

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

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

MEDICAL SERVICE

EFFECTIVE JULY 1, 1992

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

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, 656.256, 656.260, 656.268, 656.325, 656.327, 656.794(3), and Sections (2) & (3), Chapter 771, Oregon Laws 1991.

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
Amended 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-003, 5/1/85
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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 July 1, 1992 to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268(7), 656.325, 656.327, 656.794 and Sections (2) & (3), Chapter 771, Oregon Laws 1991, and govern all providers of medical services licensed or authorized to provide a product or service.

(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 subsequent 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
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80
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
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-004, 5/1/85

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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 (Temp)
Amended 4/29/90 as Admin. Order 4-1990, eff. 5/1/90 (Temp)
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
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
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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) Any medical service provider 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 objectives, 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 or as otherwise specified in these rules.

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

(9) "Days" means calendar days.

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

(11) "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.

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

(13) "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.

(14) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance.

(15) "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.

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

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

(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.

(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,

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

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

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

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

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

(28) "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.

(29) "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.

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

(31) "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.

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

(33) "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.

(34) "Promptly" means without delay.

(35) "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.

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

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

(38) "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.

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

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

Hist: Filed 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
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
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-005, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, off. 1/1/86
Amended 6/26/86 as Admin. Order 4-1986, eff. 7/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff. 3/16/87
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
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 7/20/90 as Admin. Order 14-1990, eff. 7/20/90 (Temp)
Amended 8/17/90 as Admin. Order 17-1990, eff. 8/17/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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 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

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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.

(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

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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.

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 (Temp)
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. However, this authorization does not authorize the release of information regarding federally funded drug and alcohol abuse treatment programs which are governed by Federal Regulation 42, CFR (1)(A). 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 the work related injury or illness and is not subject to revocation by the worker or the worker's representative.

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(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, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. 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. When time loss is authorized by the attending physician, 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 brief or complete narrative report. Fees for such narrative reports shall be in accordance with OAR 436-10-090(30). Progress notes from the clinical chart may suffice to give the insurer all the information the insurer needs.

(6) Reports may be handwritten but 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 relevant medical records as specified in Section (1) of this rule, progress reports and narrative reports. If the medical provider fails to comply with this requirement within 14 days, the requestor 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) The attending physician shall inform the insurer of the anticipated date of release to work, the anticipated date the worker will become medically stationary, the next appointment date, and the worker's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

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(10) At the time the attending physician declares the worker medically stationary, the attending physician shall notify the worker, the insurer, and all other medical providers who are providing services to the worker. The attending physician shall send a closing report to the insurer within 10 days of the examination in which the worker is declared medically stationary, except where a consultant examines the worker pursuant to OAR 436-10-080(2). In this instance, the attending physician shall have an additional 5 days to send the closing report. 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) After the claim is closed, the attending physician shall 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 10 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report.

(14) A medical service provider shall not unreasonably interfere with the right of the insurer, pursuant to OAR 436-10-100(1), to obtain a medical examination of the worker by a physician of their choice.

(15) When an injured worker elects to change attending physicians or is referred to a new physician who becomes primarily responsible for the worker's care, the new 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 new attending 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 within 14 days forward, upon proper request, all requested information to the new attending physician. A physician who fails to forward requested information to the new attending physician will be subject to penalties as provided by OAR 436-10-130(2).

(16) Injured workers, or their representatives, are entitled to copies of all relevant medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers upon the payment of an appropriate charge in accordance with OAR 436-10-090(30) for copies. However, records 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

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director, or the claimant, records 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
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-101, 5/1/85
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
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 7/20/90 as Admin. Order 14-1990, eff. 7/20/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, of f. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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 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 or occupational therapy 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 7 days 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 provided to the insurer by the attending physician within 14 days of the beginning of treatment.

(b) Medical services prescribed by an attending physician and provided by a chiropractor, naturopath, acupuncturist, or podiatrist 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

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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 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 as provided in accordance with OAR 436-10-090(30).

(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.

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(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 worker shall be deemed the "purchaser" and may object to the substitution of a generic drug. Workers may obtain prescriptions from a provider of their choice, unless otherwise provided for in accordance with a MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

(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 request of either the director or the insurer, original 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. If a medical service provider refuses to forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

(8) 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. If the insurer does not feel the report justifies the need for the item in the treatment and recovery of the worker and the sole issue to be addressed in the matter is whether the treatment is inappropriate, ineffective, excessive, or in violation of the rules regarding the performance of medical services, the issue shall be resolved as provided by OAR 436-10-046.

(9) Prolotherapy and thermography are not reimbursable. Such services may be administered, however, medical service providers shall not receive additional reimbursement for those services.

(10) 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.

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

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

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

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

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

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

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

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

(j) 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.

(11) 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.

(12) 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

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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.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff. 8/20/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-110, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff. 3/16/87
Amended 6/15/87 as Admin. Order 3-1987, eff. 6/15/87
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 8/21/89 as Admin. Order 2-1989, eff. 9/1/89
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 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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 without prior approval by the insurer in the following instances:

- (a) When provided to a worker who has been determined to have permanent total disability under the provisions of ORS Chapter 656; 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) 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 regarding the performance of medical services, shall be processed in accordance with OAR 436-10-046.

(3) 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 for 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 and submitted to the insurer prior to the commencement of the treatment. If the palliative care request is approved, services shall be payable from the date the approved treatment begins. 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;

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(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 180 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.

(4) Insurers shall date stamp all palliative care requests upon receipt. Within 30 days of the receipt of a written request from the attending physician to provide palliative care as described in section (3) of this rule, the insurer shall send written notification to the physician, the worker, and the worker's attorney approving or disapproving the request. Insurers that fail to comply with these requirements may be assessed civil penalties in accordance with OAR 436-10-130.

(5) If the attending physician does not receive written notice approving or disapproving the care from the insurer within 30 days as set forth in section (4) of this rule, the attending physician may request approval from the director in the manner as prescribed in section (9) of this rule.

(6) 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.

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

(8) 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.

(9) When the insurer disapproves the requested palliative care, the attending physician may request approval from the division for such treatment. Such request for the division's review must be submitted within 90 days of the date of the insurer's notice of disapproval. Where no insurer response is received, the request for division review must be submitted within 120 days of the date on the request for approval submitted to the insurer pursuant to section (3) of this rule. 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

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stated reasons for disapproval are incorrect, and may include any other supporting information the attending physician wishes to present.

(10) 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. If however, the director selects a physician or panel of physicians in accordance with OAR 436-10-047 to conduct the review, such reviews shall be completed within 75 days.

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

Hist: Filed 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 8/17/90 as Admin. Order 17-1990, eff. 8/17/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-045 Evaluating Experimental and Outmoded 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 effectiveness, outmoded or experimental, either party may request, or the director may initiate on the director's own authority, an investigation. A copy of the insurer's request for director investigation shall be submitted to the affected medical service provider(s), the worker, and worker's attorney.

(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.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-046 Medical Treatment Disputes

(1) If a worker or insurer believes a worker has received, is receiving, or is proposed to receive medical treatment for a compensable condition that is excessive, inappropriate, ineffectual or in violation of the medical rules regarding the performance of medical services, and wishes review of the treatment, the worker or insurer shall notify the director. For purposes of this rule, medical treatment means those services performed by physicians; ancillary services which are prescribed by an attending physician pursuant to OAR 436-10-040(3); any services which cannot be obtained without a physician's prescription; and those services which qualify for review under this rule pursuant to OAR 436-10-040(8). Braces, splints, and physical restorative devices will be reviewed under the provisions of this rule only where the sole issue is whether the treatments are excessive, inappropriate, ineffectual, or in violation of the rules regarding the

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performance of medical services. Restrictions on activities are not considered treatment unless the primary purpose of such restrictions is to improve the worker's condition through conservative care. Prior to notifying the director, the insurer must follow the process established in sections (3) through (5) of this rule. Disputes relating to treatment provided through a MCO contract shall be processed through the MCO dispute resolution procedures established in accordance with OAR 436-15.

(2) The director has exclusive jurisdiction over disputes relating to issues identified in section (1) of this rule. Insurers shall not issue denials for such treatment unless it is believed the medical treatment is not causally related to the accepted compensable condition. Additionally, once a director's review has been initiated, the insurer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is within the jurisdiction of the director until the director has issued an order. Medical provider bills subject to this review shall not be deemed payable pending the outcome of the review. If the insurer issues a denial for medical services after submitting a request for director's review of those services under this rule, penalties may be assessed in accordance with OAR 436-10-130.

(3) When treatment is in dispute, an insurer shall notify the medical service provider and all parties of its intent to request a review by the director. The notice of intent to request review shall be sent to the provider by Certified Mail within 180 days of the receipt of first billing for the treatment in dispute. However, notices of intent to request director review regarding proposed treatment shall be sent to the provider within 90 days of receipt of a notice of proposed treatment. Notwithstanding the provisions of this rule, when compensability of treatment is at issue before the Hearings Division of the Workers' Compensation Board or any other appellate body, the insurer may request director's review after the compensability is decided. In this instance, the request for review must be submitted within 30 days of when the order finding the treatment to be compensable is final. When the treatment in dispute is not resolved through the governing MCO's dispute resolution processes and the insurer or worker wishes review of the treatment by the director, the request for review shall be submitted to the director within 30 days of issuance of the MCO's final decision. The notice of intent shall be in a form and format as prescribed by the director and shall:

- (a) Identify the worker's name, date of injury and claim number;
- (b) Certify that the relatedness of the treatment to the work related injury is not at issue at the time of the request and that no denial has been issued or will be issued pending the outcome of the request for review;
- (c) Specify the treatment in question and why it is believed to be excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services. When the treatment has been rendered over a period of time, the insurer shall also specify the time period of the treatment in dispute. When the treatment is proposed, the insurer shall provide the director with documentation of the specific treatment plan proposed by the attending physician;
- (d) Provide all relevant and pertinent medical information along with any medical documentation which indicates that the treatment in question does not conform to accepted medical standards of care;
- (e) Identify any harm which has befallen, or might befall the worker;

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(f) If applicable, provide specific examples of how the treatment does not comply with the medical services rules;

(g) Identify the specific relief sought; and

(h) Include the following notice in prominent or bold face type:

IN ACCORDANCE WITH OAR 436-10-046, WE ARE QUESTIONING YOUR TREATMENT FOR THIS WORKER AND THE DIRECTOR REQUIRES THAT WE MUST NOTIFY YOU WE ARE INTENDING TO REQUEST THE DIRECTOR CONDUCT A REVIEW OF YOUR TREATMENT. IF WE ARE UNABLE TO RESOLVE OUR DIFFERENCES AND WISH FURTHER REVIEW, WITHIN 30 DAYS OF THIS NOTICE WE WILL FORWARD OUR REQUEST TO THE DIRECTOR ALONG WITH A COPY OF ALL RELEVANT AND PERTINENT MEDICAL INFORMATION. IF A DIRECTOR'S REVIEW IS NECESSARY TO RESOLVE THIS DISPUTE, WE ARE REQUIRED TO INCLUDE YOUR RESPONSE TO THIS NOTICE IN THE RECORDS WE SUBMIT TO THE DIRECTOR.

IF YOU FAIL TO RESPOND TO THIS NOTICE WITHIN 20 DAYS OF YOUR RECEIPT OF THIS NOTICE, FURTHER REVIEW WILL BE BASED ON THE MEDICAL RECORDS WHICH WE ARE REQUIRED TO SUPPLY TO THE DIRECTOR. THE DIRECTOR MAY ISSUE AN ORDER WHICH COULD AFFECT YOUR ABILITY TO RECEIVE REIMBURSEMENT FOR THE TREATMENT IN DISPUTE.

(4) When the worker believes the treatment the worker has received, is receiving or is proposed to receive is excessive, inappropriate, ineffectual or in violation of the medical rules regarding the performance of medical services, the worker shall request the director review the treatment in accordance with these rules. The request must be submitted to the Department within 90 days of the date the treatment was provided or proposed by the attending physician. When the treatment is proposed, the worker shall provide the director with documentation of the specific treatment plan proposed by the attending physician.

(5) Upon receipt of a notice of intent to request director review, if the medical provider wishes to respond, the provider must do so within 20 days.

(6) When an insurer cannot resolve a treatment dispute with a medical provider or when the provider fails to respond to a notice of intent, the insurer may request a review by the director. A request for director review must be received by the director within 40 days of the date on the notice of intent that was sent to the provider.

(7) The insurer requesting director review shall provide, without cost, the director and all other parties copies of the record to be reviewed. The record shall include all relevant and pertinent medical information, copies of the medical information submitted with the insurer's notice of intent, the provider's response to the notice and a statement identifying the differences between the parties. The insurer shall certify to the director that all relevant and pertinent records have been submitted and that the medical provider whose treatment is being disputed has received copies.

(8) All relevant and pertinent medical information shall be arranged in chronological order, with the oldest documents on top, and numbered in Arabic numerals in the lower right

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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.

(9) Upon receipt of a copy of the request for director's review submitted in accordance with sections (6) and (7) of this rule, the medical service provider will have 7 days to submit any additional information they wish for the director to consider.

(10) If the director determines the insurer has failed to provide all relevant and pertinent medical information, civil penalties pursuant to OAR 436-10-130, may be imposed.

(11) If any party believes that relevant and pertinent medical information has not been provided, they must specify to the director what information is inadequate and/or incomplete. The director may obtain the complete medical record from the insurer at this time or whenever the complete record is deemed necessary to properly address a dispute filed pursuant to this rule.

(12) Notwithstanding section (1) of this rule, the director may initiate a review. When such a review is initiated, the parties shall respond to the director within 10 days of receipt of a request from the director. The insurer shall provide all relevant and pertinent medical information in accordance with section (8) of this rule. The medical provider whose treatment is under review shall forward all pertinent medical records, laboratory results, and related correspondence to the director.

(13) 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 medical records and, if necessary, 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, 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.

(14) 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. The examination may include, but is not limited to:

(a) A review of all medical records and X-rays submitted.

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(b) An interview and examination of the worker.

(c) Performance of any necessary tests, laboratory studies, or X-rays except invasive tests.

(15) When an examination of a worker is conducted, the physician or panel of physicians shall mail a report to the director in writing within 5 days of the examination, with copies mailed to the worker, insurer and attending physician. The report may include, but not be limited to:

(a) Reason for the 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.

(16) After review and within 30 days of receipt of the request for director 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.

(17) 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.

(18) 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.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 8/17/90 as Admin. Order 17-1990, eff. 8/17/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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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 in accordance with ORS 656.268.

(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 examination or treatment is the subject of the 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 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 a place 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 pursuant to OAR 436-30-050, shall receive \$200, to be billed under Oregon specific code A0001. In addition, the arbiter shall receive \$50 for the report to the director, to be billed under Oregon specific code A0003. These fees apply to all single arbiter evaluations.

(b) Physicians selected to a panel of arbiters pursuant to OAR 436-30-050, shall each receive \$250 for record review and the examination. The physician who prepares and submits the report shall receive an 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.

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(c) A single physician selected pursuant to OAR 436-10-046, to review treatment, perform reasonable and appropriate tests, or 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 pursuant to OAR 436-10-046, 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.

(e) Notwithstanding the provisions of subsections (a) and (b) of this rule, the director may in a complex case requiring extensive review pre-authorize an additional fee of up to \$200 above the amounts specified. Billings for that additional amount shall be billed under Oregon specific code A0004.

(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, without providing the physician with at least 48 hours notice, each selected physician shall receive \$100.

Hist: Filed 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-048 Impairment Rating Reconsiderations

(1) When a basis for the request for reconsideration is a disagreement with impairment findings used in rating the worker's disability, the director shall appoint an arbiter or a panel of medical arbiters in the manner prescribed in OAR 436-10-047 and OAR 436-30-050.

(2) As specified by the director, the medical arbiter or panel of medical arbiters shall perform a record review or examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment. The director shall provide notice of the examination of the worker in accordance with OAR 436-10-047 and OAR 436-30-050.

(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. Pursuant to OAR 436-30-050(11), the medical arbiters shall provide copies of the arbiter report to the worker or worker's representative and the insurer. The cost of providing copies of such additional reports shall be reimbursed according to OAR 436-10-090(30).

Hist: Filed 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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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.

(2) Non-attending physicians may provide compensable medical services for a period of 30 days from the date of injury or 12 visits on the initial claim, whichever occurs first, when the worker's care is not governed by a MCO. 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 governed by that MCO 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 terms and conditions of the governing MCO.

(5) Nurse practitioners and physician's assistants may provide medical services in the same manner as 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) When the worker chooses a medical service provider whose practice is located outside the State of Oregon and the provider does not comply with these rules, the insurer may object to the worker's choice and select the medical service provider. When an insurer objects to an injured worker's choice of physician, the insurer shall notify the worker and the provider that payment for services rendered by that provider after the date of notification shall not be reimbursable. The out-of-state medical service provider must be licensed within that state to provide medical services. If the insurer does not object, the medical service provider will have the same authority to provide services and authorize time loss as similarly licensed Oregon providers.

(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. However, those persons not licensed to practice independently or not licensed to provide a medical service, may only provide treatment prescribed by the attending physician which is rendered under the physician's direct control and supervision.

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

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(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.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff. 8/20/84
Renumbered from OAR 436-69-301, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-060 Choosing And Changing Medical Providers

(1) A newly selected attending physician or a referral physician who becomes primarily responsible for the worker's care, shall notify the insurer not later than 5 days after the date of change or first treatment, using Form 829 (Change of Attending Physician). This form should only be completed and submitted when the previous attending physician is no longer going to be primarily responsible for the worker's care.

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

- (a) Emergency services by a physician;
- (b) Examinations at the request of the insurer;
- (c) Consultations or referrals initiated by the attending physician;
- (d) Referrals to radiologists and pathologists for diagnostic studies;
- (e) When workers are required to change physicians to receive compensable medical services, palliative care or time loss authorization because their medical service provider is no longer qualified as an attending physician; or

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

(5) If a worker wishes to change attending physicians beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of attending physician which is beyond the initial choice and two changes allowed, the insurer shall notify the worker whether or not the change is approved. If the insurer objects to the change, the insurer shall advise the worker of the reasons for their objection to the change, advise that the worker may request director approval, and provide the worker with a form to complete and submit to the director if they still wish to make the requested change. The form shall be in a format as prescribed by the director.

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

(7) After receipt and review, the director will issue an order advising whether or not the change is approved. Such orders are subject to review in accordance with OAR 436-10-008(5).

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-401, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-070 Elective Surgery

(1) Except as otherwise provided in accordance with a governing MCO, when the attending physician or consulting physician believes elective surgery is needed to treat a compensable injury or illness, the attending physician or the consulting physician with the approval of 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 post-surgical recovery period, and the hospital where surgery is to be performed.

(2) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the physician who

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provided the notification, 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 28 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. Insurers are not required to, but may pre-authorize elective surgery. Additionally, insurers may not require medical service providers to obtain pre-authorization. The decision as to whether or not to proceed with surgery remains with the attending physician and the claimant. Upon receipt of the billings, the insurer shall pay the undisputed amounts for services, issue a denial if they believe the services are not causally related to the compensable condition, or request review by the Director in accordance with OAR 436-10-046.

(4) An attending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (1) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and 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.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-501, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 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
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-080 Determination Of Impairment

(1) The attending physician shall notify the insurer of the date on which the worker became medically stationary from the compensable injury or illness 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 be performed. The attending physician may arrange for the worker to be examined by a consulting physician within 7 days of the examination in which the worker is declared medically stationary for all or any part of the closing examination.

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(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; muscle or tissue; 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. The use of an inclinometer to measure spinal ranges of motion is mandatory pursuant to OAR 436-35-007(4).

(4) 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.

(5) 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.

(6) 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.

(7) Findings resulting from PCE or WCE evaluations shall be reviewed by the attending physician and included in the closing report to meet the requirements of sections (2) through (6) of this rule.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-601, 5/1/85
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 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-090 Charges And Fees

(1)(a) Inpatient and outpatient hospital charges billed to insurers shall include ICD-9-CM diagnostic codes, and inpatient hospital charges shall include the diagnostic related group (DRG) number. Unless otherwise provided for by a governing MCO contract, 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, the rural hospital exemption will be based on the Financial Flexibility Index as calculated by the Oregon Health Sciences University, Office of Rural Health. As such, fee schedule exemption will be granted to all hospitals which are more than three standard deviations below the Index's zero point.

(c) Each hospital's HCFA form 2552 and audited financial statement 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, from Worksheet A-8, the expenses for:

(A) Malpractice Premiums and/or Self-Insurance Fund Contributions, less the Administrative portion of malpractice premiums and/or Self-Insurance Fund Contributions;

(B) Provider-Based physician adjustment;

(C) Provider-Based physician adjustment - general services cost center;

(D) Telephone service;

(E) Television and radio service; and

(F) Expenses identified as for physician recruitment.

(e) The basic cost/charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Use the audited financial statement and add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost/charge ratio calculated in (1)(c) to obtain the factor for bad debt and charity care.

(f) The basic cost/charge ratio shall be further modified to allow for an adequate return on assets. The Director will determine an historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate, and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's HCFA 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(g) The figures resulting from (e) and (f) will be added to the ratio calculated in (c) to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

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(h) The adjusted cost/charge ratio for each hospital shall be revised annually, at a time based on their fiscal year, as prescribed by bulletin. Each hospital shall submit a copy of their HCFA form 2552 and audited financial statements each year within 90 days of the end of their fiscal year to the Information Management Division, Department of Insurance and Finance. The adjusted cost/charge ratio schedule shall be published by bulletin twice yearly, on or before December 20 of each year to be effective for the subsequent six-month period beginning January 1, and on or before June 20 of each year to be effective for the subsequent six-month period beginning July 1.

(i) 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.

(j) 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.

(k) 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.

(1) Notwithstanding subsections (c) through (i) of this section, the cost/charge ratio shall be 1.000 for out-of-state hospitals, unless a lower rate is negotiated between the insurer and the hospital.

(m) Hospitals which provide inpatient hospital and outpatient surgical services to injured workers who are governed by a MCO may be granted exemption or partial exemption from the cost/charge ratio in accordance with OAR 436-15-090.

(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 insurer shall notify the medical provider in writing of the reasons for any reduction in payment of the medical provider's billings. 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

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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, including ICD-9-CM codes, and services identified by code numbers and descriptions found in the Oregon Relative Value Schedule or as otherwise provided in these rules. 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 current form UB82 or 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. All initial medical provider billings shall be accompanied by chart notes documenting services which have been billed.

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

(8) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness, 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;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-10-100(15); or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental pursuant to OAR 436-10-045.

(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

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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 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 assistant 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. The bills for services by these providers shall be marked with modifier 81.

(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.

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(19) 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 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:

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(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, infrared and hot packs are used in combinations of two or more during one treatment session, only one shall be reimbursed, unless two separate effects are demonstrated.

(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).

(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.

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(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 records and reports requested by an insurer, worker, employer, or their representative:

(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).

(b) Copies of medical records when requested shall be reimbursed at \$3.50 for the first page and 25 cents for each page thereafter 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 \$50 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 \$100 and identified on billings by Oregon specific code N0002.

(e) When a medical service provider is asked to review records or reports prepared by another medical provider, the medical service provider should bill for their review of the records utilizing CPT Code 99080. The billing should include the actual time spent reviewing the records or reports and should list the medical service provider's normal hourly rate for such review. This would include, but not be limited to, IME reports.

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

(a) First hour of deposition (including preparation time)
\$300 (Oregon specific code D0001)

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(b) Each subsequent hour or portion thereof
\$100 (Oregon specific code D0002)

(32) Surface EMG tests and rolling are not reimbursable.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-701, 5/1/85
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 8/21/89 as Admin. Order 2-1989, eff. 9/1/89
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 (Temp)
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
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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, Board Certified Oral Surgeon, Doctor of Chiropractic, Doctor of Naturopathy, Acupuncturist, 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 classroom instruction or an equivalent self-study course to include: workers' compensation laws and the rules governing provider reporting and billing, treatment, findings of impairment, insurer claims processing, and dispute resolution. Self-study courses must include a self-graded test.

(4) Professional associations shall provide each physician with a Certificate of Completion.

(5) All Oregon medical service providers licensed in one or more of the disciplines identified in section (1) of this rule who treat injured workers must be able to document their completion of these continuing education requirements or may be subject to penalties pursuant to ORS 656.254 3(d). Under the provisions of ORS 183.310 to 183.550 the Director may impose a sanction of forfeiture of fees and may declare a medical service provider ineligible for reimbursement for treating Workers' Compensation claimants until completion of the continuing education program is documented.

(6) When the director notifies the professional associations representing the licensed medical service providers identified in section (1) of this rule, the professional associations shall, within 6 months of such notice, update and provide the continuing education program.

(7) Professional associations shall submit the content of the continuing education programs, including self-study courses, to the Director for approval prior to dissemination to providers.

Hist: Filed 6/7/88 as Admin. Order 2-1988 Temporary, eff. 6/7/88
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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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 alternate interval 2 year terms 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 impairment, and any proposed changes in the disability 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.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-100 Insurer's Rights and Duties

(1) The insurer may obtain three medical examinations of the worker by physicians of their choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. A claim for aggravation permits a new series of three medical examinations. Examinations after the worker's claim is closed are subject to the limitations in ORS 656.268(7).

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer shall first notify and request authorization from the director. Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty. The process for requesting such authorization shall be as follows:

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(a) The insurer shall submit a request for such authorization to the director in a form and format as prescribed by the director including, but not limited to, the purpose for the examination, dates, times, places, purposes of previous examinations, and reasons why the additional examination is necessary. A copy of the request shall be provided to the worker and, if the worker is known to be represented by an attorney, the worker's attorney shall also be sent a copy of the request; and

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. If additional information is needed, the director may interview the parties or send a written request. Upon receipt of a written request for additional information from the director, the parties shall have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information. Any party aggrieved by the director's order may request a hearing by the Hearings Division of the Workers' Compensation Board pursuant to ORS 656.283 and the Board's Rules of Practice and Procedure for Contested Cases.

(3) For purposes of determining the number of insurer required examinations, the following examinations shall not be considered and do not require approval as outlined in section (2) above:

- (a) An examination conducted by or at the direction of the worker's attending physician;
- (b) An examination obtained at the request of the director;
- (c) An evaluation scheduled pursuant to ORS 656.335 and OAR 436-10-105;
- (d) A consultation obtained in accordance with OAR 436-10-070(2); and
- (e) An examination of a permanently totally disabled worker required under ORS 656.206(5).

(4) Such examinations shall be at places, times, and intervals reasonably convenient to the worker's place of employment or residence and shall not delay or interrupt proper treatment of the worker.

(5) When a worker is required to attend an examination by a physician of the insurer's choice, the insurer shall:

- (a) Comply with the notification requirements contained in OAR 436-60-095;
- (b) Agree upon the fee prior to the examination; and
- (c) Pay for the examination and reimburse the worker for all necessary related services which include, but are not limited to, child care, travel, meals and lodging. The insurer shall reimburse the worker within 30 days of receipt of an itemized bill and appropriate receipts.

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

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an examination and/or allow the worker to be so accompanied, the physician must document the reasons.

(7) Upon completion of the examination, the examining physician shall promptly send a copy of the report to the attending physician and the insurer or person requesting the exam.

(8) The insurer shall pay for compensable 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.

(9) Insurers shall date stamp medical bills and reports upon receipt and shall pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-10-090(6) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form may be returned to the medical provider for correction and resubmission. If an insurer returns such billings, it must do so within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing to the provider and the date the insurer receives the corrected billing, shall not apply toward the 45 days within which the insurer is required to make payment.

(10) Payment of medical bills in the following situations is required within 14 days of the action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later:

- (a) When there is an order designating a paying agent pursuant to ORS 656.307;
 - (b) When an insurer voluntarily rescinds a claim denial;
 - (c) When there is a Stipulated Agreement which rescinds a claim denial;
 - (d) When there is an Opinion and Order or Order on Review that has become final which overturns a claim denial;
 - (e) When medical benefits become due upon claim acceptance following a claim denial;
- and
- (f) When medical benefits become due upon claim acceptance following a claim deferral period.

(11) Failure to pay for medical services timely may:

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

(12) 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-

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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.

(13) 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.

(14) When there is a dispute over the amount of a bill or the necessity of services rendered, the insurer shall, within 45 days, pay the undisputed portion of the bill and provide specific reasons for non-payment or reduction of each medical service code. 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.

(15) 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.

(16) When an injured worker is receiving medical treatment out-of-state, the insurer shall notify the worker and the medical service provider of the following:

- (a) The Oregon fee schedule requirements;
- (b) The manner in which they can provide compensable medical services to Oregon's injured workers;
- (c) The requirement that billings for compensable services in excess of the maximum allowed under the fee schedule are not to be paid for by the insurer or billed to the worker; and
- (d) If the provider does not comply with these requirements, the insurer may object to the worker's choice and select a new provider to render the necessary care.

(17) 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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(18) 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.

(19) 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.

(20) 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.

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

(21) Insurers under contract with a MCO shall notify all newly insured employers in accordance with section (13) of this rule, prior to or on the effective date of coverage.

(22) 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.

(23) When injured workers become medically stationary or change attending physicians, the insurer shall notify those workers that are governed by a MCO contract of the manner in which they may receive compensable medical services.

(24) At least 30 days prior to any significant changes to a MCO contract affecting injured worker benefits, the insurer shall notify in accordance with OAR 436-15-035 all affected insured employers and injured workers governed by that contract of the manner in which injured workers will receive medical services.

(25) Bills for medical services rendered at the request of the insurer and for bills information submitted at the request of the insurer, which are in addition to those required in OAR 436-10-030 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(26) Insurers, insurer groups and self-insurers that have at least 100 accepted disabling claims in a calendar year, as determined by the Department of Insurance and Finance, are required to transmit detailed medical service and billing data to the Information Management Division of the Department of Insurance and Finance. Once an insurer has been determined to

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have the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. In such circumstances, the insurer may apply for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will publish a bulletin identifying the affected insurers and advising the insurers of the data and format requirements for data transmission;

(b) The data shall include all payments made during each calendar quarter for medical services which are covered by the department's fee schedules. These fee schedules include anesthesiology, medicine, evaluation and management services, physical therapy, surgery, radiology, multidisciplinary, and hospital inpatient services and hospital outpatient surgical services;

(c) The affected insurers shall submit the medical data within 45 days of the end of each calendar quarter. However, a grace period of two calendar quarters may be granted for revised requirements and also for insurers which are newly affected by these requirements; and

(d) There must be no more than fifteen percent inaccurate data in any field. Listed insurers are responsible for pre-screening the data they submit to check that all required information is reported. Reports which have more than five percent missing or invalid data in any field based on initial computerized edits will be returned to the insurer for correction and must be resubmitted within three weeks.

(27) Insurers under contract with MCOs shall, within 30 days of the end of each calendar quarter, provide to each contracted MCO a listing of all employers covered by the contract current on the last day of the quarter, including the employer's names, WCD employer number, and the estimated number of employees governed by each MCO contract. This information is necessary for the MCO to comply with reporting requirements contained in OAR 436-15-040.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-801, 5/1/85
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 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 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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 (Temp)

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

436-10-105 Disability Prevention Services

(1) When a worker has incurred a disabling injury for which a determination order or notice of closure pursuant to ORS 656.268 has not been issued, within one hundred and twenty days of the date of injury or the date a claim for aggravation was made, the insurer shall ascertain whether the worker has returned to work and if not:

(a) Whether the worker's attending physician believes the worker is capable of undertaking physical rehabilitation services; and

(b) Whether the worker is presently participating in any program of disability prevention services.

(2) The insurer shall report such findings to the director not later than 135 days from the date of injury or the date the claim for aggravation was made and, if appropriate, shall refer the worker for disability prevention services 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.

(3) The report 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.

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

(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. Any evaluation necessary to establish a disability prevention services program as defined in ORS 656.335 shall not be considered an insurer medical examination under ORS 656.325.

(6) If an evaluation is scheduled by the insurer, the insurer shall notify the worker and the worker's attorney in writing of the scheduled evaluation at least 10 days prior to the evaluation. The notice shall advise the following:

(a) The name of the evaluator or facility;

(b) The specific reasons for the evaluation, including an explanation of the type of services being considered;

(c) That reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other

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related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance; and

(d) That such an evaluation when conducted in accordance with OAR 436-10-105 and ORS 656.335 is not considered an insurer medical examination under ORS 656.325.

(7) The insurer shall submit a report to the Department within 5 days of the date a worker's 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.

(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
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-110 Fee Disputes

(1) 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 90 days of the dispute. For purposes of this rule, the day of the dispute shall be the date shown on the bill analysis from the insurer that was sent to the vendor indicating partial or non payment would be made. The request for review shall be in a form and format as prescribed by the director and must:

- (a) State specific code(s) and dates of service(s) in dispute;
- (b) State the grounds for questioning the disputed amount;
- (c) State the request for correction and relief; and

(d) Include sufficient documentation to support the review request, including but not limited to copies of original HCFA bills, chart notes, bill analysis, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute;

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(e) Certify that the involved insurer or vendor has been provided a copy of the request for review and attached supporting documentation.

(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) If additional information is necessary, the director shall so advise the insurer and vendor. Upon receipt of a written request for additional information, the parties shall have 14 days to respond. If the vendor or insurer do not provide the information requested by the director and/or when the investigation is complete, the director will issue an order resolving or dismissing the dispute based on available information. Either party may appeal to the director within 30 days of the decision, pursuant to OAR 436-10-008(5).

(4) Notwithstanding section (1) 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.

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
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-115 Complaints of Rule Violation

(1) 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) Cite the applicable rule and state the grounds for the alleged rule violation;
- (b) State the request for correction and relief; and

(c) Include sufficient documentation to support the complaint including but not limited to copies of original HCFA bills, chart notes, operative reports, bill analysis, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the complaint;

(d) Certify that the involved insurer has been provided a copy of the complaint along with supporting documentation.

(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 additional information is needed from the vendor initiating the complaint, the director shall so advise the vendor. Upon receipt of a written request for additional information, the vendor shall have 14 days to respond. If the vendor does not provide the information requested by the director, the director will take no further action on the complaint and dismiss the matter with prejudice.

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(4) If additional information is necessary from the insurer, the director shall so advise the insurer. Upon receipt of a written request for additional information, the insurer shall have 14 days to respond. If the insurer does not provide the information requested by the director, civil penalties may be assessed.

(5) 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: Fled 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 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

436-10-130 Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established pursuant to ORS 656.252 and 656.254(1) as found in OAR 436-10-030, 436-10-040, 436-10-041, 436-10-046, 436-10-048, 436-10-060, 436-10-070, 436-10-080, 436-10-090, 436-10-110, and 436-10-115 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.

(2) 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 and 656.327, has been found to:

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

(3) If the conduct as described in section (2) 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.

(4) 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.

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(5) If an insurer or worker believes sanctions under (1) or (2) of this section are appropriate, either may submit a complaint in writing to the director, pursuant to the applicable provisions of OAR 436-10-046 and OAR 436-10-115.

(6) Insurers who violate these rules shall be subject to the penalties in ORS 656.745 of not more than \$2000 for each violation or \$10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation. If the director finds any insurer in violation of OAR 436-10-030, 436-10-041, 436-10-046, 436-10-047, 436-10-070, 436-10-090, 436-10-100, or 436-10-115 civil penalties may be imposed.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-901, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90 (formerly OAR 436-10-110)
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92

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.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Renumbered from OAR 436-69-903, 5/1/85
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90 (formerly OAR 436-10-010)
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90