

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

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

**MEDICAL SERVICE**

**EFFECTIVE DECEMBER 26, 1990**

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**EXHIBIT "A"  
OREGON ADMINISTRATIVE RULES  
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**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 656.245, 656.248, 656.252, 656.254, 656.268, 656.325, 656.327, 656.794(3), and Sections (12) & (13), Chapter 2, Oregon Laws 1990, Special Session.

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

Hist: Filed 1/14/72 as Admin. Order 1-1972, eff. 1/1/72  
Amended 10/20/76 as Admin. Order 4-1976, eff. 11/1/76  
Amended 6/5/78 as Admin. Order 7-1978, eff. 6/5/78  
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80  
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Re-numbered from OAR 436-69-003, 5/1/85  
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-002 Purpose**

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

Hist: Filed 1/5/90 as Admin. Order 1-1990, eff. 2/1/90  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-003 Applicability Of Rules**

(1) These rules are effective December 26, 1990 to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.268(7), 656.325, 656.327 and 656.794, and govern all providers 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, and other such rules specifying charges and fees, shall be applicable to all services rendered subsequent to the effective-date of these rules.

(3) These rules apply to all compensable claims existing or arising on or after July 1, 1990.

(4) The provisions of OAR 436-10-041, and 046 shall apply to all disputes and requests for palliative care review received by the director on or after the effective date of these rules.

(5) The provisions of OAR 436-10-041 as amended shall also apply to all palliative care requests filed with insurers from July 1, 1990 to the effective date of these rules, where the insurer has failed to approve or disapprove of the palliative care request prior to or within 30 days after the effective date of these rules.

Hist: Filed 10/20/76, as Admin. Order 4-1976, eff. 11/1/76  
Filed 6/5/78 as Admin. Order 7-1978, eff. 6/5/78  
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Amended 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  
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 Amended 12/10/85, as Admin. Order 6-1985; eff. 1/1/86  
 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 (formerly OAR 436-10-004)  
 Amended 1/24/90 as Admin. Order 3-1990, eff. 2/1/90 (Temporary)  
 Amended 4/29/90 as Admin. Order 4-1990, eff. 5/1/90 (Temporary)  
 Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)  
 Amended 8/7/90 as Admin. Order 16-1990, eff. 8/7/90  
 Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-005 Definitions**

For the purpose of these rules 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 and who is:

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

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

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

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

(e) A person authorized to be an attending physician, in accordance with a managed care organization contract.

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

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

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

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

(6) "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. A consulting physician may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensation injury.

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- (7) "Current Procedural Terminology" or "CPT" means the Current Procedural Terminology, most recently published by the American Medical Association.
- (8) "Customary Fee" means a fee that falls within the range of fees normally charged for a given service.
- (9) "Department" means the Oregon Department of Insurance and Finance, including the Board, the Director and all their assistants and employees.
- (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. 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.
- (11) "Director" is the Director of the Department of Insurance and Finance or the Director's delegate for the matter.
- (12) "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.
- (13) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance, consisting of the Compliance Section, Evaluation Section, Medical Review and Abuse Section, and Rehabilitation Review Section.
- (14) "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.
- (15) "First Chiropractic Visit" means a worker's first visit to a chiropractic physician on the initial claim.
- (16) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.
- (17) "Health Care Provider" means an entity or group of entities, such as a medical clinic, a hospital, or group of medical clinics or hospitals, organized to provide a facility for medical care and medical services.
- (18) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.
- (19) "Hospital" means an institution licensed by the State of Oregon as a hospital.
- (20) "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.
- (21) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

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(22) "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 which has been certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

(23) "Major Orthopedic or Neurologic Surgery" means operations on the brain, 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.

(24) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and is certified in accordance with OAR 436, Division 15.

(25) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or related services such as any medication, crutch, prosthesis, brace, support or physical restorative device.

(26) "Medical Service provider" means a person duly licensed to practice one or more of the healing arts in that state.

(27) "Medical Provider" means a medical service provider or a health care provider.

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

(29) "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician pursuant to ORS 656.005 and subsections 1(c) and 1(d) of this rule.

(30) "Objective Findings" means those findings on examination including, but not limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence (test results) substantiated by clinical findings.

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

(32) "Palliative Care" means a medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition as compared to those medical services rendered to diagnose, heal or permanently alleviate or eliminate an undesirable medical condition.

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

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

(35) "Promptly" means without delay.

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

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

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

(39) "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.

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

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

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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) Any party, as defined by ORS 656.005(20) and including SAIF Corporation as a designated processing agent pursuant to ORS 656.054, aggrieved by an action taken pursuant to these rules in which a worker's right to compensation, or the amount thereof, is 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

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Contested Cases under the Workers' Compensation Law except where otherwise provided in ORS chapter 656.

(2) If the worker, insurer, or SAIF Corporation as a designated processing agent pursuant to ORS 656.054 is aggrieved by an order of the director, issued pursuant to ORS 656.327(1), that no bona fide medical services dispute exists, it may appeal the order. The request for review shall be in accordance with ORS chapter 656 and the Board's Rules of Practice and Procedures for Contested Cases under the Workers' Compensation Law. The request for review shall be made directly to the Workers' Compensation Board within 30 days of the issuance of the order which is the date of mailing or other service of an order. Upon review, the order of the director may be modified only if not supported by substantial evidence in the record created by the director.

(3) If the worker, insurer, SAIF Corporation as a designated processing agent pursuant to ORS 656.054, or medical service provider is aggrieved by an order of the director issued pursuant to ORS 656.327(2) relating to any bona fide medical services dispute, it may request a review by the Hearings Division of the Workers' Compensation Board on said order. The request for review shall be in accordance with ORS chapter 656 and the Board's Rules of Practice and Procedures for Contested Cases under the Workers' Compensation Law. Review of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the board, except the order of the director may be modified only if it is not supported by substantial evidence in the record created by the director.

(4) Any party as described in section (3) aggrieved by a proposed order or proposed assessment of civil penalty of the division issued pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740.

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing shall be granted unless the request is in writing and specifies the grounds upon which the person requesting said hearing contests the proposed order or assessment.

(b) The request for hearing must be filed with the administrator of the Workers' Compensation Division within 20 days of receipt by the aggrieved person of notice of the proposed order or assessment. No hearing shall be granted unless the request is received by the administrator within said 20 days of receipt of notice.

(5) Any party as described in section (3) aggrieved by an action or order of the division pursuant to these rules, other than as described in sections (2), (3) and (4), where such action or order qualifies for review by hearing before the director as a contested case, may request review pursuant to ORS 183.310 through 183.550 as modified by these rules pursuant to ORS 183.315(1). When the matter qualifies for review as a contested case, the process for review shall be as follows:

(a) The request for hearing must be sent in writing to the administrator of the Workers' Compensation Division. No hearing shall be granted unless the request is in writing and specifies the grounds upon which the action or order is contested and is received by the administrator within 30 days of the action or from the date of mailing or other service of an order.

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(b) The hearing shall be conducted by the director or the director's designee.

(c) Any order in a contested case issued by another person on behalf of the director is a proposed order subject to revision by the director. The director may allow objections to the proposed order to be filed for the director's consideration within 30 days of the mailing date or other service of the proposed order.

(6) Any party as described in section (3) aggrieved by an action taken by persons other than the division pursuant to these rules except as described in sections (1) through (5) above may request administrative review by the division on behalf of the director, except as otherwise provided in this section. Only the insurer or attending physician aggrieved by an order approving or disapproving palliative care to enable an injured worker to continue current employment may request review by the director pursuant to OAR 436-10-041. The process for administrative review permitted by this section shall be as follows:

(a) The request for administrative review shall be made in writing to the administrator of the Workers' Compensation Division within 90 days of the action. No administrative review shall be granted unless the request specifies the grounds upon which the action is contested and is received by the administrator within 90 days of the contested action unless the director or his designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) The review, including whether the request is timely and appropriate, may be conducted by the administrator, or the administrator's designee, on behalf of the director.

(c) In the course of said review the person conducting the review may require or allow such input or information from the parties or others as he or she deems to be helpful.

(d) The person conducting the review will specify in his determination if a party aggrieved thereby may request a contested case hearing before the director pursuant to ORS 183.310.

(e) Any request for a contested case hearing before the director regarding a review determination made pursuant to this section must comply with the procedures provided in section (5) above.

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Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-030      Reporting Requirements for Medical Providers**

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any physician, hospital, or other medical service provider to supply relevant information regarding the worker's occupational injury or illness to the insurer, the managed care organization, 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 or other conditions related to the same body part. 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

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the work related injury or illness and is not subject to revocation by the worker or the worker's representative.

(2) The first medical service provider on the initial claim 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) All medical service providers shall notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss.

(4) Attending physicians shall submit verification of the worker's inability to work resulting from an occupational injury or disease upon request from the insurer. Medical services provided by the attending physician are not compensable until the attending physician submits such verification. In addition to attending physicians, the following medical service providers may authorize time loss:

(a) For a period of 30 days from the date of the first visit on the initial claim, nurse practitioners certified by the Oregon State Board of Nursing and physician assistants registered by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type A, Type B, or Type C rural hospitals described in ORS 442.470 and as prescribed in OAR 436-10-050(5).

(b) A medical service provider who by MCO contract has been designated to be able to authorize temporary disability compensation.

(5) 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 may suffice to give the insurer all the information the insurer needs.

(6) Reports may be handwritten but all shall be legible and include all relevant or requested information.

(7) Chart notes shall be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(8) The medical provider shall promptly respond to the request for progress reports and narrative reports. If the medical provider fails to comply with this requirement within 14 days, the insurer may send another request by certified mail, return receipt requested. If within 14 days the medical provider has not complied with this request, penalties under OAR 436-10-130 or 436-15-120 may be imposed.

(9) 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 any medical provider can determine these matters they must

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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.

(10) At the time the attending physician examines the worker and declares the worker medically stationary, the attending physician shall promptly notify the worker, the insurer, and all other medical providers who are providing services to the worker. The attending physician shall also promptly send a report to the insurer. The report shall contain all information required in accordance with OAR 436-10-080.

(11) The attending physician shall advise the insurer and the worker within 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.

(12) The attending physician shall, after a claim has been closed, advise the insurer within 5 days after treatment is resumed and the reopening of a claim is recommended. A report from an attending physician establishing a worsened condition, supported by objective findings is a claim for aggravation, as defined by ORS 656.273 and OAR 436-60-005. The attending physician need not be the same physician who released the worker when the claim was closed.

(13) Consultations. The attending physician may request consultation regarding conditions related to an accepted claim. The attending physician shall promptly notify the insurer of the request for consultation. This requirement does not apply to diagnostic studies performed by radiologists and pathologists. The attending physician shall provide the consultant with all relevant clinical information. The consultant shall submit a copy of his consultation report to the attending physician and the insurer within 14 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report.

(14) When an injured worker elects to change attending physicians, the newly selected attending physician shall so notify the insurer not later than 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).

(15) 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.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82  
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Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88  
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 Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-040 Medical Services**

(1)(a) Medical services, including diagnostic services, provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards, or to these rules, or which are unrelated to the compensable injury are not reimbursable.

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

(2) Frequency and extent of treatment shall not be more than the nature of the injury or the process of a recovery requires, and shall be provided in accordance with utilization and treatment standards as prescribed by the department, or pursuant to a MCO contract. Insurers have the right to require evidence of the efficacy of treatment. Unless otherwise provided for by statutes, utilization and treatment standards established by the department or MCO contract, 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 provision of or limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided.

(3)(a) Ancillary services including, but not limited to, physical therapy, biofeedback or acupuncture by a medical service provider other than the attending physician shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment 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 signed treatment plan shall be promptly provided to the insurer by the attending physician.

(b) Medical services prescribed by an attending physician and provided by a chiropractor or naturopath shall be subject to the treatment plan requirements set forth in (3)(a) of this rule.

(c) Unless otherwise provided for within utilization and treatment standards prescribed by the department or MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days, and 4 visits a month thereafter. This statement of fact does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline to be used concerning the accountability for services being provided. The attending physician shall document the need for services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-10-046 should be followed when an insurer believes the treatment plan is inappropriate.

(d) Outpatient occupational therapy is compensable only when provided under a written treatment plan as described above. CPT codes 97900 and 97901 in the Oregon Relative Value Schedule denote occupational therapy and shall be used only for services provided by a licensed

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occupational therapist. In addition, CPT Code 97902 shall be used to denote the initial visit for evaluation and establishment of the treatment program.

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

(f) The treatment plan requirements of this section may be modified or waived in accordance with the contract provisions of a managed care organization.

(4)(a) The attending physician, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, shall within 20 days complete the evaluation or refer the worker for such evaluation. The attending physician shall notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(b) Fees for a physical capacity evaluation (PCE) and a work capacity evaluation (WCE) shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable reimbursement shall be as follows:

(A) FIRST LEVEL PCE: This is a general evaluation to establish early return-to-work capability or a specific evaluation requested to measure the physical capacity of a specific body part. This level requires not less than 45 minutes of actual claimant contact. The fee for this PCE shall be no greater than \$100, unless otherwise approved by the insurer prior to the examination, and shall include the evaluation and report. A first level PCE should be billed using Oregon specific code 99196.

(B) SECOND LEVEL PCE: This is a PCE requested by the insurer, or attending physician, to measure general residual functional capacity to perform work or provide other general evaluation information. This level requires not less than one hour and 45 minutes of actual claimant contact. The fee for this PCE shall be no greater than \$225, unless otherwise approved by the insurer prior to the examination, and shall include the evaluation and report. A second level PCE should be billed using Oregon specific code 99197.

(C) WORK CAPACITY EVALUATION: This is a residual functional capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. This level requires not less than 6 hours of actual claimant contact. The fee for a WCE shall be no greater than \$475, unless otherwise approved by the insurer prior to the examination, and shall include the evaluation and report. A work capacity evaluation should be billed using Oregon specific code 99198.

(c) No fee shall be paid for the completion of a work release form or completion of a physical capacity evaluation form where no tests are performed.

(5) A pharmacist or dispensing physician shall dispense generic drugs to injured workers in accordance with and pursuant to ORS 689.515. For the purposes of this rule, the claimant shall be deemed the "purchaser" and may object to the substitution of a generic drug. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

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(6) 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 a compensable gastrointestinal condition.

(7) 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 non-payment of the fee for the radiological study.

(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) The insurer shall respond to a written request for authorization for prolotherapy or thermography within 21 days of receipt of the request. All requests shall be submitted on the Department of Insurance and Finance Form 2000. Thermography shall be billed using Oregon specific codes 93763 (cervical), 93764 (thoracic) and 93765 (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 myelopathic 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

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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) 97530 - 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) The costs of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury, is a compensable medical expense, whether the worker actually received a physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eye glasses.

(14) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review the efficacy of treatment, frequency and necessity of care, and accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-10-090(30). If the evaluation of the records must be conducted on-site, the provider shall furnish a reasonable work-site for the records to be reviewed at no cost. These records shall be provided or made available for review within 14 days of a request. Failure to provide the records in a timely manner may result in a sanction or penalty as provided in OAR 436-10-130.

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**436-10-041 Palliative Care**

(1) For the purposes of this rule, workers are medically stationary when determined to be so by the worker's attending physician or as established in accordance with OAR 436-30-035. After the worker has become medically stationary, palliative care is compensable:

(a) When provided to a worker who has been determined to have permanent total disability; or

(b) When necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition; or

(c) To monitor the status of a prosthetic device.

(2) When the worker's attending physician believes that palliative care, which would otherwise not be compensable, is appropriate to enable the worker to continue current employment, authorization to provide such treatment may be requested. To obtain such authorization, the attending physician must first mail a written request for approval of such treatment to the insurer. The written request shall be in a form and format as prescribed by the director. The request shall:

(a) Contain any objective findings;

(b) Identify the medical condition by ICD-9-CM diagnosis for which the palliative treatment is proposed;

(c) Provide a proposed treatment plan which includes the specific treatment modalities, the name of the provider who will perform the treatment, and the frequency and duration of the care to be given, not to exceed 120 days;

(d) Describe how the requested palliative care is related to the accepted compensable condition;

(e) Describe how the proposed treatment will enable the injured worker to continue employment and the adverse effect on the injured worker if the palliative care is not approved; and

(f) Any other information the director, by bulletin, may prescribe.

(3) Within 30 days of the receipt of a written request from the attending physician to provide palliative care as described in section (2) of this rule, the insurer shall send written notification to the physician approving or disapproving the request.

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(4) If the attending physician does not receive written notice disapproving the care from the insurer within 30 days as set forth in section (3) of this rule, the request for palliative care shall be approved.

(5) Subsequent requests for palliative care shall be 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.

(6) When the palliative care request is approved, the insurer shall be responsible for providing reimbursement for palliative care provided as prescribed in the treatment plan.

(7) When the request for palliative care is not approved, the insurer shall provide specific reasons for not approving the care. The insurer, in writing, shall:

(a) Identify any disagreement with the attending physician's diagnosis for which the palliative treatment is proposed;

(b) Provide any reasons why the proposed treatment plan is not acceptable;

(c) Identify why the proposed treatment will not enable the injured worker to continue current employment; and/or

(d) Provide any other reasons they believe the proposed palliative care is not appropriate.

(8) When the insurer disapproves the requested palliative care, the attending physician may request approval from the division for such treatment. The request from the attending physician must include a copy of the original request to the insurer, a copy of the complete response from the insurer, an explanation as to why the insurer's stated reasons for disapproval are incorrect, and any other supporting information the attending physician wishes to present.

(9)(a) Except as provided in subsection (b) of this section, within 30 days of receipt of the attending physician's request for approval, the division will review the request and issue a final order approving or disapproving the treatment.

(b) The director may select a physician or panel of physicians in accordance with OAR 436-10-047 to conduct the review. When such reviews are conducted, the division's review shall be completed within 40 days.

(10) Review of disputes relating to palliative care provided in accordance with section (1) of this rule, where the worker, the insurer, or the director believes the palliative care is excessive, inappropriate, ineffectual, or in violation of the rules, shall be processed in accordance with OAR 436-10-046.

(11) Review of orders issued pursuant to section (9) of this rule shall be subject to director review pursuant to OAR 436-10-008(6).

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**436-10-045      Evaluating Treatment**

(1) If an injured worker, an insurer, or the director feels that any medical treatment recommended for, or provided to, a worker or workers, is unscientific, unproven as to its

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effectiveness, outmoded or experimental, either party may request, or the director may initiate on the director's own authority, an investigation.

(2) The investigation may include a request for the advice from 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 non-compensable.

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

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**436-10-046 Medical Services Disputes**

(1) If a worker or insurer believes a worker is receiving or has been provided medical treatment for a compensable condition that is excessive, inappropriate, ineffectual or in violation of the medical rules, and wishes review of the treatment by the director, the worker or insurer shall notify the director. The party providing notice of an intent to request director review shall provide, without cost, the director and all other parties copies of all documentation wished reviewed as follows:

(a) The documents containing medical information and records regarding the treatment shall be arranged in chronological order and numbered in Arabic numerals in the lower right corner of each page, beginning with the document of earliest date. The numbers shall be preceded by the designation "Ex," and pagination of multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document two shall be designated "Ex 2-2." The documents shall have an index which includes the document numbers, description of each document, author, number of pages and date of the document.

(b) When requested by the worker or director, the insurer shall provide a complete copy of the claimant's medical record to all parties, without cost.

(2) The notice of intent to request review by the director herein must be mailed within 180 days of the treatment in question. All notices of intent to request director's review shall be in writing, and include, but not be limited to:

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

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(e) Copies of all supporting documents containing medical information and records regarding the treatment in the manner described in subsection (1)(a) of this rule; and

(f) The requested relief sought.

(3) Once a notice of intent to request review is made pursuant to sections (1) and (2) of this rule, the insurer shall not deny the claim for medical services nor shall medical provider bills subject to this review be deemed payable pending the outcome of the review.

(4) All parties must exchange all information they wish to have considered for the record as follows:

(a) Within 20 days of said mailing date of the notice of intent to request review, other parties may mail any additional documentation, which has not already been provided, to the director and the other parties. All additional information must be submitted in the manner set forth in (1)(a) above.

(b) Within 10 days of receipt of other parties documentation, but no later than 30 days from the said mailing date of the initial notice of intent to request review, the parties shall attempt to resolve their differences. The party giving notice shall inform the director and the other parties, in writing, that either the matter for review has been resolved, or that they request director review. The request for director review shall specify the differences between the parties.

(c) Upon receipt of such request, the director shall initiate a review.

(5) Notwithstanding section (1) of this rule, the director may initiate a review. The director shall notify the parties who shall provide records in accordance with subsection (1) of this rule. Within 15 days of the mailing date of a request by the director, the attending physician shall forward all pertinent medical records, laboratory results, and related correspondence in chronological order with an index of the records provided to the director.

(6) The director will review all initial and supplemental medical information and records regarding the treatment submitted by the parties, or other such records as requested by the director. If the director determines that no bona fide medical services dispute exists, the director will issue an order pursuant to ORS 656.327(1). If the director determines that a bona fide medical services dispute exists, the director may cause an appropriate medical service provider(s) to examine the worker and perform any reasonable and necessary medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), the worker may refuse a test without sanction.

(a) The director may select a physician or convene a panel of physicians to conduct this review in accordance with OAR 436-10-047.

(b) When a physician is selected to conduct a review, the physician shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed.

(c) When a panel of physicians is selected, it shall be composed of Oregon physicians and at least one member of any such panel shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed.

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(7) When an examination of the worker is necessary, the director shall inform the worker of the date, time, and location of the examination with copies to the insurer, attending physician and the selected physician or panel members.

(8) The examination may include, but not be limited to:

- (a) A review of all medical records and X-rays submitted.
- (b) An interview and examination of the worker.
- (c) Performance of any necessary tests, laboratory studies, or X-rays except invasive tests.

(9) When an examination of a worker is conducted, the physician or panel of physicians shall submit a report to the director in writing with copies mailed to the worker, insurer and attending physician. The report 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.
- (i) Whether current treatment is excessive, inappropriate, ineffectual, or in violation of the rules.
- (j) Whether or not the current treatment should be continued, modified or terminated.

(10) After review, the director will issue a proposed and final order, with findings of fact, to the parties. Any party may comment on the proposed order within 10 days of issuance of the order. Ten days after issuance of the order, the proposed order will become final unless revised by the director. Revision of the proposed order may be upon the director's own motion or upon a motion by a party showing error, omission, or misconstruction of an applicable law.

(11) If the director issues an order declaring medical treatment to be excessive, inappropriate, ineffectual, or in violation of the rules, the worker is not obligated to pay for such treatment.

(12) If the director issues an order pursuant to this section, review shall be based on substantial evidence in the record in accordance with ORS 656.327(2) and OAR 436-10-008(3). The director may reopen the record, abate the order, and reconsider the order before a request for review is filed or, if none is filed, before the time for requesting review expires.

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**436-10-047 Medical Arbiters and Panels of Physicians**

(1) In consultation with the Workers' Compensation Management-Labor Advisory Committee pursuant to ORS 656.790, the director shall establish and maintain a list of physicians to be used as follows:

(a) To appoint a medical arbiter or a panel of medical arbiters to review impairment rating reconsideration requests, in accordance with OAR 436-30-050.

(b) To appoint an appropriate physician or a panel of physicians to review medical treatment or medical services disputes pursuant to ORS 656.327 or review the necessity of palliative care pursuant to OAR 436-10-041.

(2) Arbiters, panels of arbiters, physicians, and panels of physicians will be selected by the director. To be eligible to receive reimbursement for treating injured workers, all Oregon medical providers must be available to be medical arbiters or panel members upon request of the director. Arbiters and panel members shall not include any Oregon medical providers whose treatment is under review, or any medical provider whose license is under suspension by the provider's licensing board.

(3) The physician, members of the panel of physicians, the medical arbiter or panel of medical arbiters appointed pursuant to this rule acting pursuant to the authority of the director are agents of the department and subject to the provisions of ORS 30.260 to 30.300. The findings of the panel of physicians, the medical arbiter or panel of medical arbiters, all of the records and all communications to or before a panel or arbiter are privileged and are not discoverable or admissible in any proceeding other than those under this chapter.

(4) No physician selected pursuant to this rule shall be examined or subject to administrative or civil liability regarding participation in or the findings of the physician, panel or medical arbiter(s) or any matter before the physician, panel or medical arbiter(s) other than in proceedings under Chapter 656 and the department's rules adopted thereto.

(5) When a worker is required to attend an examination pursuant to this rule the director shall within 14 days of the request for an examination, send notice of the examination to the worker and all affected parties. The notice shall inform all parties of the the time, date, location and purpose of the examination. Such examinations shall be at places and times reasonably convenient to the worker.

(6) The arbiters, the panels of arbiters, the physicians and the panels of physicians selected pursuant to this rule shall be paid as follows:

(a) A single medical arbiter appointed for impairment determination shall bill according to actual level of service provided, as identified in the Oregon Relative Value Schedule. In addition, the arbiter shall receive \$50 for the report to the director, to be billed under Oregon specific code A0001.

(b) Physicians selected to a panel of arbiters shall each receive \$250 for record review and the examination. The physician who prepares and submits the report shall receive an

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additional \$50. Billings by each arbiter selected to a panel shall be billed under Oregon specific code A0002. Billing for the panel report shall be billed under Oregon specific code A0003.

(c) A single physician selected to review treatment, perform reasonable and appropriate tests, examine the worker, and submit a report to the director shall receive \$150 per hour up to a maximum of 4 hours for record review and examination. The physician will also receive \$100 for preparation and submission of the report. Billings for services by a single physician shall be billed under Oregon specific code P0001 for the examination and Oregon specific code P0003 for the report.

(d) Physicians selected to serve on a panel of physicians shall each receive \$150 per hour up to a maximum of 4 hours for record review and panel examination. The panel member who prepares and submits the panel report shall receive an additional \$100. Billings by each physician selected to a panel shall be billed under Oregon specific code P0002. Billings for the panel report shall be billed under Oregon specific code P0003.

(7) The costs related to record review, examinations and reports pursuant to this rule, shall be paid by the insurer. If additional diagnostic tests are required, the costs for these tests shall be reimbursed in accordance with the fee schedule. The insurer shall also pay the worker for all necessary related services which include, but are not limited to, child care, travel, meals and lodging pursuant to OAR 436-60-070. If a worker fails to appear for a required examination under this section, each selected physician shall receive \$50.

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**436-10-048          Impairment Rating Reconsiderations**

(1) Upon receipt of a request for reconsideration pursuant to OAR 436-30-050, the director shall appoint an arbiter or a panel of medical arbiters in the manner prescribed in OAR 436-10-047.

(2) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment. The examination of the worker and/or medical records must be performed within 30 days of the request for review. The director shall provide notice of the examination of the worker in accordance with OAR 436-10-047.

(3) Within 5 working days after the examination, the arbiter or panel of arbiters shall submit a report to the division in a form and format as prescribed by the director.

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**436-10-050          Who May Provide Medical Services**

(1) When an employer of a worker becomes subject to a MCO contract and the worker is receiving compensable medical services, the medical service provider, subject to the limitations contained in this rule, may continue to provide services to the worker until the worker becomes medically stationary or changes physicians, whichever occurs first. Thereafter, further compensable medical services or time loss authorization, required by the worker must be provided in accordance with the provisions of the MCO contract.

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(2) Non-attending physicians, who are not members of a MCO certified pursuant to OAR 436-15-030, may provide compensable medical services for a period of 30 days from the date of injury or 12 visits on the initial claim, whichever ever occurs first. Thereafter, medical services provided are not compensable without the written authorization of an attending physician.

(3) Non-attending physicians, who are members of a managed care organization (MCO) certified pursuant to OAR 436-15-030, may provide medical services to an injured worker to the extent provided for by the contract between the MCO and the non-attending physician.

(4) Primary care physicians who are not members of the MCO that meet the qualifications specified in OAR 436-15-070 may provide medical services to injured workers subject to the contract provisions of the governing MCO.

(5) Nurse practitioners and physician's assistants may provide medical services as provided for non-attending physicians. Additionally, those nurse practitioners and physician assistants practicing in rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are as determined by the Oregon Department of Human Resources, Office of Health Policy, in conjunction with the Office of Rural Health, Oregon Health Sciences University. The primary service areas for hospitals shall be as determined by the Oregon Department of Human Resources, Office of Health Policy.

(6) Notwithstanding ORS 656.005(1), when the worker chooses a medical service provider outside the State of Oregon, the insurer may object to the worker's choice and select the medical service provider. The out-of-state medical service provider must be licensed within that state to provide medical services. If approved by the insurer, the medical service provider will have the same authority to provide services and authorize time loss as similarly licensed Oregon providers. Payment for treatment or services rendered to the worker after the insurer has objected to the worker's choice of medical service provider may be rejected by the insurer.

(7) 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.

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

(9) A physician assistant, registered under ORS 677.515, may provide services and be reimbursed as provided by OAR 436-10-090(16) when the physician assistant is approved for independent practice by the Board of Medical Examiners. 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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**436-10-060      Choosing And Changing Medical Providers**

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

(2) The worker may have only one attending physician at a time. Simultaneous or concurrent treatment by other medical service providers shall be based upon a written request of the attending physician, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for in these rules, all treatments must be authorized by the injured worker's attending physician to be reimbursable. Fees for treatment by more than one physician at the same time are payable only when 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, unless as otherwise provided for by a MCO contract, 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. The limitations of the worker's right to choose physicians pursuant to this section begin with the date of injury and extend through the life of the claim. The following, however, do not count in this calculation:

(a) Examinations at the request of the insurer;

(b) Consultations requested by the attending physician;

(c) For workers who were receiving medical services on or before July 1, 1990, and the worker was required to change physicians to receive compensable medical services, palliative care or time loss authorization because their medical service provider no longer qualified as an attending physician.

(d) Referrals to radiologists and pathologists for diagnostic studies.

(e) Changes of attending physician required due to conditions beyond the worker's control. This would include, but not be limited to, when the physician terminates practice or leaves the area.

(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. If an attending physician begins treatment without being informed that the worker has been given the required notification the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made and inform the claimant of the right to seek approval of the director.

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**436-10-070 Elective Surgery**

(1) When the attending physician believes elective surgery is needed for occupational injury or illness, the attending physician shall give the insurer actual notice at least 7 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 attending physician.

(2) When elective major orthopedic or neurological surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the attending physician, within 7 days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired. When requested, the consultation shall be completed within 21 days after notice to the attending physician.

(3) (a) Within 7 days of the consultation, the insurer shall notify the surgeon of the consultant's findings. If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the attending physician, the insurer may request director review in accordance with OAR 436-10-046.

(b) If the attending physician 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 attending physician and the claimant.

(4) An attending physician who prescribes or 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 attending physician 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 7 days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases the attending physician should endeavor to notify the insurer of the need for emergency surgery.

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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 of the date the worker became medically stationary and whether or not the worker is released to any form of work.

(2) If the attending physician determines that the injury related condition has resolved, returning the worker to pre-injury status, the attending physician shall so state. If there is permanent residual loss of use or function, a closing examination as described in this rule shall

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be performed. The attending physician may refer the worker to a consulting physician who is a licensed medical doctor, doctor of osteopathy, or board certified oral surgeon for all or any part of the closing examination.

(3) The closing examination report does not include any rating of impairment or disability, but describes impairments to be rated by either the insurer or the director. For the purposes of this rule, a closing examination report must describe findings of impairment due to the injury or occupational disease including, but not limited to, loss of member; measured ranges of motion in degrees in all appropriate planes; loss of strength in the injured part(s); measureable atrophy; muscle spasm; areas and grades of reflex, sensory and motor changes.

(4) If the attending physician refers the worker to a consulting physician for all or any part of a closing examination, the attending physician must review the report and concur in writing, or write a report describing any findings with which the attending physician disagrees. If the attending physician feels that the consulting physician's report adequately describes all of the findings of impairment, the attending physician may by written concurrence submit the report in lieu of the attending physician's own closing examination report.

(5) For those injuries with potential to result in permanent residual loss of use or function of the head, spine, shoulder, hip, or internal organ system; the workers' residual functional capacity is required. When the worker has been declared medically stationary, the physician may specify the worker's residual functional capacity or shall refer the worker for completion of a PCE or WCE (as described in OAR 436-10-040) as needed pursuant to the following situations:

(a) The worker's capacity to lift and carry is required when the worker has not been released to return to regular work, has not returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A WCE is required when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(c) Findings resulting from such evaluations shall be reviewed by the attending physician and included in the closing report as necessary to meet the requirements of sections (2) through (5) of this rule.

(6) The director may prescribe by bulletin what comprises a complete closing report, including, but not limited to, those specific clinical findings related to the specific body part or system affected. The bulletin may also include the impairment rating format or form to be used as a supplement to the narrative report.

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**436-10-090            Charges And Fees**

(1)(a) Hospital charges billed to insurers shall include appropriate ICD-9-CM diagnostic codes and the appropriate diagnostic related group (DRG) number. Insurers shall reimburse

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hospitals for inpatient hospital and outpatient surgical services rendered on or after January 1, 1991, 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) Notwithstanding subsection (1)(a), the director may exclude rural hospitals defined in ORS 442.470 from imposition of the adjusted cost/charge ratio based upon a determination of economic necessity. For the purposes of this rule, factors upon which the director may conclude that an economic necessity exists include, but are not limited to the following:

(A) Current financial condition of the hospital;

(B) Occupancy rates;

(C) Proximity to other hospitals;

(D) Affiliations and/or ownership; and/or

(E) Determinations by the Oregon Department of Human Resources, Office of Health Policy that the hospital is considered to be at risk.

(c) 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 (d), by the total patient revenues from Worksheet G-2.

(d) 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.

(e) 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 (c) above, by 15 percent. The resulting figure shall be added to the ratio calculated in (c) to obtain the adjusted cost/charge ratio.

(f) 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 HCFA form 2552 to the Information Management Division, Research and Analysis Section, at the Department of Insurance and Finance. On or before December 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 January 1.

(g) 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.

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(h) 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.

(i) 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:

(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 in the Oregon Relative Value Schedule, or elsewhere in these rules. The medical provider shall not attempt to collect from the injured worker any amounts reduced by the insurer pursuant to this rule.

(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 medical providers. The director shall periodically issue a bulletin to all parties establishing the fee that shall apply to all similar disputes which arise. The director shall incorporate the fee into the Oregon Relative Value Schedule at the next revision. 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
- (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 otherwise provided in these rules. Hospitals may bill for inpatient services and surgery using the International Classification of Diseases, 9th edition – with Clinical Manifestations (ICD-9-CM). The definitions of commonality in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services, except as otherwise provided in the Oregon Relative Value Schedule or in these rules.

(6) All medical providers shall submit bills for medical services on form UB82 or 1980 or 1984 form HCFA 1500, except for dental billings which shall be submitted on ADA dental claim forms. Billings shall include the worker'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 re-submission. All initial medical provider billings shall be accompanied by chart notes documenting services which have been billed.

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(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, with the following exceptions:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment that has not been prescribed by the worker's attending physician. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period as set forth in OAR 436-10-050;

(c) When the injured worker seeks palliative care, except as provided in OAR 436-10-041, after the worker has been provided notice that the worker is medically stationary; or

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract.

(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 by report.

(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.

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

(15) (a) 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 or Oregon specific codes and reimbursed at no

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more than the 75th percentile as shown in the Oregon Relative Value Schedule. Such services include outpatient physical therapy, outpatient X-rays and emergency department treatment and physician's services.

(b) 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. Diagnostic testing done prior to inpatient treatment or outpatient surgical services shall be considered part of the hospital services subject to the hospital fee schedule.

(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 10 percent of the surgeon's reimbursable fee.

(17) Laboratory fees shall be billed in accordance with ORS 676.310. If any 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 physician charges.

(18) Reimbursement to physicians shall not exceed 20 percent above the physician's costs for braces, supports and other medical devices. Invoices for devices with a unit price greater than \$25 shall be provided on request of insurer. Invoices for devices with a unit price under \$25 shall be provided upon request of the director.

(19) Fees for surgical procedures shall be billed based upon the CPT codes or Oregon specific codes and corresponding descriptions found in the Oregon Relative Value Schedule. When more than one surgeon performs surgery, the process for billing shall be 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 Oregon 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 through 22585 as specified in the Oregon Relative Value Schedule.

(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 listed in the Oregon Relative Value Schedule and the subsequent procedures paid at 10 percent of the value listed.

(e) Surgery following severe trauma, for which several procedures are required and which take considerable time, and for which the surgeon feels his or her fees should not be

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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 Oregon Relative Value Schedule. Physician's services for inpatient myelograms are subject to the Oregon Relative Value Schedule.

(20) (a) When two bills are submitted for an X-ray, one by the person taking the X-ray (technical component to be designated by modifier 27) and one by the radiologist who interprets the X-ray (professional component to be designated by modifier 26), the maximum allowable fee is to be divided between them. The technical component is to be reimbursed at 60 percent of the maximum allowable fee and the professional component is to be reimbursed at 40 percent of the maximum allowable fee.

(b) Physicians, other than the radiologist, who inject air, contrast materials or isotopes as part of a radiologic study, shall bill for this service using CPT codes from the surgery section. For example, CPT code 62284 shall be used for the injection for myelography. This fee for the injection will be reimbursed in addition to the value of the complete procedure. The complete procedure fee shall be reimbursed based on 60 percent for the technical component and 40 percent for the professional component.

(21) Outpatient hospital services shall be reimbursed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the Oregon 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 Oregon 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 Oregon 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. This rule does not apply when a physical therapist uses CPT codes 97200 and 97201 from the Oregon Relative Value Schedule for physical therapy.

(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) (a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening 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 (CARF or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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(b) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive reimbursement for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to 6 months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(c) Billings for medical services provided within a CARF or JCAHO accredited multidisciplinary program which do not have established CPT codes shall be billed based upon the Oregon specific codes identified in the Oregon Relative Value Schedule for multidisciplinary programs. Billings using the multidisciplinary codes must include copies of the treatment record which specifies the type of service rendered, the medical provider who provided the service, whether treatment was individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(d) When an attending physician approves a multidisciplinary treatment program for an injured worker, the attending physician must provide the insurer with a copy of the approved treatment program within 7 days of the beginning of the treatment program.

(e) Notwithstanding section (5) of this rule, program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

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

(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 Oregon Relative Value Schedule.

(28) Mechanical muscle testing shall be reimbursable a maximum of three times during a treatment program when prescribed and approved by the attending physician: 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 in writing by the insurer prior to the testing. The fee for mechanical muscle testing includes a copy of the computer printout results from the machine, 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 and codes for reports:

a. A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-10-090(6).

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b. Copies of medical records when requested by insurer shall be reimbursed at 25 cents a page and identified on billings by Oregon specific code R0001.

c. Brief Narrative - Summary of treatment to date and current status; answer to 3-5 specific questions shall be reimbursed at \$25 and identified on billings by Oregon specific code N0001.

d. Complete Narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary information shall be reimbursed at \$50 and identified on billings by Oregon specific code N0002.

(31) Fee and codes for a deposition (includes preparation time):

a. First hour \$300 (Oregon specific code D0001)

b. Each subsequent hour \$100 (Oregon specific code D0002)

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**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.

(3) The continuing education program shall consist of a minimum of two hours of instruction at least once every two years, 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) Any medical service provider who seeks reimbursement for treating injured workers and 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'

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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.

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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 in which the expenses were incurred, a standard expense voucher for reimbursement.

(4) 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. The committee shall also include one representative each of insurers, employers and workers.

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

(6) 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.

(c) To prepare and submit to the director proposed 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.

(7) The medical advisor shall provide liaison between the committee and the director and the department shall provide staff and administration support to the Committee. The medical advisor is appointed by the Division to provide advice on medical issues.

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**436-10-100      Insurer's Rights and Duties**

(1)(a) The 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. However, examinations after the worker's claim is closed are subject to the limitations in ORS 656.268(7).

(A) 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.

(B) 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) An Independent Medical Examination (IME) is a medical examination which may be requested only by the insurer. 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) The insurer shall pay for medical services relating to a compensable injury claim, except as provided by OAR 436-60-055. Compensable medical services include but are not limited to medical, surgical, hospital, nursing, ambulances, drugs, medicine, crutches, prosthetic appliances, braces, supports, and physical rehabilitation.

(4) Insurers shall date stamp medical bills upon receipt and shall pay bills for medical services on accepted claims 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. Billings which are 60 days old or older at the time of claim acceptance become due promptly upon claim acceptance. Failure to pay for medical services timely may:

(a) Result in civil penalties pursuant to OAR 436-10-130;

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(b) Result in the assessment of penalties and fees in accordance with OAR 436-60-155; and

(c) Shall render insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(5) Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with OAR 436-60-070. Reimbursement by the insurer to the worker for transportation costs to visit their medical service provider may be limited to a city, metropolitan area, or a reasonable distance from the nearest city or metropolitan area in which the worker resides and where a physician providing like services is available. However, a worker who relocates within the State of Oregon may continue treating with the medical service provider and be reimbursed transportation costs accordingly. If an insurer limits reimbursement under this section, it shall provide the worker a written explanation and a list of providers who provide similar services within a reasonable traveling distance for the worker. The insurer shall inform the worker that treatment may continue with the medical service provider and that reimbursement of transportation costs may be limited as described.

(6) 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.

(7) When there is a dispute over the necessity of services rendered or the amount of a bill, the insurer shall, within 60 days, pay the undisputed portion of the bill and provide a reason for nonpayment of the disputed amount. Resolution of treatment disputes shall be made in accordance with OAR 436-10-046 and OAR 436-15. Resolution of billing disputes shall be made in accordance with OAR 436-10-110 and OAR 436-15.

(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.

(10) Insurers shall notify all injured workers in writing immediately following receipt of notice or knowledge of a claim of the manner in which they may receive medical services for compensable injuries.

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(11) Insurers shall notify all injured workers in writing, immediately following notice or knowledge that the worker is medically stationary, of the manner in which they may receive palliative care in accordance with OAR 436-10-041.

(12) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician, the insurer shall be responsible for reimbursement to all affected medical service providers for services rendered until the insurer provides notice to such providers of the medically stationary status.

(13) Insurers who enter into a MCO contract in accordance with OAR 436-15, shall, at least 30 days prior to the effective date of the contract, notify the affected insured employers of the following:

- (a) The names and addresses of the MCO medical providers;
- (b) The manner in which injured workers can receive compensable medical services within the MCO;
- (c) The manner in which injured workers can receive compensable medical services by medical providers outside the MCO.

(14) Insurers under contract with a MCO shall notify all newly insured employers in accordance with section (10) of this rule, prior to or on the effective date of coverage.

(15) Insurers under contract with MCO's shall notify the worker in writing immediately following receipt of notice or knowledge of a claim of the eligible medical providers and the manner in which they may receive medical services for compensable injuries. If the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician, the insurer shall notify the medical service provider that services rendered after the date of notification shall not be compensable. This notification requirement also applies to non-member health care providers.

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Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88  
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88  
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90  
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-101      Monitoring and Auditing Medical Providers**

(1) The department will monitor and conduct periodic audits of medical providers to ensure compliance with ORS Chapter 656 and these rules.

(2) Medical providers shall maintain records necessary to disclose the extent of services furnished to injured workers. At a minimum, these records must include, but are not limited to, documentation relating to the level and type of service provided. All records maintained or required to be maintained shall be disclosed upon request of the director. These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.

Hist: Filed 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)

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Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**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.

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

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(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.

(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.

Hist: Filed 6/26/86 as Admin. Order 4-1986, eff. 7/1/86  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**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 request for review must be submitted to the division within 180 days of the dispute 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 if the request for review 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) Notwithstanding sections (1) & (2) of this rule, fee disputes involving insurers covered by MCO contracts shall first be processed in accordance with the internal dispute resolution procedure required by OAR 436-15.

(4) 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 30 days of the decision, pursuant to OAR 436-10-008(5).

Hist: Filed 6/26/86 as Admin. Order 4-1986, eff. 7/1/86  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-115      Complaints of Rule Violation**

(1)(a) In the event a vendor of medical services is aggrieved by the conduct of an insurer, the vendor may request review by the division. Complaints pertaining to violations of these rules shall be in writing and must:

- (A) State the grounds for alleging rule violation;
- (B) Include the specific contention of error;

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(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 payment records, interviews with the parties to the complaint, selection of a physician or panel of physicians, 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  
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)  
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**436-10-130            Sanctions and Civil Penalties**

(1) If the 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) Non-payment or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board.

(2) If the 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, 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) Non-payment 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

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

(b) 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.

(c) 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)(b) 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 panel of physicians 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 panel of physicians, 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.

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Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90

**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 delivering a copy to the party through certified mail or in any manner provided by Oregon Rules of Civil Procedure 7 D.

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