

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

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10**

MEDICAL SERVICE

EFFECTIVE FEBRUARY 1, 1990

TABLE OF CONTENTS

RULE		PAGE
436-10-001	Authority For Rules	1
436-10-002	Purpose.....	1
436-10-003	Applicability Of Rules	1
436-10-005	Definitions	1
436-10-006	Administration of Rules.....	4
436-10-008	Administrative Review	4
436-10-030	Reporting.....	4
436-10-040	Medical Services.....	6
436-10-045	Evaluating Treatment	10
436-10-046	Medical Panels.....	10
436-10-050	Who May Provide Services.....	12
436-10-060	Choosing And Changing Doctors	12
436-10-070	Elective Surgery.....	13
436-10-080	Determination Of Impairment	14
436-10-090	Charges And Fees	14
436-10-091	Continuing Medical Education	19
436-10-095	Advisory Committee on Medical Care.....	20
436-10-100	Insurer's Rights and Duties.....	21
436-10-105	Disability Prevention Services.....	22
436-10-110	Fee Disputes	24
436-10-115	Complaints of Rule Violation	24
436-10-130	Sanctions and Civil Penalties	25
436-10-135	Service Of Orders.....	26
APPENDIX A --	OREGON RELATIVE VALUE SCHEDULE FOR MEDICAL SERVICE.....	28

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

**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010**

436-10-001 Authority For Rules

(1) These rules are promulgated under the Director's general rulemaking authority of ORS 656.726(3) and specific authority under ORS 656.248, 656.252, 656.254, 656.325, and ORS 656.794(3) to provide for: reasonable rates to be paid for medical services; review of medical reports involving unnecessary medical services; prompt submission of medical reports; and penalties.

(2) The Advisory Committee on Medical Care, appointed by the Director under provisions of ORS 656.794, participated in the drafting of these rules.

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Amended 10/20/76 as Admin. Order 4-1976, eff. 11/1/76
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Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
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436-10-002 Purpose

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

Hist: Filed 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-003 Applicability Of Rules

(1) These rules are effective to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.325, and 656.794, and govern all vendors of medical services licensed or authorized to provide a product or service which is chargeable as a claims cost.

(2) The provisions of OAR 436-10-090 shall be applicable to all services rendered subsequent to the effective date of these rules.

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Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
(formerly OAR 436-10-004)

436-10-005 Definitions

Unless the context otherwise requires:

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

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

(2) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(3) "Claim" means a written request for compensation from a worker or worker's agent, or any compensable injury or illness of which an employer has notice or knowledge.

(4) "Claimant" means the worker making a claim.

(5) "Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in diagnosis and/or treatment, and who may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness.

(6) "Current Procedural Terminology" means the Current Procedural Terminology, fourth edition, 1985, published by the American Medical Association.

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

(8) "Department" means the Oregon Department of Insurance and Finance, consisting of the Board, the Director and all their assistants and employees.

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

A medical service provided at a site removed from the physician, or provided when the physician is not present on the premises, is not under the direct control and supervision of the physician.

(10) "Director" is the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

(11) "Disability Prevention Services" means services provided to an injured worker to prevent the injury from causing continuing disability. Such services include physical restoration and psychologic, psychiatric, and vocational evaluation and counseling.

(12) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance, consisting of the Compliance Section, Evaluation Section and Rehabilitation Review Section.

(13) "Elective Surgery" means surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

(14) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

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

(16) "Hospital" means an institution licensed by the State of Oregon as a hospital.

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

(17) "Insurer" means the State Accident Insurance Fund Corporation, a guaranty contract carrier, or a self-insured employer.

(18) "Major Orthopedic or Neurologic Surgery" means operations on the spine, shoulder, elbow, hip, knee or ankle joints; replacement of any joint; surgery for thoracic outlet syndrome. Surgery for carpal tunnel syndrome is not major neurologic surgery.

(19) "Medical Director" means the physician in the Workers' Compensation Division.

(20) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device.

(21) "Medically Stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(22) "Peer Review" means the evaluation of the care provided to a worker by review of the pertinent records and/or personal interview with the attending physician or consultant. Such review may be conducted by a committee of the provider's peers and/or any other appropriate body selected by the director.

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

(24) "Physician" or "Doctor" means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate.

(25) "Promptly" means without delay.

(26) "Report" means transmittal of medical information in a narrative letter, on a form or in progress notes from the worker's medical file. Reports may be handwritten but all shall be legible and include all relevant or requested information.

(27) "Treating Physician" means attending physician.

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

(29) "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 shall be considered to have the same meaning as Work Capacity Evaluation.

(30) "Worker" means a subject worker as defined in ORS 656.005.

(31) "Work Hardening" means an individualized, medically ordered and monitored, work oriented treatment process. Involves the worker in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance and productivity to return to work goals.

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

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436-10-006 Administration of Rules

Any orders issued by the Division in carrying out the Director's authority to enforce ORS Chapter 656 and the rules adopted pursuant thereto, are considered orders of the Director.

Hist: Filed 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-008 Administrative Review

(1) With the exception of the compensability of medical services identified pursuant to ORS 656.254(4) and OAR 436-10-040, any party, as defined by ORS 656.005(19) and including SAIF as a designated processing agent pursuant to ORS 656.054, aggrieved by an action taken pursuant to the rules in this division regarding those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue, may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS Chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law.

(2) Any party, as defined by ORS 656.005(19) and including SAIF as a designated processing agent pursuant to ORS 656.054, or medical provider aggrieved by an action taken pursuant to these rules involving any matters other than those defined in subsection (1), including any matter arising under ORS 656.248 or any proceeding resulting therefrom, but exclusive of other issues pursuant to ORS 656.327, may request a hearing of the director. A request for a hearing under this subsection shall be directed in writing to the division. No hearing shall be granted unless the party's or medical provider's request for hearing is received by the division within thirty (30) days of the action or from the date of mailing or other service of the order.

(a) The contested case hearing shall be conducted by the director unless the director designates a referee of the Hearings Division of the Workers' Compensation Board, or some other person, to conduct the hearing.

(b) Notwithstanding ORS 183.315(1), the issuance of orders under this subsection, the conduct of hearings and judicial review thereof shall be as provided in ORS 183.415 through ORS 183.495 and in accordance with OAR 137-03-001 through 137-04-010 of the Attorney General's Uniform and Model Rules of Procedure, except as expressly provided herein.

Hist: Filed 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-030 Reporting

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any physician, hospital, or other medical vendor to supply relevant information

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

regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, or the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. No person who reports to these persons in accordance with Department rules shall bear any legal liability for disclosure of such (ORS 656.252). The physician may require evidence from the representative of his or her representative capacity. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative.

(2) The initial attending physician shall complete the first medical report (Department of Insurance and Finance Form 827) in every detail and mail it to the proper insurer no later than 72 hours after the claimant's first visit (Saturdays, Sundays and holidays will not be counted in the 72-hour period). Diagnoses stated on the 827 and all subsequent reports shall conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(3) Progress reports are essential. The insurer may require progress reports every 15 days through the use of the physician's supplemental report form (Department of Insurance and Finance Form 828). If more information is required, the insurer may request a limited or comprehensive narrative report. Progress notes from the clinical chart, if legible, may suffice to give the insurer all the information the insurer needs.

(4) The attending physician shall promptly respond to the request for progress reports. If the physician or other vendor of services fails to comply with this requirement within 10 days, the insurer may send another request by certified mail, return receipt requested. If within 10 days the physician or other vendor has not complied with this request, penalties under OAR 436-10-130 may be imposed.

(5) ORS 656.252 requires the attending physician to inform the insurer of the anticipated date of release to work, the anticipated date the worker will become medically stationary and the next appointment date. To the extent the physician can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(6) The attending physician shall advise the insurer and the worker within five (5) days of the date the injured worker is released to return to work. The physician shall not notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

(7) The attending physician shall, after a claim has been closed, advise the insurer within five (5) days after treatment is resumed or the reopening of a claim is recommended. The attending physician need not be the same physician who released the worker when the claim was closed.

(8) Consultations. The attending physician may request consultation regarding conditions related to an accepted claim. The attending physician shall promptly notify the insurer of the referral (referrals to radiologists and pathologists for diagnostic studies are exempt from this requirement). The attending physician shall provide the consultant with all the available clinical information. The consultant shall submit a copy of his consultation report to the attending

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

physician and the insurer within 10 working days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report.

(9) When an injured worker elects to change attending physicians, the newly selected attending physician shall so notify the insurer not later than five (5) days after the change or the date of first treatment using Department of Insurance and Finance Form 829. The newly selected physician shall make a diligent effort to secure from the previous physician, or from the insurer, all of the available medical information including information concerning previous temporary total disability periods. The previous attending physician shall immediately forward, upon proper request, all requested information and X-rays to the new attending physician. A physician who fails to forward requested information and X-rays to the new attending physician will be subject to penalties as provided by OAR 436-10-130(2).

(10) Injured workers, or their representatives, are entitled to copies of all relevant medical information. This information should ordinarily be available from the insurers, but may be obtained from physicians upon the payment of an appropriate charge for copies. However, reports that contain medical and psychological information relevant to the claim, which in the judgment of the writer of the report should not be shown to the worker because it would not be in the worker's best interest, must be supplied to the worker's representative but need not be supplied to the worker directly. Upon request by the insurer, the director, or the claimant, chart notes containing the relevant information shall be provided subject to the above exception.

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436-10-040 Medical Services

(1)(a) The insurer shall pay for all medical services which the nature of the compensable injury or 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.

(b) When there is a question regarding the competency or ethical behavior of a medical provider, the medical director may refer the matter to the appropriate licensing board.

(2)(a) Frequency and extent of treatment shall not be more than the nature of the injury or 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. If the insurer finds the report does not

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

justify treatment in excess of the guidelines, the insurer shall issue a partial denial of the specific treatment or services denied to the worker, with a copy to the physician.

(b) A reasonable fee is payable for this report.

(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.

(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.

(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. If the insurer finds the report does not justify treatment in excess of the guidelines, the insurer shall either issue a partial denial of the disputed treatment to the worker with a copy to the medical provider, or request a medical panel.

(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) 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) The attending physician, when requested to complete a physical capacities evaluation form provided by the insurer, shall within 20 days perform an evaluation, if necessary, and complete the form, or refer the worker for such evaluation, or notify the insurer and the worker in writing that the worker is incapable of participating in such evaluation.

When a general physical capacity evaluation, other than a job-specific work capacity evaluation, is necessary and tests are performed for the purpose of completing an evaluation form provided by the insurer, the fee payable to the provider who performs the evaluation shall be no greater than \$175.00. No fee shall be paid for the

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

mere completion of a work release form or completion of a physical capacity evaluation form where no tests are performed.

The fee for a job-specific work capacity evaluation, as defined in 436-10-005(26), shall be agreed upon in advance between the provider and the insurer. If no fee is agreed upon in advance, the parties may submit the dispute to the Director who shall determine a fee in an amount no greater than \$475.00.

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

(7) Dietary supplements including, but not limited to, minerals, vitamins and amino acids 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.

(8) 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 or the process of recovery requires" that the item be furnished. The report must specifically set forth 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.

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

(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 submitted on the Department of Insurance and Finance Form 2000 and shall be answered within 14 working days of receipt by insurer or approval will be assumed.

Thermography shall be billed using code 93760 (cervical), 93761 (thoracic) and 93762 (lumbar). When two or more areas are examined by thermography the first area shall be reimbursed at no more than 100 percent of the maximum allowable fee, the second area at no more than 50 percent of the maximum allowable fee and the third and subsequent areas at no more than 25 percent of the maximum allowable fee.

(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.

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

(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. 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.

(13) Frequency and extent of diagnostic testing shall not be more than the nature of the injury or the process of recovery requires.

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

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436-10-045 Evaluating Treatment

(1) If an insurer, worker or the director feels that any medical treatment recommended for, or provided to, a worker or workers, is unscientific, unproven, outmoded or experimental, either party may request, or the director may initiate on the director's own authority, an investigation.

(2) The investigation shall include the advice of the licensing boards of practitioners who might be affected.

(3) The director may submit the record of the investigation to the Advisory Committee on Medical Care which shall review the record and conduct any further inquiry the committee considers necessary. The committee shall render a recommendation to the director as to whether or not the committee considers the treatment in question to be unscientific, unproven, outmoded or experimental.

(4) The director may adopt a rule declaring the treatment to be noncompensable.

(5) No sums deleted by an insurer under the rule referred to in (4) above shall be charged to a worker.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-046 Medical Panels

(1) If a worker, insurer or the director believes a worker's treatment is excessive, inappropriate, ineffectual or in violation of the medical rules, either may request, and the director may establish on the director's own motion, a medical panel. A request for a medical panel from a worker or insurer shall be in writing and include:

(a) The worker's name and claim number;

(b) The insurer's and medical provider's names and addresses;

(c) Reasons treatment is thought to be excessive, inappropriate or ineffectual; and/or specific examples of failure to comply with the medical rules; and

(d) Any harm which has befallen, or might befall, the worker.

(2) Any party requesting a review shall notify all other parties, including the medical provider, at the same time the request is made to the director. If the director initiates the panel the director shall notify the parties.

(3) No later than five days after receiving the request the director shall notify the parties whether or not a panel will be authorized and shall inform the parties of their responsibilities in the matter.

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

(4) Once the panel is authorized, the insurer shall not deny the claim for medical services, nor shall the worker request a hearing on any issues subject to the director's jurisdiction, until an order is issued.

(5) The panel, composed of Oregon physicians whose treatment is not under review and licensed in the same healing art as the physician whose treatment is under review, shall be established as follows:

(a) No later than 10 days after the director authorizes the panel the worker and the insurer shall each choose a physician and notify the director.

(b) If either the worker or the insurer fails to inform the director of the physician chosen in the allotted time, the director shall choose the physician.

(c) The two physicians shall choose a third physician no later than 20 days after the director authorizes the panel.

(d) If the third physician is not chosen in the allotted time, the director shall choose the third panel member.

(e) The director shall inform the panel the date the panel's report is due, which will be no later than 40 days after the selection of the panel is complete.

(6) The director shall inform the worker of the date, time, and location of the examination with copies to the insurer, attending physician and panel members.

(7) The insurer and attending physician shall forward all pertinent medical records, laboratory results and X-rays to the medical panel.

(8) The medical panel may:

(a) Review all medical records and X-rays submitted.

(b) Interview and examine the worker.

(c) Perform any necessary tests, laboratory studies and X-rays except invasive tests.

(d) Submit a report in writing to the director containing the panel's recommendation, with copies to the worker, insurer, and attending physician.

The recommendation may include, but not be limited to:

(a) Reason for the panel examination.

(b) Past medical history.

(c) Current medical problem.

(d) Current treatment

(e) Results of the examination.

(f) Results of tests performed.

(g) Diagnosis.

(h) The medically stationary status.

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

- (i) Whether current treatment is excessive, inappropriate or ineffectual.
- (j) Whether or not the current treatment should be continued, modified or terminated.
- (10) Within 10 days of receipt of the report the director shall issue a final order.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-050 Who May Provide Services

(1) Physicians licensed by the Board of Medical Examiners, the Board of Dental Examiners, the Board of Chiropractic Examiners, the Board of Naturopathic Examiners, and Nurse Practitioners licensed by the Board of Nursing may be designated as attending physicians.

(2) Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service, or by persons not licensed to provide a medical service who work under the direct control and supervision of the attending physician.

(3) The insurer may pay for treatment by prayer or spiritual means.

(4) A physician assistant, registered under ORS 677.515, may provide services and be reimbursed as provided by OAR 436-10-090(9) only under the following conditions:

(a) The physician assistant is approved for independent practice by the Board of Medical Examiners.

(b) The physician assistant may prescribe treatment to be performed by others only when the person who is to provide the treatment is licensed to do so.

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Renumbered from OAR 436-69-301, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88

436-10-060 Choosing And Changing Doctors

(1) A newly selected attending physician shall notify the insurer not later than five (5) days after the date of change or first treatment, using Form 829 (Change of Attending Physician).

(2) The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician who shall promptly notify the insurer of the request. Fees for treatment by more than one physician at the same time are payable only when the medical conditions present are related to the treatment of the compensable injury or illness and are sufficiently different that separate medical skills are needed for proper treatment.

(3) The worker is allowed to change physicians by choice two times after the initial choice. Referral by the attending physician to another attending physician, regardless of whether at the request of the claimant or on the physician's own initiative, shall count in this calculation. Examinations at the request of the insurer, and consultations requested by the attending physician, do not constitute a change in attending physician.

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

(4) When a worker has made an initial choice of attending physician and subsequently changed two times, the insurer shall inform the worker by certified mail that any subsequent changes must have the approval of the insurer or the director.

In the event that the worker again changes physician without the approval of the insurer, the insurer may deny payment for services rendered by the additional physician and inform the claimant of the right to seek approval of the director.

If a physician begins treatment without being informed that the worker has been given the required notification the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made.

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Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
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436-10-070 Elective Surgery

(1) When the attending surgeon believes elective surgery is needed for occupational injury or illness, the surgeon shall give the insurer actual notice at least five (5) working days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, an estimate of the surgical date, and the hospital where surgery is to be performed. The notice of intent to perform surgery must come from the surgeon who intends to perform the operation.

(2) When elective major orthopedic or neurological surgery is recommended, the insurer may recommend an independent consultation with a physician of the insurer's choice. The insurer shall notify the attending physician within five (5) days if a consultation is desired. The consultation shall be scheduled within seven (7) days, and take place no later than thirty (30) days, after notice to the attending physician.

(3)(a) Upon receipt of the consultant's report, the insurer shall notify the surgeon within 72 hours whether payment will be made for the proposed surgery.

(b) If the surgeon and consultant disagree about the need for surgery, the insurer may inform the claimant of the consultant's opinion. The decision as to whether or not to proceed with surgery remains with the surgeon and the claimant.

(4) A physician who proceeds to perform elective major orthopedic or neurological surgery without providing the insurer with the required prior notification and opportunity to obtain consultation shall be subject to penalties as provided in OAR 436-10-130(2). If a financial penalty is imposed on the surgeon for violation of these rules in the form of a fine or reduction or recovery of fees, no part of such fine or reduction or recovery of fees may be sought from the claimant.

(5) Surgery which must be performed promptly, i.e., before five (5) 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 surgeon should endeavor to notify the insurer of the need for emergency surgery.

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

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436-10-080 Determination Of Impairment

(1) When the patient has become medically stationary from the compensable injury or illness, the attending physician shall notify the insurer. If there is no permanent impairment the attending physician shall so state. If there is permanent impairment, the attending physician may elect to perform a closing examination prior to writing a complete report. A reasonable fee may be charged for the examination and report.

(2) The report must contain all pertinent objective findings such as loss of member, measured ranges of motion, strength, measurable atrophy, muscle spasm, reflex changes, sensory changes, etc. The physician does not rate disability, but describes impairments. The division shall prescribe by bulletin the method and format in which the examination findings shall be reported.

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436-10-090 Charges And Fees

(1)(a) Hospital charges billed to insurers shall include appropriate ICD-9 diagnostic codes and the appropriate diagnostic related group (DRG) number. Insurers shall reimburse hospitals for inpatient hospital and outpatient surgical services rendered on or after February 1, 1990, using the current adjusted cost/charge ratio. Insurers shall audit each bill for inpatient services and outpatient surgical services for mathematical accuracy and compensability. The resulting sum shall be multiplied by a hospital's adjusted cost/charge ratio to determine the allowable payment.

(b) A hospital's HCFA form 2552 shall be the basis for determining its adjusted cost/charge ratio. The basic cost/charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A shall be modified by adding the adjustments to expenses for both the "Malpractice Premiums and/or Self-Insurance Fund Contributions" shown on line 37 (less line 37-A) of Worksheet A-8, and the "Provider-Based Physician Adjustments" on lines 8 and 9 of Worksheet A-8.

(d) The basic cost/charge ratio shall be further modified to allow for a return on equity where applicable, and/or to cover any patient related services not otherwise included in the ratio calculated in subsection (b) above. The actual calculation will consist of multiplying the difference of 1.000 less the ratio calculated in subsection (b) above, by 15 percent. The resulting figure shall be added to the ratio calculated in (b) to obtain the adjusted cost/charge ratio.

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

(e) The adjusted cost/charge ratio schedule shall be revised annually. On or before October 1 of each year, each hospital shall submit a copy of their most recently filed form 2552 to the division. On or before January 20 of each year, the division shall publish by bulletin the revised adjusted cost/charge ratio schedule for hospitals, to be effective for the subsequent twelve-month period beginning February 1.

(f) For those newly formed or established hospitals for which no HCFA form 2552 has been filed, or for those hospitals that do not file Worksheet G-2 with the submission of their HCFA form 2552, the division shall determine an adjusted cost/charge ratio for the hospital based upon the adjusted cost/charge ratios of a group of hospitals of similar size and/or geographic location.

(g) If the financial circumstances of a hospital unexpectedly and/or dramatically change, the division may revise the hospital's adjusted cost/charge ratio to allow equitable payment.

(h) If audit of a hospital's HCFA form 2552 by the Health Care Financing Administration produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost/charge ratio to reflect the data developed subsequent to the initial calculation.

(i) Notwithstanding subsection (e), the division shall compute the adjusted cost/charge ratios for the twelve-month period beginning February 1, 1990, using the HCFA forms filed with the Adult and Family Services Division of the Department of Human Services as of December 31, 1989.

(2) The insurer may not pay any more than the medical provider's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 75th percentile of the usual and customary fees as determined by the director, and as published and attached hereto as Appendix "A". The medical provider may not attempt to collect from the injured worker any sums deleted by the insurer.

(3) The director shall review and update medical fees annually by bulletin using data from a statistically valid survey, the physician service component of the National Consumer Price Index, or from any state agency having access to usual and customary medical fee information.

(4) When there is a dispute about a fee for a medical service for which no CPT code or relative value has been established, the director shall determine and promulgate a reasonable fee for the services, which shall be the same for all primary health care providers. The director shall issue an order to all parties establishing the fee in the particular case and shall apply the fee to all similar disputes which arise. The director shall incorporate the fee into the department's relative value scale at the next hearing on the medical service rules. When determining such a fee the director shall consider:

- (a) The relative difficulty of the service
- (b) The fee for like or similar services; and

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

(c) The skill, time, risk and investment of the medical provider and other medical providers in delivering the service.

(5) All billings shall be fully itemized and services identified by code numbers and descriptions found in the Current Procedural Terminology or as described in OAR 436-10-040(12)(a) through (j). Hospitals may bill for inpatient services and surgery using the International Classification of Diseases, 9th edition--with Clinical Manifestations (ICD9-CM). The definitions of commonality in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services.

(6) Beginning January 1, 1989, all medical providers shall submit bills for medical services on form UB82 or 1980 or 1984 form HCFA 1500. Billings shall include the claimant's full name, date of injury, the employer's name and, if available, the insurer's claim number. Billings not correctly filled out may be returned to the medical provider for correction and resubmission. All medical provider billings shall be accompanied by chart notes documenting services which have been billed.

(7) When a provider of medical services, including a hospital, submits a bill to an insurer for medical services, the medical provider shall submit a copy of such bill to the worker to whom the services were provided. The copy to the worker shall be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the worker.

(8) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The medical provider may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness.

(9) The medical provider shall bill the medical provider's usual fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public.

(10) The medical provider shall not bill for services not provided to the worker, nor shall the medical provider bill multiple charges for the same service. Rebillings shall indicate that the charges have been previously billed.

(11) Medical providers shall not submit false or fraudulent billings. As used in this section, "false or fraudulent" shall mean an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person.

(12) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided. Any service not identifiable with a code number shall be adequately described.

(13) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings will be subject to discounts, not to exceed 10 percent, for each 30 day period or fraction thereof, beyond 60 days.

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

(14) Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

(15) When services are provided in hospital emergency or outpatient departments which are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes and reimbursed at no more than the 75th percentile as shown in the department's relative value schedule. Such services include outpatient physical therapy, outpatient X-rays and emergency department treatment and physician's services.

When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment.

(16) Physician's assistants or nurse practitioner fees will be paid at the rate of 80 percent of a physician's fee for a comparable service except that assisting in surgery shall be paid at the rate of 50 percent of the comparable fee for a physician assisting in surgery.

(17) Laboratory fees shall be billed in accordance with ORS 676.310. If the attending or consulting physician submits a bill for laboratory services that were performed in an independent laboratory, the bill shall show the amount charged by the laboratory and any service fee that the attending or consulting physician charges.

(18) Physician mark-up shall not exceed 20 percent for braces, supports and other medical devices with a unit price greater than \$25. Invoices for these devices shall be provided on request of insurer.

(19) Fees for surgical procedures shall be billed as follows:

(a) When two surgeons operate and one performs a discectomy and one performs an arthrodesis, each procedure is to be billed separately. The maximum allowable fee for each procedure, as listed in the Relative Value Schedule, shall be reduced by 25 percent.

When the surgeons assist each other throughout the operation each may bill an additional fee of 20 percent of the other surgeon's fee as an assistant's fee.

When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' fees.

(b) When one surgeon performs a discectomy and arthrodesis the procedure shall be billed under CPT Codes 22550-22565 and/or CPT Codes 22730-22735.

(c) When multiple surgical procedures are performed, the principal procedure is reimbursed at 100 percent of the maximum allowable fee, the secondary procedure is reimbursed at 50 percent of the maximum allowable fee and all subsequent procedures are reimbursed at 25 percent of the maximum allowable fee.

(d) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value in the RVS and the subsequent procedures paid at 10 percent of the value listed in the RVS.

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

(e) Surgery following severe trauma, for which several procedures are required and which take considerable time, and for which the surgeon feels his fees should not be reduced, can receive special consideration by the insurer. Such a request must be accompanied by written documentation and justification.

(f) Hospital charges for inpatient myelograms are not subject to the Relative Value Schedule. Physician's services for inpatient myelograms are subject to the Relative Value Schedule.

(20) When two bills are submitted for an X-ray, one by the person taking the X-ray (technical component) and one by the radiologist who interprets the X-ray (professional component), the maximum allowable fee is to be divided between them.

The technical component is reimbursed at 60 percent of the maximum allowable fee and the professional component is reimbursed at 40 percent of the maximum allowable fee.

(21) Outpatient hospital service shall be billed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the Relative Value Schedule, are to be applied to hospital bills only for outpatient services.

(b) CAT scans, when performed as an outpatient service, are subject to the limitations of the Relative Value Schedule. When multiple areas are examined by CAT scan, the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the Relative Value Schedule.

(22) A physical medicine modality or manipulation, when applied to two or more areas at one visit, shall be reimbursed at 100 percent of the maximum allowable fee for the first area treated, 50 percent for the second area treated, and 25 percent for all subsequent areas treated.

(23) When ultrasound, diathermy, microwave, ultraviolet and hot packs are used in combinations of two or more during one treatment session, only one shall be reimbursed.

(24) When multiple treatments are provided simultaneously by a table, machine or device there shall be a notation on the bill that treatments were provided simultaneously by a table, machine or device and there shall be one charge.

(25) Effective January 1, 1991, treatment in a pain center program, physical rehabilitation program or a substance abuse program is not reimbursable unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (C.A.R.F.) or the Joint Commission on Accreditation of Healthcare Organizations (J.C.A.H.O.)

(26) Dimethylsulfoxide (DMSO) is not reimbursable except for treatment of compensable interstitial cystitis.

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

(27) When multiple areas are examined using Magnetic Resonance Imaging (MRI) the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the Relative Value Schedule.

(28) Mechanical muscle testing shall be reimbursable three times during a treatment program: once near the beginning, once near the middle and once near the end of the treatment program. Additional mechanical muscle testing is reimbursable only when authorized by the insurer prior to the testing. The fee for mechanical muscle testing includes an interpretation of the results and a report.

(29) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, the costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer. Modifiers from the CPT shall be used to indicate reduced billing.

(30) Fees for reports:

a. A medical provider may not charge any fee for completing a medical report form required by the director under this chapter.

b. Copies of office progress notes when requested by insurer - 25 cents a page

c. Brief Narrative - Summary of Rx to date and current status; answer to 3-5 specific questions - \$25

d. Complete narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary? - \$50

(31) Fee for a deposition (Includes preparation time):

a. First hour \$300;

b. Each subsequent hour \$100

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Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-091 Continuing Medical Education

(1) The professional associations required to provide continuing education in Workers' Compensation are those of the following licensed medical service providers: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Doctor of Naturopathy, Doctor of Podiatric Medicine, Doctor of Dental Surgery or Doctor of Dental Medicine, Nurse Practitioner and Licensed Physical Therapist.

(2) The continuing education program shall be made available to all similarly licensed medical service providers irrespective of membership in the association.

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

(3) The continuing education program shall consist of a minimum of two hours of instruction, to include: history of Workers' Compensation; ORS Chapter 656; claims processing (insurer, Evaluation Section, Hearings Division), and the Department Medical Rules.

(4) Professional associations shall require the provider of continuing medical education to maintain a list of all licensed medical service providers who have attended a session of continuing education in Workers' Compensation and provide each attendee with a Certificate of Attendance.

(5) After January 1, 1989, any medical provider who cannot document attendance at a continuing education session in Workers' Compensation will be subject to penalties pursuant to ORS 656.254 3(d). Under the provisions of ORS 183.310 to 183.550 the Director may impose a sanction of forfeiture of fees and may declare a medical service provider ineligible for reimbursement for treating Workers' Compensation claimants until attendance at a continuing education in Workers' Compensation session is documented.

(6) The professional associations shall update the continuing education program after every regular session of the Legislature and provide a mechanism for providers to document participation in the update.

(7) Professional associations shall submit the content of the continuing education programs to the Director for approval prior to dissemination to providers.

Hist: Filed 6/7/88 as Admin. Order 2-1988 Temp., eff. 6/7/88
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436-10-095 Advisory Committee on Medical Care

(1) The Advisory Committee on Medical Care shall be appointed by the director pursuant to ORS 656.794.

(2) Committee members shall be reimbursed necessary travel and other expenses from the administrative fund.

(3) Committee members shall submit to the director, no later than the end of the quarter the expenses were incurred, a standard expense voucher for reimbursement.

(4) The committee shall elect a chairman and vice chairman from its members and establish their terms of office.

(5) The committee shall consist of two Doctors of Medicine, one Doctor of Osteopathy, one Doctor of Chiropractic, one Doctor of Naturopathy and either one Doctor of Dental Surgery or one Doctor of Dental Medicine, all of whom shall be qualified to be attending physicians. The committee shall also include one representative each of insurers, employers and workers.

(6) The members shall serve at the pleasure of the director.

(7) The duties of the committee shall include:

(a) To advise the director on matters relating to the provision of medical care to injured workers.

(b) To review proposed standards for medical evaluation of disabilities, and any proposed future changes in the standards, and to make recommendations to the director.

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

(c) To prepare and submit to the director rules governing the provision of medical care for compensable conditions, including the rates for medical service, and to advise the director on any other proposed rules regarding medical care.

(d) To advise the director on medical care questions.

(8) The medical director shall provide liaison between the committee and the director and shall provide staff and administration support to the Committee.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

436-10-100 Insurer's Rights and Duties

(1)(a) The director or insurer may obtain medical examinations of the worker by physicians of their choice. The number of such examinations is limited by ORS 656.325 to three separate medical examinations during each open period of a claim. A claim for aggravation permits a new series of three medical examinations. In the event the insurer believes that a need exists for more than three examinations, the insurer shall request approval of the director. In arriving at a decision the director will consider such matters as the date of injury, date of last examination, nature of examinations that have been performed, the complexities of the medical issues. The worker shall be notified of the purpose of the examination. Such examinations shall be at places, times, and intervals reasonably convenient to the worker, and shall not delay or interrupt proper treatment of the worker. The person conducting the examination shall determine the conditions under which the examination will be conducted, including but not limited to, whether a video camera, tape recorder or third party may be present at the examination.

(b) The examiner shall promptly send a copy of the report to the attending physician and the insurer or person requesting the exam.

(c) Any physician who unreasonably and without good cause interferes with the right of the insurer to obtain examination by physicians of their choice may be subject to penalties.

(d) Independent Medical Examination (IME) is a special consultation which may be requested only by the insurer or with the insurer's prior authorization. The fee for an IME is to be agreed upon prior to the examination. When a worker known to be represented by a lawyer is scheduled for an IME, the worker's lawyer shall be sent simultaneously a copy of the notification sent to the worker.

(e) When a worker is required to attend an IME the insurer shall pay for the examination and all necessary related services which include, but are not limited to, child care, travel, meals and lodging. The insurer shall reimburse the worker within 60 days of receipt of an itemized bill and appropriate receipts.

(2) An examination obtained at the request of the Evaluation Section is not considered one of the three examinations allowed to the insurer.

(3) Insurer shall pay bills for medical services within 60 days of receipt of the bill, if the billing is submitted in proper form and clearly shows that the treatment is related to the accepted compensable injury or disease. Failure to do so shall render

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

insurer liable to pay a reasonable monthly service charge after the 60th day, if the provider customarily levies such a service charge to the general public.

(4) In claims which have been denied and are on appeal, the insurer shall notify the vendor promptly of any change of status of the claim.

(5) In the event of a dispute over portions of a billing, the insurer shall pay within 60 days the undisputed portion of the bill.

(6) In the event a vendor of medical services feels aggrieved by the conduct of an insurer, the vendor may request review by the division, pursuant to OAR 436-10-115(1). If the matter involves a fee or billing dispute that is 180 days old or less, the vendor may appeal to the division pursuant to OAR 436-10-110(1).

(7) The limitations of the workers' right to choose attending physicians (ORS 656.245) begin with the date of injury and extend through the life of the claim.

(8) The insurer shall establish an audit program for bills for all medical services to determine that services are billed as provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director and that bills are submitted in a timely manner. The audit shall be continuous and shall include no fewer than 10 percent of medical bills. The insurer shall provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation shall include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(9) When authorizing payment for out-of-state treatment, the insurer shall agree with the medical provider both on the fee to be paid and that the medical provider will not request additional payment from the worker. Where the insurer and medical provider cannot agree upon a fee, the insurer shall inform the medical provider that the payment will not be in excess of that allowed by the Oregon fee schedule, and that acceptance of reimbursement is conditioned upon the medical provider foregoing collection efforts against the worker.

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436-10-105 Disability Prevention Services

(1) Whenever a worker's file indicates the worker's compensable injury disability would improve, or worker's return to work would be expedited by disability prevention services, the insurer shall immediately schedule the worker into such services. The insurer may first schedule the worker for an evaluation to determine if/what services are required.

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

(2) When a worker is scheduled into disability prevention services, the insurer shall keep a record showing the provider, the services to be provided, the goal of the services, and the anticipated time of completion.

(3) One hundred and twenty days after the worker has suffered a disabling compensable injury, or has made a claim for aggravation for such an injury, the insurer shall ascertain whether the worker has returned to work and is still working, and shall report as prescribed in (4) and (7) of these rules to the Department unless:

(a) A report has already been made to the Department that the worker is being provided vocational assistance services (OAR 436-120-170); or

(b) A determination order has been requested or issued, or

(c) A notice of claim closure has been issued.

(4) The report shall be submitted to the Department no later than the 135th calendar day after the date of injury or date the claim is made for aggravation, and shall include, but not be limited to:

(a) A description of the worker's disability prevention program and anticipated date of completion of the program;

(b) Whether the worker has returned to work and is still working;

(c) Whether the worker is medically stationary;

(d) Whether the attending physician believes the worker is capable of participating in a disability prevention services program.

(5) A worker not receiving disability prevention services at the time of the report shall be immediately scheduled for such services, including an evaluation if necessary. An evaluation, if performed, shall not be considered an independent medical examination under ORS 656.325.

(6) The form and format of the report shall be prescribed by department bulletin.

(7) The insurer shall submit a report to the Department within 5 days of the date a workers vocational assistance plan is closed, or has been interrupted 120 calendar days, for medical reasons.

(8)(a) Reports submitted pursuant to ORS 656.335 shall be reviewed to determine if appropriate disability prevention services are being provided the worker.

(b) If service being provided is determined by a medical review not to be preparing the worker for return to gainful employment, the director may order the insurer to provide appropriate disability prevention services.

(9) The insurer may be required to submit monitoring reports regarding a worker's progress in a disability prevention service program.

(10) If a worker, insurer, or attending physician disagrees with the determination of the Department, an appeal to the director may be made. The director shall review the matter and issue a written decision.

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

(11) Any party aggrieved by an action taken under the rules which affects the worker's claim may request a hearing in accordance with ORS Chapter 656 and the Workers' Compensation Board Rules of Practice and Procedure for Contested Cases.

(12) An insurer who fails to report as required by ORS 656.335 may be subject to penalties as provided by OAR 436-10-110(6).

Hist: Filed 6/26/86 as Admin. Order 4-1986, ef. 7/1/86

436-10-110 Fee Disputes

(1)(a) In the event of a dispute about fees between the vendor and the insurer, either may request review by the division. The review request shall be in writing and must:

- (A) State the grounds for questioning the disputed amount;
- (B) Include the specific contention of error;
- (C) State the request for correction and relief; and
- (D) Include sufficient documentation to support the review request.

(b) The division shall return the review request to the originating party for completion if the application does not satisfy the requirements of this rule.

(2) The division shall investigate the matter upon which review was requested. The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider's peers.

(3) Upon completion of the investigation of a fee dispute, the division shall order the relief necessary to resolve the dispute. Either party may appeal to the director within thirty (30) days of the decision, pursuant to OAR 436-10-008.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-901, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-115 Complaints of Rule Violation

(1)(a) Complaints pertaining to violations of these rules shall be directed in writing to the division. The complaint must:

- (A) State the grounds for alleging rule violation;
- (B) Include the specific contention of error;
- (C) State the complainant's request for correction and relief; and
- (D) Include sufficient documentation to support the complaint.

(b) The division shall return the complaint to the originating party for completion if the application does not satisfy the requirements of this rule.

(2) The division shall investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and

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

payment records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers.

(3) If the division determines upon completion of the investigation that there has been a rule violation, the division may issue penalties pursuant to OAR 436-10-130.

Hist: Filed 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-130 Sanctions and Civil Penalties

(1) If the medical director finds any violation of OAR 436-10-040, 436-10-045, 436-10-050, 436-10-060 or 436-10-100(1)(c) the director may impose, one or more of the following sanctions;

- (a) Reprimand by the director;
- (b) Nonpayment or recovery of fees in part, or whole, for services rendered;
- (c) Referral to the appropriate licensing board.

(2) If the medical director finds any violation of the rules enforcing the provisions of ORS 656.248, 656.252 and 656.254 as found in OAR 436-10-030, 436-10-040(1), 436-10-070, 436-10-080 and 436-10-090 of these rules, the director may impose, one or more of the following sanctions:

- (a) Reprimand by the director;
- (b) Nonpayment or recovery of fees in part, or whole, for services rendered;
- (c) Referral to the appropriate licensing board; or
- (d) Civil penalty not to exceed \$1,000 for each occurrence. In determining the amount of penalty to be assessed, the director shall 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.

(3) (a) The director may impose a penalty of forfeiture of fees and a fine not to exceed \$1,000 for each occurrence any health care practitioner who, pursuant to ORS 656.254, has been found to:

- (A) Fail to comply with the medical rules; or
- (B) Provide medical treatment that is excessive, inappropriate or ineffectual; or
- (C) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(b) Notwithstanding ORS 656.254(3)(a), if the complaint against a medical provider is made pursuant only to (A) above, the director need not submit the issue of whether or not a medical provider violated the administrative rules to a medical panel.

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

(c) If the conduct as described in paragraph (a) above is found to be repeated and willful, the director may declare the practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(d) A health care practitioner 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 claimants for a period not to exceed three years. A certified copy of the revocation or suspension order shall be prima facie justification for the director's order.

(4)(a) If an insurer or worker believes penalties under (3)(a) and/or (3)(c) of this section are appropriate, either may submit a complaint in writing to the director, pursuant to OAR 436-10-115.

(b) The director shall investigate the allegations and may seek advice from the Advisory Committee on Medical Care, practitioner's licensing boards, professional associations or a medical panel established under OAR 436-10-046.

(c) At the completion of the investigation, the director may adopt the recommendations of the Advisory Committee on Medical Care, licensing board, professional association or medical panel, and may assess civil penalties as provided in (3)(a) above.

(5) Insurers who violate these rules shall be subject to the penalties in ORS 656.745.

Hist: Formerly OAR 436-10-110
Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-901, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90

436-10-135 Service Of Orders

(1) When the director imposes a sanction or assesses a penalty under the provisions of 436-10-130, the order, including a notice of the party's appeal rights, shall be served on the party.

(2) The order shall be served by:

(a) Delivering a copy to the party in the manner provided for personal service in Rule 7 D.(2), Oregon Rules of Civil Procedure; or

(b) Sending a copy to the party by certified mail with instructions to deliver to the addressee only, return receipt requested. If the party is a corporation, the certified mail may be delivered to any person named in Rule 7 D. (3)(b), Oregon Rules of Civil Procedure.

(3) Orders issued pursuant to these rules shall contain the following notice:

"IF YOU DISAGREE WITH THIS ORDER, YOU MAY REQUEST A HEARING. YOUR REQUEST MUST BE IN WRITING, DIRECTED TO THE DIRECTOR, DEPARTMENT OF INSURANCE AND FINANCE, LABOR AND INDUSTRIES BUILDING, SALEM, OREGON 97310. THE REQUEST MUST SPECIFY THE GROUNDS UPON WHICH YOU CONTEST THE ORDER. THE REQUEST FOR HEARING MUST BE RECEIVED BY THE DEPARTMENT WITHIN 30 CALENDAR DAYS AFTER YOU RECEIVE THIS ORDER. IF YOU DO NOT FILE A REQUEST FOR HEARING WITHIN

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

THE TIME ALLOWED, THIS ORDER WILL BECOME FINAL AND WILL NOT BE
SUBJECT TO REVIEW BY ANY AGENCY OR COURT."

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Renumbered from OAR 436-69-903, 5/1/85
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
(formerly OAR 436-10-010)

DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICE

APPENDIX A
OREGON RELATIVE VALUE SCHEDULE
FOR MEDICAL SERVICE

(1) The coding structure is that of the Current Procedural Terminology (CPT), Fourth Edition, 1985.

(2) There are five sections, each of which has its own schedule of relative values which is completely independent of and unrelated to any of the other four sections.

(3) In each section the code unit is followed by a relative value number, when such has been established. When no value has been established, the provider must submit with the billing a description of the service in detail sufficient for the payor to judge whether the fee is reasonable.

(4) In the surgery section, a third column shows the number of days of post-operative care included in the fee.

(5) In the radiology section, the second column shows the total value of an examination, i.e., costs of X-ray film, interpretation and making a report of the study.

(6) Physicians who inject air, contrast material or isotopes as part of a radiologic study shall bill for this service using CPT codes from the surgery section, e.g. 62284 - injection for myelography.

(7) The Definitions and Items of Commonalty, Current Procedural Terminology, pp. xiv - xviii, 1985, and the definitions in OAR 436-10-040(12), shall be the basis for determining levels of service. A disagreement about the level of service may be referred, by the physician, to the Medical Director, who may resolve the issue in favor of either party.