

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICES**

EFFECTIVE FEBRUARY 11, 1999

**OREGON ADMINISTRATIVE RULES (TEMPORARY)
CHAPTER 436, DIVISION 010, RULES 0230 & 0265**

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[Bracketed 8 point text is deleted] ; **bold/underlined text is added**

Medical Services And Treatment Guidelines

OAR 436-010-0230 (1) Medical 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 are not reimbursable.

(2) Insurers have the right to require evidence of the frequency, extent and efficacy of treatment. Unless otherwise provided for by statute, or within utilization and treatment standards established by the department or MCO contract, treatment typically 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 rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment.

(3)(a) Except as otherwise provided by the MCO, 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 by the attending physician [prior to commencement of treatment] **and carried out under a treatment plan prepared prior to the commencement of treatment and signed by the attending physician within 30 days of beginning treatment.** The medical service provider shall provide an initial copy of the treatment plan to the attending physician and the insurer within seven days of [the] beginning [of] treatment. A copy of the treatment plan signed by the attending physician shall be provided to the insurer by the medical service provider within 30 days of [the] beginning [of] treatment. The treatment plan shall include objectives, modalities, frequency of treatment and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided pursuant to ORS 656.245(2)(b)(A).

(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 rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment. The attending physician shall document the need for services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

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

(5) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), 1(b) and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. 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 have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an 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 or they are provided in accordance with a utilization and treatment standard adopted by the director. 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 and accompanied by a report. 14" x 36" lateral views are not reimbursable.

(8) 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 medical provider. A reasonable charge may be made for the costs of delivery of films. If a medical 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.

(9) Articles including but not limited to 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" the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(10) The cost 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, including when the worker received no 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.

Stat. Auth: ORS 656.726(3)

Stats. Implemented: ORS 656.245, 656.248, 656.252

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Insurer Medical Examinations (IME)

OAR 436-010-0265 (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, Board's Own Motion, or reopening of a claim where the worker becomes enrolled or actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "insurer medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician. Examinations shall not include invasive procedures without the prior consent of the worker **in the form and format as the director may prescribe by bulletin**. The examination may be conducted by one or more medical providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the medical providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(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:

(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 the worker's attorney; 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. 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.

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(3) In determining whether to approve or deny the request for an additional IME, the director may give consideration, but is not limited, to the following:

(a) Whether an IME involving the same discipline(s) and/or review of the same condition has been completed within the past six months.

(b) Whether there has been a significant change in the worker's condition.

(c) Whether there is a new condition or compensable aspect introduced to the claim.

(d) Whether there is a conflict of medical opinion about a worker's treatment, impairment, stationary status or other issue critical to claim processing/benefits.

(e) Whether the IME is requested to establish a preponderance for medically stationary status.

(f) Whether the IME is medically harmful to the worker.

(g) Whether the IME requested is for a condition for which the worker has sought treatment or the condition has been included in the compensable claim.

(4) 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 OAR Chapter 438.

(5) For purposes of determining the number of insurer required examinations, any examinations scheduled but not completed are not counted as a statutory IME. The following examinations shall not be considered IMEs and do not require approval as outlined in section (2) above:

(a) An examination conducted by or at the request or direction of the worker's attending physician;

(b) An examination obtained at the request of the director;

(c) A consultation obtained in accordance with OAR 436-010-0250(3);

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

(e) An examination by a consulting physician that has been arranged by the worker's attending physician in accordance with OAR 436-010-0280.

(6) Examinations shall be at times and intervals reasonably convenient to the worker and shall not delay or interrupt proper treatment of the worker.

(7) When a worker is required to attend an examination by a physician of the insurer's choice, the insurer shall comply with the notification and reimbursement requirements contained in OAR 436-060-0070 and OAR 436-060-0095.

(8) 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 by a family member or friend during the examination. If the physician does not approve a worker's request to record an examination or allow the

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worker to be so accompanied, the physician must document the reasons.

(9) Upon completion of the examination, the examining physician shall send a copy of the report to the insurer and attending physician within seven days.

Stat. Auth: ORS 656.726(3)

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