

**DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE**

**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10, RULE 040**

EFFECTIVE JUNE 15, 1987

436-10-040 Medical Services

(1)(a) The insurer shall pay for all medical services which the nature of the compensable injury and the process of recovery requires. The insurer will not pay for care unrelated to the compensable injury. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable. Billings for services which appear to the insurer to be in excess of the standards set forth in these rules, or of generally accepted medical standards, may be referred to the medical director. Such referral shall be made within 60 days of receipt of the bill.

(b) Peer review committees shall be composed of health care providers licensed under the same authority as the health care provider who rendered the services being reviewed. The committees shall provide advice and assistance to the medical director on other health matters when requested. The director may solicit recommendations from professional associations, licensing authorities and professional schools.

(c) The report of such committee shall be submitted to the director who may:

(A) Issue an order compelling compliance with the judgment of the committee, or

(B) Forward the report to the insurer and provider for appropriate action.

(2)(a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed.

(b) A reasonable fee is payable for this report. A judgment by the insurer that the report does not set forth sufficient grounds for the frequency of treatment in excess of the standard may be referred by the physician to the medical director. The medical director may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(3) X-ray films must be of diagnostic quality. 14" x 36" lateral views are not reimbursable. Billings for X-rays are not reimbursable without a report of the findings. Upon the request of either the director or the insurer, X-ray films shall be forwarded to the director or the insurer. Films shall be returned to the vendor. A reasonable charge may be made for the costs of delivery of films. Refusal of the physician to forward the films to the director or the insurer upon proper request shall result in nonpayment of the fee for the radiological study.

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(4)(a) Physical therapy, biofeedback or acupuncture shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment and which must be completed and signed by the attending physician within one week of the beginning of treatment. The treatment plan shall include objectives, modalities, frequency of treatment and duration. A copy of the progress notes shall be provided insurer upon request.

(b) The initial treatment plan shall be for no more than 20 therapy visits in the first 60 days. If more than 20 therapy visits are required in the first 60 days or more than four therapy visits a month after the first 60 days, the physician shall submit a report documenting the need for services in excess of the guidelines upon request of the insurer.

(c) Outpatient occupational therapy is compensable only when provided under a written treatment plan as described above. CPT codes 97900 and 97901 in Appendix A denote occupational therapy and shall be used only for services provided by a licensed occupational therapist. In addition, CPT Code 97902 shall be used to denote the initial visit for evaluation and establishment of the treatment program.

(d) [(c)] A judgment by the insurer that the report does not justify treatment in excess of the guidelines shall promptly be communicated to the physician and the therapist. The physician may appeal to the medical director who may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(e) [(d)] The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for the therapy service. No additional fee shall be paid except a reasonable amount for copies or summaries of the records of treatment.

(5) Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

(6) Dietary supplements - such as minerals and vitamins are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from compensable gastrointestinal injury.

(7) Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury and the process of recovery requires" that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to rest areas or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(8) Insurers and claimants are not responsible for payment for treatment procedures rendered in connection with the compensable injury that are not approved and taught by accredited institutions of the licentiate's profession. If the insurer believes procedures to be inappropriate, of unproven value or experimental in nature, the issue may be referred to the medical director who may refer the matter to a committee of consultants of the provider's peers.

(9) Prolotherapy is not reimbursable without prior authorization by insurer.

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(10) Liquid crystal thermography, photographic or electronic, is not reimbursable without prior authorization. Insurer may require documentation to show why its use is preferable to usual diagnostic tests. Insurer may limit the number of times it may be used in each case.

(11) A written request for authorization for prolotherapy or thermography shall be answered within 14 working days of receipt by insurer or approval will be assumed.

(12) The descriptions of medical services for CPT numbers itemized in (a) through (j) shall be the basis for determining the appropriate level of service.

(a) 95831 - Muscle Testing, Manual, Separate Procedure, Extremity, with Report (also includes 95832, 95833, 95834) - Detailed individual testing of multiple muscles of a patient with a severe neuropathic or myopathic disorder. It does not apply to general or specific muscle testing done during a regular physical examination.

(b) 97110 - Therapeutic Exercises - Instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a physician or therapist present and supervising would not be covered by Code 97110.

(c) 97112 - Neuromuscular Reeducation - The provision of direct services to a patient who has had muscle paralysis and is undergoing recovery or regeneration. Examples would be severe trauma to nervous system, cerebral vascular accident and systemic neurological disease. The code does not apply to massaging or exercising relatively normal muscles or treatment of minor disuse atrophy, e.g. following cast removal.

(d) 97114 - Functional Activities - The development and instruction in specific activities for persons who are severely handicapped or debilitated. The code does not apply to routine exercises for relatively normal individuals.

(e) 97116 - Gait Training - Teaching individuals with severe neurological or muscular-skeletal disorders to ambulate in the face of their handicap or to ambulate with an assistive device. This code does not apply to simple instructions given relatively normal individuals with minor or transient abnormalities of gait who do not require an assistive device.

(f) 97220 - Hubbard Tank - This service involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals.

(g) 97240 - Pool Therapy with Therapeutic Exercises - This service is provided individually, in a pool, to severely debilitated or neurologically impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.

(h) 97540 - Activities of Daily Living - Services provided in an office or clinic to severely impaired individuals, e.g. how to get in and out of a tub; how to make a bed; how to prepare meals in a kitchen. It does not apply to simple instructions or counseling in body mechanics given briefly to a patient.

(i) 97720 - Extremity Testing for Strength, Dexterity, or Stamina - Detailed testing of a patient with a generalized neurological or debilitating disease. It does not apply to routine physical examinations of relatively unimpaired individuals.

(j) 97740 - Kinetic Activities - When there are major impairments or disabilities which preclude the patient performing the activities and exercises that are ordinarily prescribed.

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Considerable time is spent developing specific, individualized therapeutic exercises and instructing the patient in how to perform them. This code does not apply to instructions in routine exercises.

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