

**ADMINISTRATIVE ORDER NO. 99-061  
EFFECTIVE OCTOBER 25, 1999**

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
OREGON ADMINISTRATIVE (TEMPORARY) RULES  
CHAPTER 436**

**DIVISION 009      OREGON MEDICAL FEE AND RELATIVE VALUE SCHEDULE  
DIVISION 010      MEDICAL SERVICES  
DIVISION 015      MANAGED CARE ORGANIZATIONS**

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OREGON MEDICAL FEE AND RELATIVE VALUE SCHEDULE

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EXHIBIT "A"  
OREGON ADMINISTRATIVE RULES  
CHAPTER 436, DIVISION 009 (TEMPORARY RULES)

**436-009-0008 Administrative Review, Fee Disputes and Contested cases**

Administrative review before the director:

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical fees and non-payment of compensable medical bills. A party need not be represented to participate in the administrative review before the director except as provided in ORS Chapter 183 and OAR Chapter 436, Division 001.

(b) Any party may request the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, a director's order shall be issued.

(c) All issues pertaining to disagreement about medical fees or non-payment of bills within an MCO are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting administrative review of the matter by the director. If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director.

(2) The medical provider, injured worker or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. Administrative review by the director must be requested within 60 days of the date the MCO issues its final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. **Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438, Division 005.**

(c) The director may, on the director's own motion, initiate a medical services review at

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any time.

**(d) When there is a formal denial of the underlying condition or a denial of the causal relationship between the medical service and the accepted condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.**

(3) Parties shall submit requests for administrative review to the director in the form and format prescribed by the director. The requesting party shall simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

- (a) Identify the worker's name, date of injury, insurer, and claim number.
- (b) Specify the issues in dispute and the relief sought.
- (c) Provide the specific dates of the unpaid disputed treatment.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original HCFA bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that the involved parties have been provided a copy of the request for review and attached supporting documentation and, if known, that there is no issue of causation or compensability of the underlying claim or condition.

(4) The division shall investigate the matter upon which review was requested.

(a) 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.

(b) If additional information is necessary, the director shall so advise the parties. Upon receipt of a written request for additional information, the parties shall have 14 days to respond. If a party does not provide the information requested by the director prior to completion of the investigation, the director shall issue an order resolving or dismissing the dispute based on available information.

(c) Pursuant to section (5) of this rule, within 30 days of the administrative order, any party may appeal to a contested case before the director.

(5) Contested Cases Before the Director: Pursuant to 183.310 through 183.550, as modified by OAR Chapter 436, Division 001 and ORS 656.704(2), any party that disagrees with an action or order of the director pursuant to these rules, may request a contested case before the director. For purposes of these rules, "contested case" has the meaning prescribed in ORS 183.310(2) and OAR Chapter 436 Division 001. A party may appeal to the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested, and include a copy of the order being appealed.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of

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action being appealed.

(6) Contested Case Hearings of Sanction and Civil Penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as described in OAR 436-010-0008(13).

(7) Director's Administrative Review of Other Actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (6) of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (5) of this rule.

**Stat. Auth.:** ORS 656.704, 656.726(3)

**Stats. Implemented:** ORS 656.704

**Hist:** Renumbered from OAR 436-010-01 10(1), (2), (3), (4), and (5) to OAR 436-009-0008(2), (3), (4), and (5);  
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EXHIBIT "A"  
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CHAPTER 436, DIVISION 010 (TEMPORARY RULES)

**436-010-0008 Administrative Review and Contested Cases**

(1) Administrative Review Before the Director:

(a) **Except as otherwise provided in ORS 656.704(3)(b)**, [T]the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.260 and 656.327[, such as medical treatment issues; related services; palliative care; medical rule violations; advances in curative care; curative care to stabilize a temporary and acute waxing and waning of a worker's condition; experimental, outmoded, unproven, or unscientific treatment; request for change of attending physician; and requests for insurer medical examinations in excess of those allowed by statute.

(b) All disputes regarding medical services, whether past, present, or future, that are disapproved for reasons other than a formal denial of the underlying claim will be processed in accordance with subsections (5) through (12) of this rule].

(c)[(b) A party need not be represented to participate in the administrative review before the director except as provided in ORS Chapter 183 and OAR Chapter 436, Division 001.

(d)[(c) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, a director's order shall be issued.

(2) Administrative review and contested case processes for change of attending physician issues are in OAR 436-010-0220; additional insurer medical examination (IMEs) matters are in OAR 436-010-0265; and, fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

(3) When there is a formal [decision that denies] **denial of** the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. [Pursuant to ORS 656.262(7)(a) the receipt of a medical bill or request for medical services is not a formal claim for aggravation or a request to have a new condition accepted. The director shall not consider a disapproval letter in response to a claim for medical services a denial of the compensability of the underlying claim unless the letter is consistent with the provisions of ORS 656.262 and clearly articulates the basis for the denial.] After the compensability of the underlying claim [or condition] is **finally** decided [before another adjudicatory body], any party may request director's review of appropriate medical issues within 30 days after the date the [compensability of the underlying claim or condition has been adjudicated and that] decision becomes final by operation of law.

**(4) When there is a denial of the causal relationship between the medical service and the accepted condition or the underlying condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.**

(4)[(5) All issues pertaining to disagreement about medical services within a Managed Care Organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the injured worker, are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an

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administrative review of the matter by the director.

[(5)](6) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision under the MCO's internal dispute resolution process. If a party has been denied access to an MCO internal dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. **Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438, Division 005.**

(c) Disputes regarding elective surgery shall be processed in accordance with OAR 436-010-0250.

(d) The director may, on the director's own motion, initiate a medical services review at any time.

(e) Medical provider bills for treatment or services which are subject to director's review shall not be deemed payable pending the outcome of the review.

[(6)](7) Parties shall submit requests for administrative review to the director in the form and format prescribed by the director. The requesting party shall simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

- (a) Identify the worker's name, date of injury, insurer, and claim number;
- (b) Specify what issues are in dispute and specify with particularity the relief sought.
- (c) Provide the specific dates of the unpaid disputed treatment .

[(7)](8) In addition to medical evidence relating to the medical services dispute, all parties may submit other relevant information, including but not limited to, written factual information, sworn affidavits, and legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain addition evidence consistent with statute.

[(8)](9) When a request for administrative review is filed pursuant to ORS 656.260 or 656.327, the insurer shall provide a record packet, without cost, to the director and all other parties or their representatives as follows:

- (a) The packet shall include certification that there is no issue of compensability of the

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underlying claim or condition; and, if there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet shall include a complete, indexed copy of the worker's medical record **and other documents** that [is] **are** arguably related to the medical service in dispute [and other information described in section (8) of this rule], arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages and date of the document. The packet shall include the following notice in bold face type:

**As required by OAR 436-010-0008<sup>(8)</sup>, we hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order which could affect reimbursement for the disputed medical service(s).**

(c) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer shall provide the record within 14 days of the director's request in the form and format described in this rule.

(e) If the insurer fails to submit the record in the time and format specified in this rule, the director may penalize or sanction the insurer under OAR 436-010-0340.

[<sup>(9)</sup>]**(10)** If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review shall be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

(b) When a panel of physicians is selected, at least one panel member shall be a practitioner of the healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

(c) When such an examination of the worker is required, the director shall notify the appropriate parties of the date, time, and location of the examination. The physician or panel shall not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted **to the director** [in accordance with sections (6) to (8) of this rule] for

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screening [by the director] as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination may include, but is not limited to:

- (A) a review of all medical records and diagnostic tests submitted,
- (B) an examination of the worker, and
- (C) any necessary and reasonable medical tests.

[(10)]**(11)** The director shall review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

(a) If the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order pursuant to ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical services dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(b) When a bona fide dispute exists, the director will issue an administrative order and provide notice of the record used in the review.

(A) The parties will have 30 days from the issuance of the order to request a contested case hearing before the director.

(B) The director may on the director's own motion reconsider any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case order is issued.

(C) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this subsection and may respond to such evidence submitted by others.

(D) Any party requesting reconsideration or responding to a reconsideration request shall simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

[(11)]**(12)** If the director issues an order declaring an already rendered medical service inappropriate, or otherwise in violation of the statute or medical services rules, the worker is not obligated to pay for such medical service.

[(12)]**(13)** Contested Cases Before the Director: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other

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action of the director is contested, and include a copy of the administrative order being appealed.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of action being appealed.

(c) The hearing shall be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(d) In the review of orders issued pursuant to ORS 656.327(2) and ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, administrative orders may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(e) For claims not enrolled in an MCO, disputes about whether a medical service after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c) and whether a medical treatment is unscientific, unproven, outmoded or experimental under ORS 656.245(3), are subject to administrative review by the director. If appealed, review at contested case hearing is not subject to the "no new medical evidence or issues rule" in subsection [(12)](13)(d) of this rule. However, if the disputed medical service is determined compensable under ORS 656.245(1)(c) or 656.245(3) all disputes and assertions about whether the compensable medical services are excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services are subject to the substantial evidence rule at contested case hearing.

[(13)](14) Contested Case Hearings of Sanction and Civil Penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be filed with the division within [20] 60 days after service of the order or notice of assessment.

(c) The Division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

[(14)](15) Director's Administrative Review of Other Actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through [(13)](14) of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within ninety (90) days of the disputed action and must specify the grounds upon which the action is contested.

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(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section [(12)]**(13)** of this rule.

**Stat. Auth.:** ORS 656.726(3)

**Stats. Implemented:** ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704

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Amended \*\*\*\*\* as Admin. Order 99-\*\*\*, eff. 10/23/99 (Temp)

**Amended 10/25/99 as Admin. Order 99-061, eff. 10/25/99 (Temp)**

**436-010-0210 Who May Provide Medical Services and Authorize Timeloss**

(1) Attending physicians may authorize time loss and provide medical services subject to the limitations of these rules. However, an MCO may designate any medical service provider as an attending physician who may provide medical services to an enrolled worker in accordance with ORS 656.260.

(2) Authorized primary care physicians may provide medical services to injured workers subject to the terms and conditions of the governing MCO.

(3) 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. Those persons not licensed to treat 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.

(4) Nurse practitioners and physician's assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits during that 30 day period on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those nurse practitioners and physician assistants practicing in Type A, Type B, and Type C 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 contained in ORS 442.470.

(5) Nurse practitioners and physicians' assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(3)(a), nor under the direct control and supervision of the attending physician.

(6) A physician assistant, [registered] **licensed** under ORS 677.515, may provide services when the physician assistant is approved for practice by the Board of Medical Examiners.

(7) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's

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request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer shall give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

(a) If the insurer does not approve the worker's out-of-state physician, notice to the worker shall clearly state the reason(s) for the denial, identify at least two other physicians of the same healing art and specialty whom it would approve, and reasons for the insurer denial which may include but are not limited to the out-of-state physician's refusal to comply with OAR 436-009 and 436-010. The notice shall also inform the worker that if the worker disagrees with the denial, the worker may refer the matter to the director for review under the provisions of OAR 436-010-0220.

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer shall immediately notify the worker and the medical service provider in writing of the following:

(A) The Oregon fee schedule requirements;

(B) The manner in which the out-of-state physician may provide compensable medical services to Oregon injured workers; and

(C) Billings for compensable services in excess of the maximum allowed under the fee schedule may not be paid by the insurer.

(8) After giving prior approval, if the out-of-state physician does not comply with OAR 436-010, the insurer may object to the worker's choice of physician and shall notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by that physician after notification shall not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

(9) If the worker is aggrieved by an insurer decision to object to an out-of-state attending physician, the worker or the worker's representative may refer the matter to the director for review under the provisions of OAR 436-010-0220.

**Stat. Auth:** ORS 656.726(3)

**Stats. Implemented:** ORS 656.005(12), 656.245, 656.260

**Hist:** Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82  
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**Amended 10/25/99 as Admin. Order 99-061, eff. 10/25/99 (Temp)**

**436-010-0270 Insurer's Rights and Duties**

(1) Insurers shall notify the injured worker 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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(2) Insurers may obtain relevant medical records, using a computer-generated equivalent of any authorized Release of Information prescribed by the Director, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(3) In claims which have been denied and are on appeal, the insurer shall notify the medical provider and MCO, if any, within ten days of any change of status of the claim.

(4) Immediately following notice or knowledge that the worker is medically stationary, insurers shall notify all injured workers **and the attending physician** in writing which medical services remain compensable under the system and the manner in which they may receive palliative care in accordance with OAR 436-010-0290. The director may, by bulletin, prescribe the form or format for such notification.

(5) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician, the insurer shall [provide notice to medical service providers of the medically stationary status within 24 hours] **notify all medical service providers of the worker's medically stationary status. The insurer shall be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician.**

(6) Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(d) and OAR 436-060-0070.

(a) Reimbursement by the insurer to the worker for transportation costs to visit their attending physician may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician of the same specialty who is in a geographically closer medical community in relationship to the worker's home. All medical practitioners within a metropolitan area are considered part of the same medical community and therefore are not considered geographically closer than any other physician in that metropolitan medical community for purposes of travel reimbursement.

(b) A worker who relocates within the State of Oregon may continue treating with the established attending physician and be reimbursed transportation costs.

(c) Prior to limiting reimbursement under (a) of this rule, the insurer shall provide the worker a written explanation and a list of providers who can timely provide similar services within a reasonable traveling distance for the worker. The insurer shall inform the worker that treatment may continue with the established attending physician; however, reimbursement of transportation costs may be limited as described.

(d) When the director decides travel reimbursement disputes at administrative review or contested case level, the determination will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

**Stat. Auth:** ORS 656.726(3)

**Stat. Implemented:** ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

**Hist:** Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82  
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EXHIBIT "A"  
OREGON ADMINISTRATIVE RULES  
CHAPTER 436, DIVISION 015 (TEMPORARY RULES)

**436-015-0008 Administrative Review**

(1) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, administrative review shall continue.

(2) Administrative Review Before the Director: The process for administrative review of such matters shall be as follows:

(a) Any party that disagrees with an action taken by an MCO pursuant to OAR 436-015 shall first use the dispute resolution process of the MCO.

(b) The aggrieved party shall file a written request for administrative review with the administrator of the Workers' Compensation Division within 60 days of the date the MCO issues a final decision under the MCO's dispute resolution process. If a party has been denied access to an MCO dispute resolution process because the complaint or dispute was not included in the MCO's dispute resolution process or because the MCO's dispute resolution process was not completed for reasons beyond a party's control, the party may request administrative review within 60 days of the failure of the MCO to issue a decision. The request must specify the grounds upon which the action is contested.

(c) The director shall create a documentary record sufficient for judicial review. The director may require and allow the parties to submit such input and information appropriate to complete the review.

(d) The director shall review the relevant information and issue an order. The order shall specify that it will become final and not subject to further review unless a written request for hearing is filed with the administrator within 30 days of the mailing date of the order.

(3) Contested Cases Before the Director: Any party that disagrees with an order pursuant to this rule may request a contested case hearing before the director as follows:

(a) The party shall file a written request for a contested case hearing with the administrator of the Workers' Compensation Division within 30 days of the mailing date of the order. The request shall specify the grounds upon which the order is contested.

(b) The hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(c) In the review of orders issued pursuant to ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, administrative orders may be modified at hearing only if the administrative order is not supported by substantial evidence in the record or reflects an error of law. The dispute may be

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remanded to the MCO for further evidence taking, correction, or other necessary action if the director determines the record has been improperly, incompletely or otherwise insufficiently developed.

(4) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of civil penalty issued by the director pursuant to ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) The party shall file a written request for a hearing with the administrator of the Workers' Compensation Division within [20] **60** days after service of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The Division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(c) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(5) Hearings on the Suspension or Revocation of an MCO's Certification:

(a) At a hearing on a notice of intent to suspend issued pursuant to OAR 436-015-0080(2), the MCO must show cause why it should be permitted to continue to provide services under these rules.

(A) If the director determines that the acts or omissions of the MCO justify suspension of the MCO's certification, the director may issue an order suspending the MCO for a period of time up to a maximum of one year or may initiate revocation proceedings pursuant to OAR 436-015-0080(5). If the director determines that the acts or omissions of the MCO do not justify suspension, the director shall issue an order withdrawing the notice.

(B) The order must be served upon the MCO as provided in OAR 436-015-0130.

(C) If the MCO disagrees with the order, it may request a contested case hearing before the director by filing a written request with the administrator within 60 days of the date of service of the order.

(D) The contested case hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(b) A revocation issued pursuant to OAR 436-015-0080(5) shall become effective within 10 days after service of such notice upon the MCO unless within such period of time the MCO corrects the grounds for revocation to the satisfaction of the director or files a written request for hearing with the administrator of the Workers' Compensation Division.

(A) If the MCO appeals, the administrator shall set a date for a hearing and shall give the MCO at least ten days notice of the time and place of the hearing. At hearing, the MCO shall show cause why it should be permitted to continue to provide services under these rules.

(B) Within thirty days after the hearing, the director shall issue an order affirming or

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withdrawing the revocation. The director shall serve a copy of the order upon the MCO as provided in OAR 436-015-0130.

(C) If the MCO disagrees with the order, it may request a contested case hearing before the director by filing a written request with the administrator within 60 days of the date of service of the order.

(D) The contested case hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(c) An emergency revocation issued pursuant to OAR 436-015-0008(5), is effective immediately. The MCO must file a request for contested case hearing within 60 days of the date of service of the order. The contested case hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

**Stat. Auth.:** 183.310 thru 550 and ORS 656.726(3)

**Stats. Implemented:** ORS 656.260

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#### **436-015-0035 Coverage Responsibility of an MCO**

(1) An MCO shall provide comprehensive medical services in accordance with its certification to all enrolled injured workers covered by the insurer/MCO contract.

(2) The director shall designate an MCO's initial GSA and approve any expansions to the MCO's service area. Injured workers shall not be governed by an MCO until the director has approved the geographical service area. GSAs shall be established by postal zip code. The MCO may only provide contract services to those GSAs approved by the director.

(3) Any expansion of an MCO's GSA must be approved by the director. The request for expansion must identify the postal zip code areas of the proposed expansion and include evidence that the MCO has an adequate provider panel in the new areas which meet the minimum requirements as set forth in OAR 436-015-0030. An MCO may be authorized by the director to expand the GSA without the minimum categories of medical service providers when the MCO establishes that there are not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers, the MCO must allow workers to seek treatment outside the MCO from providers in those categories, consistent with the MCO's treatment and utilization standards. Such providers, unlike primary care physicians cannot be required to comply with the terms and conditions regarding services performed by the MCO. However, while such providers are not themselves bound by the MCO's treatment and utilization standards, workers are subject to those standards.

(4) An MCO may contract only with an insurer as defined in OAR 436-010-0005. When an MCO contracts with an insurer to provide services, the contract shall specify those employers governed by the contract. The MCO/insurer contract must include the following terms and conditions:

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- (a) The contract must specify who is governed by the contract;
- (b) The insured's place of employment must be within the authorized geographical service area;
- (c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location shall be governed by the same MCO(s). When insurers contract with multiple MCOs each worker shall have initial choice at time of injury to select which MCO will manage their care except when the employer provides a coordinated health care insurance program as defined in OAR 436-010-0005(6);
- (d) Workers enrolled in an MCO shall receive medical services in the manner prescribed by the terms and conditions of the contract; and
- (e) To ensure continuity of care, the contract shall specify the manner in which injured workers will receive medical services on open claims including but not be limited to the following:
- (A) Upon enrollment, allowing the worker to continue to treat with a non-qualified medical service provider for at least seven days after the mailing date of the notice of enrollment; and
- (B) Upon termination or expiration of the MCO/insurer contract, allows the workers to continue treatment in accordance with ORS 656.245(4)(a).
- [ (5) When MCO coverage for an injured worker is transferred from one MCO to another, the worker may continue to treat with their attending physician if that physician also qualifies as an attending physician under the new MCO/insurer contract or law and agrees to the terms and conditions of the new MCO, until a change of physician is necessary based upon the MCO's treatment standards and protocols. ]
- [ (6) **(5)** Notwithstanding the requirements of this rule, failure of the MCO to provide such medical services does not relieve the insurers of their responsibility to ensure benefits are provided injured workers under ORS Chapter 656.

**Stat. Auth.:** ORS 656.726(3)

**Stats. Implemented:** ORS 656.245 and 260

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