codes G0477, G0478, G0479, G0480, G0481, G0482 and G0483;
-Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
-Specify how providers must complete boxes 32 and 32a on the National Uniform Claim Committee 1500 Claim Form;
-Exclude platelet rich plasma injections from compensability;
-Eliminate the list of hospitals subject to including Medicare Severity Diagnosis Related Group (MS-DRG) codes on their bills, in favor of a general requirement to include the MS-DRG codes, unless the hospital is a critical access hospital or if the bill contains revenue code 002x.
-Replace the requirement for an insurer or insurer's representative to respond to a question from a provider or a worker about reimbursement within 48 hours with a requirement to do so within two days; require that explanations to workers about out-of-pocket expenses and explanations of benefits sent to health care providers specify two days instead of 48 hours to respond to questions;
-Remove a redundant requirement for health care providers to send multidisciplinary treatment programs to insurers - already in OAR 436-010;
-Increase the maximum payable for hearing aids, without approval by the insurer or director, from $5000 to $7000 for a pair and from $2500 to

$3500 for a single hearing aid;
Allow a worker to upgrade a hearing aid by paying the price difference;
-Require that compounded drugs be billed at the component ingredient level, listing each ingredient's national drug code (NDC), and that ingredients without an NDC are not reimbursable;
-Set the maximum allowable fee for a compound drug at 83.5% of the average wholesale price (AWP) for each individual ingredient, plus a single compounding fee of $10.00;
-Replace the mileage reimbursement rate payable to interpreters, currently $0.50 per mile, with the private vehicle mileage rate published in Bulletin 112; and
-Clarify in the matrix for health care provider types that a physician assistant who is not, or is no longer, eligible to provide treatment as a Type B attending physician is not required to have a written treatment plan if the physician assistant provides care that is authorized by an attending physician.

The agency has amended OAR 436-010, "Medical Services," to:
-Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
-Replace the requirement for an insurer to forward a copy of an independent medical exam report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report with a requirement to do so within three days; and
-Clarify in the matrix for health care provider types that a physician assistant who is not, or is no longer, eligible to provide treatment as a Type B attending physician is not required to have a written treatment plan if the physician assistant provides care that is authorized by an attending physician.

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Rules Coordinator Name	Email Address