

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of:)
 OAR 436-010, Medical Services) SUMMARY OF
) TESTIMONY AND
) AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency’s conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated July 2015. On July 21, 2015, a public rulemaking hearing was held as announced at 9 a.m. in Room B of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record was held open for written comment through July 27, 2015.

No one testified at the public rulemaking hearing, recorded below as exhibit 4. The public submitted three written documents as testimony.

Testimony list:

Exhibit	Testifying
<u>1</u>	The department entered the proposed rules into the record as exhibit #1.
<u>2</u>	Krishna Balasubramani, Attorney at Law
<u>3</u>	Diana E. Godwin, Attorney at Law
<u>4</u>	Record of hearing – no testimony
<u>5</u>	Jaye Caroline Fraser, SAIF Corporation

Testimony 1: OAR 436-010

Exhibit 2

“* * * why not have attending physicians also review the training materials? I assume it doesn’t take much time and it would really help with the communication and confirm that the attending physicians knows that he or she is signing up for. Perhaps follow the language that exists for IME doctors – “(i) Reviewed IME training materials provided or approved by the director found at www.oregonwcdoc.info”

Response: Thank you for your testimony. It is not entirely clear what training materials you are referring to, but we think the recommendation is to set training standards for type A attending physicians (MDs, DOs, oral surgeons) that are equivalent to those in place for type B physicians

**Oregon Administrative Rules, Chapter 436
Public Testimony & Agency Responses**

(DCs, PAs, NPs). While ORS 656.799 currently provides clear authority for the director to establish training materials for type B attending physicians, there is no explicit provision in ORS chapter 656 for the director to issue rules on training for type A attending physicians.

ORS 656.329 formerly required professional medical associations to establish continuing medical education programs in a manner prescribed by the director to instruct providers on the requirements of the workers' compensation law. ORS 656.329 was repealed by 1995 Or Laws, ch. 94, s. 11.

Testimony 2: OAR 436-010-0005(7)

Exhibit 5

“The definition for "come along provider" appears incomplete and thus potentially misleading. SAIF suggests the definition should either clarify that the treatment is under the terms of ORS 656.260(4)(g) and ORS 656.245(5), or, rather than referring the reader to "see OAR 436-015-0070, the rule could state that the definition is "subject to" OAR 436-015-0070.”

Response: Thank you for your testimony. We respectfully disagree with your assessment. As with other definitions, the definition of “come along provider” doesn’t include substantive provisions, in this case regarding the necessary qualifications and limitations applicable to come along providers. The definition does include a cross-reference to OAR 436-015-0070 to assist the reader in finding where the definition is used in context.

Testimony 3: OAR 436-010-0005(8)

Exhibit 3

“We support the addition of the definition of “date stamp.” ”

Response: Thank you for your testimony.

Testimony 4: OAR 436-010-0005(30)

Exhibit 5

““Patient.” * * * Perhaps using "patient" rather than "worker" or "injured worker" is an attempt to use a word more commonly employed by medical providers. SAIF is not aware the current terminology causes confusion for medical providers. Moreover, "patient" it not consistently used throughout the administrative scheme or even in this rule division, and may create potential confusion rather than clarity.”

Response: Thank you for your testimony. The advisory committee did not express concerns about using the term “patient,” and it has been in use without any apparent issues in the Division 009 rules. The division applied the same criteria in the Division 010 rules as we did in the Division 009 rules when using the term patient; wherever the rules are directed to treating providers, we have used the term “patient” to facilitate understanding.

Testimony 5: OAR 436-010-0008(1)(e)

Exhibit 5

“(l)(e) States that when the director declares a medical treatment or service inappropriate or in violation of rules, the worker is not obligated to pay for such. * * * The worker may be liable to pay for a variety services rendered in violation of rules, as delineated in OAR 436-009-0010(9). In addition, using "such" as the end of the sentence is unclear.”

Response: Thank you for your testimony. The division did not make a change to the current rule language (See current 010-0008(11)). The division is unaware that this rule language has caused any issues, but you may raise it for discussion by an advisory committee when these rules are next reopened.

**Oregon Administrative Rules, Chapter 436
Public Testimony & Agency Responses**

Testimony 6: OAR 436-010-0008(2)(c)

Exhibit 5

“SAIF suggests retaining the deleted reference to section 0250 for elective surgery disputes; the reference to OAR 436-010-0250 was helpful. * * *”

Response: Thank you for your testimony. In trying to streamline some of these rules, rule 0008(2)(c) was identified as having limited usefulness, because it is a subsection that merely refers to another rule. The division does not expect that this change will cause confusion. However, if you can identify problems that are created by removing the language, please raise these problems at the next advisory committee meeting.

Testimony 7: OAR 436-010-0008(2)(c)

Exhibit 5

“* * * Section 2's number series seems incorrect. Section (2)(a) ends with a colon, and the next section is (2)(b). It seems proposed subsection (2)(a) should not be numbered, and the proposed (2)(b) should be (2)(a).”

Response: Thank you for your testimony. We have renumbered section (2).

Testimony 8: OAR 436-010-0008(3)(c)(E)

Exhibit 5

“This provision requires a statement from the insurer that there either is, or is not, an issue of compensability of the "underlying claim or condition". The phrase "underlying claim or condition" does not appear in ORS Chapter 656 and as such, its meaning is unclear.”

Response: Thank you for your testimony. The phrase "underlying claim or condition" has been in these rules for several years, and to our knowledge has not created any problems. Therefore, the division is not inclined to make any changes at this point.

Testimony 9: OAR 436-010-0008(7)

Exhibit 5

“SAIF finds the order of this rule's paragraphs confusing. In particular, paragraph (d) refers to "the director's order" but the kind of order to which it refers, is unclear. SAIF suggests moving this sentence to (7)(b) rather than referencing it in (7)(d). * * *”

Response: Thank you for your testimony. Please see response to Testimony 10.

Testimony 10: OAR 436-010-0008(7)

Exhibit 5

“* * * SAIF finds the second sentence of paragraph (d) relating to the standard of review of an administrative order redundant and confusing. Simply stating that in any hearing on review of a director's order concerning a medical service under ORS 656.245, ORS 656.327, or ORS 656.260, the record is closed, and the ALJ will review the order for substantial evidence or errors of law, would be clear. See, *Liberty Northwest Insurance Corporation v. Kraft*, 205 Or App 59 (2006); *Liberty Northwest Ins. Corp. v. Mundell*, 219 Or App 358 (2008). Also see OAR 436-001-0225(2) ("In medical service and medical treatment disputes under ORS 656.245, 656.247(3)(a), and 656.327, and managed care disputes under ORS 656.260(16), the administrative law judge may modify the director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. New evidence or issues may not be admitted or considered.”)

Response: Thank you for your testimony. After further reviewing subsection (d) we not only agree that the second sentence is redundant, but the entire subsection (d) is superfluous and can be removed. We have also made the reference to 656.245(3) in 010-0008(7)(b) broader by referring to all of 656.245.

**Oregon Administrative Rules, Chapter 436
Public Testimony & Agency Responses**

Testimony 11: OAR 436-010-0210 (rule title) *Exhibit 5*

“SAIF finds this section's current title more descriptive than the proposed title for anyone searching the rules for information. The proposed title does not capture the rule's references to treatments by other providers on referral from an attending physician. In addition, using a slash instead of words may be unclear. If reverting to the current title is unsatisfactory, SAIF suggests the title read, "Attending Physicians, Authorized Nurse Practitioners, and Time-Loss Authorizations." ”

Response: Thank you for your testimony. The division has changed the title as suggested.

Testimony 12: OAR 436-010-0210(3) *Exhibit 5*

“* * * This section details compensable medical services a nurse practitioner may and may not provide, but does not mention closing exams. SAIF suggests this section add language stating that nurse practitioners must refer the worker to a type A physician for closing exams.”

Response: Thank you for your testimony. Rule 010-0280(1) already states what you're looking for.

Testimony 13: OAR 436-010-0210(4) *Exhibit 5*

“Unlicensed to Provide Medical Services: SAIF suggests this section on unlicensed providers belongs in OAR 436-010-0230, Medical services and treatment guidelines.”

Response: Thank you for your testimony. Rule 0210 describes treatment authority for several categories of providers, and this provision on services by certain unlicensed providers appears to be appropriately listed in this rule.

Testimony 14: OAR 436-010-0230(4) *Exhibit 5*

“SAIF does not understand or agree with the proposed language stating "A medical provider may refuse to meet with an employer or insurer representative." This blanket statement may discourage good working relationships between medical providers and insurance carriers and may hamper the insurer's ability to discuss a plan of care or show the provider evidence relating to the worker's condition or care.”

Response: Thank you for your testimony. This sentence has been in the Division 010 rules since April of 2013. It was included to address concerns expressed by health care providers, and it did not prompt public testimony at the time. If you are aware of problems created by this rule provision, you may bring the issue to the rulemaking advisory committee the next time these rules are opened.

Testimony 15: OAR 436-010-0230(6)(7) *Exhibit 5*

“Ancillary services. The rule does not specify whether it also applies to closed claims. In closed claims, there are additional requirements under ORS 656.245(1)(c)(J).”

Response: Thank you for your testimony. In closed claims, the responsibility to submit a palliative care request lies with the attending physician. This rule addresses primarily the ancillary care provider's responsibility to complete and forward the treatment plan. If you are aware that providers are confusing palliative care requests and treatment plans, you may bring the issue to the rulemaking advisory committee the next time these rules are opened.

**Oregon Administrative Rules, Chapter 436
Public Testimony & Agency Responses**

Testimony 16: OAR 436-010-0230(7)

Exhibit 3

“We strongly support the proposed revisions in re-numbered subsection (7) of OAR 436-010-0230 regarding preparation and submission of a treatment plan to the workers’ compensation insurer and the patient’s attending provider. The new language provides that in the circumstance where a provider fails to send the treatment plan within seven days the insurer is not required to pay those dates of service that occurred prior to the date the provider sends the plan, but will pay for the dates of service that occur after the provider sends the plan. This change addresses a long-standing problem.

“Under the current wording of this rule, the insurer can decline to pay for all dates of service if the provider fails to send the treatment plan within seven days, even those dates of service that occur after the provider does send the plan. This has resulted in unwarranted denials of payment and friction between insurers and providers. * * *”

Response: Thank you for your testimony.

Testimony 17: OAR 436-010-0230(12)

Exhibit 5

“Diagnostics. This rule is ambiguous; it states pre-authorization is not a guarantee of payment, but requires the insurer to respond whether the service is "approved or denied." In addition, the utility of this action is unclear and the terms "approved or denied" are different than the term "pre-authorized." Thus, it is unclear whether an approval will be a guarantee of payment. When a claims adjuster is obtaining evidence to evaluate the compensability of a new condition in an accepted claim, this rule forces them to approve or deny a service that may later turn out to be either compensable or not compensable. Some "diagnostic" services involve invasive procedures; participants should not be misled into thinking that an insurer will pay for a service when it may not.”

Response: Thank you for your testimony. The division agrees that the term pre-authorized may have a different meaning than approved. Therefore, the division revised language as follows:

The insurer must respond to the provider’s request in writing whether the service is **pre-authorized or not pre-authorized**~~approved or denied~~ within 14 days of receipt of the request.

Testimony 18: OAR 436-010-0240

Exhibit 2

“* * * under 436-10-240 why “must” an insurer use that specific form? Why not that form or something similar/

(5) Release to Return to Work. (a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient’s medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner

Response: Thank you for your testimony. The “Release to Return to Work,” Form 3245, was created at the recommendation of a paperwork reduction taskforce in 1999. Physicians found it difficult to complete so many different insurer forms, so the rules were amended to require that insurers were only able to insist upon one standard form, Form 3245, though providers may use their own form if the insurer doesn’t specify the 3245.

**Oregon Administrative Rules, Chapter 436
Public Testimony & Agency Responses**

Testimony 19: OAR 436-010-0241(4)(a) *Exhibit 5*

“Aggravation. SAIF suggests this rule would be clearer if it stated that the physician's report must document the worker's inability to work due to an actual worsening of a compensable condition.”

Response: Thank you for your testimony. The proposed rule language already contains this requirement in (4)(b), because the attending physician’s report must include objective findings that document: “Whether the patient is unable to work as a result of the compensable worsening.”

Testimony 20: OAR 436-010-0250(10) *Exhibit 5*

“This rule provides notice of penalties to physicians who fail to comply with the rule requiring sufficient notice of a proposed elective surgery to the insurer. However, it also tells the physician the insurer may still be liable for the surgery, which may make the rule's notice provisions ineffectual. SAIF recommends removing the last sentence of this section.”

Response: Thank you for your testimony. This rule makes it clear that the recommending physician may be subject to civil penalties for failure to meet the seven day notice requirement. However, payment for elective surgery is not contingent on timely notice, and the statement “The insurer may still be responsible to pay for the elective surgery.” is intended to remove any confusion about this.

Testimony 21: OAR 436-010-0270(1)(d) *Exhibit 5*

“The second sentence of this rule is worded very broadly and, as written, is not authorized by statute.”

Response: Thank you for your testimony. The division believes this rule is consistent with ORS 656.245(1)(d); relevant wording was added to section .245 in 1999 – see 1999 Or Laws ch. 868, s. 1.

Testimony 22: OAR 436-010-0270(3) *Exhibit 5*

“Preauthorization. This rule is inconsistent with OAR 436-010-0230(12) in that it omits the provision stating that preauthorization is not a guarantee of payment. SAIF's concerns regarding OAR 436-010-023(12) set out above also apply here.”

Response: Thank you for your testimony. The division agrees that the term pre-authorized may have a different meaning than approved. Therefore, we have revised the language to be consistent with pre-authorization.

The response must include whether the service is pre-authorized or not pre-authorized.

Dated this 18th day of August, 2015.



Oregon

Kate Brown, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
1-800-452-0288, 503-947-7810
www.wcd.oregon.gov

June 11, 2015

**Exhibit
"1"**

Proposed Changes to Workers' Compensation Rules

Medical services in workers' compensation claims

The Workers' Compensation Division proposes changes to OAR 436-010, Medical Services.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

When is the hearing? July 21, 2015, 9 a.m.

Where is the hearing? Labor & Industries Building
350 Winter Street NE, Room B (basement)
Salem, Oregon 97301

How can I make a comment? Come to the hearing and speak, send written comments, or do both. Send written comments to:
Email – fred.h.bruyns@oregon.gov
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Phone – 503-947-7717; Fax – 503-947-7514

The closing date for written comments is July 27, 2015.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's website –
www.wcd.oregon.gov/policy/rules/rules.html#proprules

Or call 503-947-7717 to get free paper copies

Questions? Contact Fred Bruyns, 503-947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*
A Statement of Need and Fiscal Impact accompanies this form

FILED
6-11-15 2:30 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division
Agency and Division
Fred Bruyns
Rules Coordinator
Department of Consumer and Business Services, Workers' Compensation Division, PO Box 14480, Salem, OR 97309-0405
Address

Administrative Rules Chapter Number
436
(503) 947-7717
Telephone

RULE CAPTION

Medical services in workers' compensation claims

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
7-21-15	9:00 a.m.	Rm B, Labor & Industries Bldg., 350 Winter Street NE, Salem, Oregon	Fred Bruyns

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

436-010, 436-010-0241, ~~436-010-0275~~ *AB 6-15-15*

AMEND:

436-010

REPEAL:

436-010, 436-010-0002, 436-010-0003, 436-010-0006, 436-010-0275

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.
From 436-010-0260 to 436-010-0335

Statutory Authority:

ORS 656.252, 656.254, 656.726(4)

Other Authority:

Statutes Implemented:

ORS ch. 656, primarily 656.245, 656.252, 656.254, 656.260, 656.264, 656.325, 656.327, 656.745

RULE SUMMARY

The public may also listen to the hearing or testify by telephone:
Dial-in number is 213-787-0529; Access code is 9221262#.

The agency proposes to amend OAR 436-010, "Medical Services," to:

- Substantially revise and reorganize division 010, including deleting obsolete and otherwise unnecessary wording, to make the rules more comprehensive and to facilitate consistent understanding (Much of the text marked as "new" is in fact current, but it is marked because it has been moved.);
- Clarify that, for disputes under ORS 656.260 or 656.327, the dispute record packet must include certification whether there is or is not an issue of compensability of the underlying claim or condition.
- Move some regulations to division 009 for separate public review and hearing, and move some regulations from division 009 to division 010, so that regulations relevant to the medical fee schedule and medical services are located with related rules;
- Add definitions of "come-along" provider, "date stamp," and "patient," and delete definitions of terms not used in division 010;
- Limit denial of reimbursement based on late submission of a treatment plan by an ancillary service provider to those services provided before the treatment plan is sent;
- Require that the insurer must approve or disapprove (not just respond to) a health care provider's request for pre-authorization of a

diagnostic study within 14 days of receipt of the request; and

- Encourage providers to adhere to the new opioid guidelines approved by the Medical Advisory Committee.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

<u>07-27-2015 Close of Business</u>	<u>Fred Bruyns</u>	<u>fred.h.bruyns@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

diagnostic study within 14 days of receipt of the request; and

- Encourage providers to adhere to the new opioid guidelines approved by the Medical Advisory Committee.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

<u>07-27-2015 Close of Business</u>	<u>Fred Bruyns</u>	<u>fred.h.bruyns@state.or.us</u>
Last Day (<i>m/d/yyyy</i>) and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT
A Notice of Proposed Rulemaking Hearing accompanies this form.

FILED
6-11-15 2:30 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division
Agency and Division

436
Administrative Rules Chapter Number

Medical services in workers' compensation claims

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

Amendment of OAR 436-010, Medical Services

Statutory Authority:

ORS 656.252, 656.254, 656.726(4)

Other Authority:

Statutes Implemented:

ORS ch. 656, primarily 656.245, 656.252, 656.254, 656.260, 656.264, 656.325, 656.327, 656.745

Need for the Rule(s):

The proposed changes are needed in order to improve the clarity and consistency of the rules governing medical services delivery and related reporting.

Documents Relied Upon, and where they are available:

Advisory committee meeting records and written advice. These records are available for public inspection in the office of the Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

Fiscal and Economic Impact:

The agency projects that proposed rule changes will have no significant positive or negative fiscal or economic impacts on the agency, other state agencies, units of local government, or the public.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

The agency estimates that proposed rule changes will produce no significant cost of compliance for state agencies, units of local government, or the public.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

The agency estimates that Oregon has at least 12,000 medical providers. Many of these businesses would be small businesses as defined by ORS 183.310(10).

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

The agency projects that proposed rule changes would not significantly affect businesses' costs for reporting, recordkeeping, administration, or professional services.

c. Equipment, supplies, labor and increased administration required for compliance:

The agency projects that proposed rule changes would not significantly affect businesses' costs for equipment, supplies, or labor/administration required for compliance.

How were small businesses involved in the development of this rule?

The agency sent invitations for advisory committee participation to more than three thousand stakeholders, including small businesses, and small business representatives served on the committee.

Administrative Rule Advisory Committee consulted?: Yes
If not, why?:

<u>07-27-2015 Close of Business</u>	<u>Fred Bruyns</u>	<u>fred.h.bruyns@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Proposed

TABLE OF CONTENTS

Rule	Page
436-010-0001 Administration of These Rules	1
436-010-0005 Definitions.....	1
436-010-0008 Request for Review before the Director	5
General.....	5
Time Frames and Conditions.....	5
Form and Required Information.	6
Physician Review.....	7
Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).....	8
Director Order and Reconsideration.	9
Hearings.....	9
Other Proceedings.....	10
436-010-0200 Medical Advisory Committee	10
436-010-0210 Attending Physician and Authorized Nurse Practitioner/Time-Loss Authorization	10
Emergency Room Physicians.	11
Authorized Nurse Practitioners.....	11
Unlicensed to Provide Medical Services.	11
Out-of-State Attending Physicians.	11
436-010-0220 Choosing and Changing Medical Providers.....	12
Changing Attending Physician or Authorized Nurse Practitioner.....	13
Insurer Notice to the Worker.	14
Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.....	14
Managed Care Organization (MCO) Enrolled Workers. An MCO enrolled worker must choose:	15
436-010-0225 Choosing a Person to Provide Interpreter Services.....	15

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

436-010-0230	Medical Services and Treatment Guidelines.....	15
	Consent to Attend a Medical Appointment.	15
	Request for Records at a Medical Appointment.	16
	Requesting a Medical Provider Consultation.	16
	Ancillary Services – Treatment Plan.	16
	Massage Therapy.	16
	Therapy Guidelines and Requirements.	17
	Physical Capacity Evaluation.	17
	Prescription Medication.	17
	Diagnostics.....	18
	Articles.....	18
	Physical Restorative Services.	18
	Lumbar Artificial Disc Replacement Guidelines.....	18
	Cervical Artificial Disc Replacement Guidelines.....	19
436-010-0240	Medical Records and Reporting Requirements for Medical Providers.....	20
	Medical Records and Reports.	20
	Diagnostic Studies.	20
	Release of Medical Records.	21
	Release to Return to Work.....	22
	Time Loss and Medically Stationary.	22
	Consultations.	22
436-010-0241	Form 827, Worker’s and Health Care Provider’s Report for Workers’ Compensation Claims	23
	First Visit.	23
	New or Omitted Medical Condition.	23
	Change of Attending Physician.	23
	Aggravation.	23
436-010-0250	Elective Surgery	24
436-010-0265	Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs).....	25
	General.....	25
	IME/WRME Authorization.	26
	IME Training.	27
	IME Related Forms.....	27
	IME Observer.	27
	Invasive Procedure.....	28

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

Video or tape record the exam.....	28
Objection to the IME Location.....	28
Failure to Attend an IME.....	28
IME Report.....	28
Request for Additional Exams.....	29
Other Exams – Not Considered IMEs.....	30
436-010-0270 Insurer’s Rights and Duties	30
Notifications.....	30
Medical Records Requests.....	30
Pre-authorization.....	31
Insurer’s Duties under MCO Contracts.....	31
436-010-0280 Determination of Impairment / Closing Exams	33
436-010-0290 Medical Care After Medically Stationary	36
Palliative Care.....	36
Curative Care.....	37
Advances in Medical Science.....	37
436-010-0300 Requesting Exclusion of Medical Treatment from Compensability	38
436-010-0330 Medical Arbiters and Physician Reviewers.....	38
436-010-0335 Monitoring and Auditing Medical Providers.....	38
436-010-0340 Sanctions and Civil Penalties	39
Appendix A Matrix for health care provider types.....	41
Appendix B IME Training Curriculum Requirements.....	42
Appendix C IME Standards.....	45

NOTE: These rules are published with and without marked changes. The table of contents above links to the clean copy. To review the copy with marked changes, [click here](#). [To review the copy with marked changes, click here](#).

HISTORY LINES: These rules include only the most recent “History” lines. A rule’s history line shows when the rule was last revised and its effective date. To obtain a “Chapter 436 revision history index,” please call the Workers’ Compensation Division, 503-947-7627, or visit the division’s website: <http://wcd.oregon.gov/policy/rules/history.html>

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

Blank page for two-sided printing

Oregon Administrative rules OAR chapter 436

[CLICK: Link to version with marked changes >>>](#)

436-010-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and OAR chapter 436, are considered orders of the director.

(2) **Authority for Rules.** These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.

(3) **Purpose. [Formerly rule 0002]** The purpose of these rules is to establish uniform guidelines for administering the delivery of and payment for medical services to workers within the workers' compensation system.

(4) **Applicability of Rules. [Formerly rule 0003]**

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

Hist: Amended 12/17//01 as Admin. Order 01-065, eff 1/1/02

436-010-0005 Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) **"Administrative review"** means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(3) **"Attending physician"** has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider Types."

(4) **"Authorized nurse practitioner"** means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.

ORDER NO. 15-XXX

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

(5) “**Board**” means the Workers’ Compensation Board and includes its Hearings Division.

(6) “**Chart note**” means a notation made in chronological order in a medical record in which the medical service provider records information such as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return-to-work goals and status.

(7) “**Come-along provider**” means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who continues to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)

(8) “**Date stamp**” means to stamp or display the initial receipt date and the recipient’s name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(9) “**Days**” means calendar days.

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

(11) “**Direct medical sequela**” means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a “direct medical sequela.”

(12) “**Division**” means the Workers’ Compensation Division of the Department of Consumer and Business Services.

(13) “**Eligible worker**” means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO’s authorized geographical service area, covered by an insurer that has a contract with that MCO.

(14) “**Enrolled**” means an eligible worker has received notification from the insurer that the worker is being required to treat under the provisions of a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker’s primary residence is more than 100 miles outside the managed care organization’s certified geographical service area.

(15) “**Health care practitioner or health care provider**” has the same meaning as a “medical service provider.”

(16) “**Hearings Division**” means the Hearings Division of the Workers’ Compensation Board.

(17) “**Home health care**” means necessary medical and medically related services provided in the patient’s home environment. These services may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

ORDER NO. 15-XXX

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

(18) **“Hospital”** means an institution licensed by the State of Oregon as a hospital.

(19) **“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 or authorized nurse practitioner. For nondisabling claims, the “initial claim” means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(20) **“Insurer”** means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407.

(21) **“Interim medical benefits”** means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer’s notice of the claim.

(22) **“Mailed or mailing date”** means the date a document is postmarked. Requests submitted by facsimile or “fax” are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the Workers’ Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(23) **“Managed care organization” or “MCO”** means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(24) **“Medical evidence”** includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, X-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(25) **“Medical provider”** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(26) **“Medical service”** means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, or other related services; drugs, medicine, crutches, prosthetic appliances, braces, and supports; and where necessary, physical restorative services.

(27) **“Medical service provider”** means a person duly licensed to practice one or more of the healing arts.

(28) **“Medical treatment”** means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker’s condition through

ORDER NO. 15-XXX

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

conservative care.

(29) **“Parties”** mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(30) **“Patient”** means the same as worker as defined in ORS 656.005(30).

(31) **“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 Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(32) **“Physical restorative services”** means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the patient’s highest functional ability consistent with the patient’s condition.

(33) **“Report”** means medical information transmitted in written form containing relevant subjective or 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.

(34) **“Residual functional capacity”** means a patient’s remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

(35) **“Specialist physician”** means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient’s compensable injury.

(36) **“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 has the same meaning as Work Capacity Evaluation.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.000 et seq.; 656.005

Hist: Amended 11/1/07 as Admin. Order 07-057, eff. 1/2/08

Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

ORDER NO. 15-XXX

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

436-010-0006 Administration of Rules [Repealed/combined with rule 0001]

436-010-0008 Request for Review before the Director

(1) General.

(a) Administrative review before the director:

(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(B) A party does not need to be represented to participate in the administrative review before the director.

(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(b) All issues pertaining to disagreements 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 worker, are subject to 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 administrative review of the matter before the director.

(c) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

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

(e) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.

(2) Time Frames and Conditions.

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

(b) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless

ORDER NO. 15-XXX

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

the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

(c) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to the MCO dispute resolution 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. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review before the director.

(d) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review before the director within 90 days of the date the party knew, or should have known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

(e) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

- (A) Identify the worker's name, date of injury, insurer, and claim number;
- (B) Specify the issues in dispute and the relief sought; and
- (C) Provide the specific dates of the unpaid disputed treatment or services.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses

ORDER NO. 15-XXX

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

and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327(3)(c), the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

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

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

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

(C) If the requesting party is not the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

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

(E) Except for disputes regarding interim medical benefits, the packet must include certification stating that there is an issue of compensability of the underlying claim or condition or stating that there is not an issue of compensability of the underlying claim or condition. If the insurer issued a denial that has been reversed by the Hearings Division, the Board, or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

(4) **Physician Review (E.g., appropriateness).** If the director determines a review by a physician is indicated to resolve the dispute, the director, under 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 exam as part of the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review must be a practitioner of the same

ORDER NO. 15-XXX

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

healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

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

(c) When such an exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the exam. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel unless it relates to the exam date, time, location, or attendance. If the parties have special questions they want addressed by the physician or panel, the questions must be submitted to the director for screening 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 exam 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.

(5) Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

- (A) A party fails to honor the agreement;
- (B) The agreement was based on misrepresentation;
- (C) Implementation of the agreement is not feasible because of unforeseen circumstances; or
- (D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order. If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical 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.

ORDER NO. 15-XXX

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

(6) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw 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 information that 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 must be mailed to the director before the administrative order becomes final.

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

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

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(7) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245(3), 656.247, 656.260(14) or (16), or 656.327(2), no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order 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.

(c) Contested case hearings of sanctions 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 under 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 mailed to the administrator within 60 days after the mailing date of the order or notice of assessment.

(C) The administrator will forward the request and other pertinent information to the Workers' Compensation Board.

(d) If the director's order is appealed, review at hearing is subject to the "no new medical evidence or issues rule" in subsection (7)(b) of this rule. However, if the disputed medical

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

service or medical treatment 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 hearing.

(8) Other Proceedings.

(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party not covered under sections (1) through (7) of this rule, may request administrative review before the director.

(b) 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.

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

Stat. Auth.: ORS 656.726(4)

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

Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08
 Amended 12-1-2009 as Admin. Order 09-055, eff. 1-1-2010

436-010-0200 Medical Advisory Committee

The Medical Advisory Committee members are appointed by the director of the Department of Consumer and Business Services. The committee must include one insurer representative, one employer representative, one worker representative, one managed care organization representative, and a diverse group of health care providers representative of those providing medical care to injured or ill workers.

The director may appoint other persons as may be determined necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. When appointing members, the director should select health care providers who will consider the perspective of specialty care, primary care, and ancillary care providers and consider the ability of members to represent the interests of the community at large.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.794

Hist: Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0210 Attending Physician and Authorized Nurse Practitioner/Time-Loss Authorization

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes time loss, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

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

(b) Type A and B attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A “Matrix for Health Care Provider Types”)

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker’s attending physician or authorized nurse practitioner.

(2) Emergency Room Physicians. Emergency room physicians may authorize time loss for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in his or her private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

(3) Authorized Nurse Practitioners.

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician’s authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

(4) Unlicensed to Provide Medical Services. Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician’s direct control and supervision. Home health care provided by a patient’s family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(5) Out-of-State Attending Physicians. The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker’s request or becomes aware of the worker’s request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker’s choice of attending physician within 14 days.

(a) If the insurer approves the worker’s choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

(A) The Oregon medical fee and payment rules, OAR 436-009;

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

ORDER NO. 15-XXX

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

(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

(b) If the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:

(A) Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,

(B) Identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, and

(C) Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.

(6) If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:

(a) The reasons for withdrawing the approval,

(b) That any future services provided by that physician will not be paid by the insurer, and

(c) That the worker may be liable for payment of services provided after the date of notification.

(7) If the worker disagrees with the insurer's decision to disapprove an out-of-state attending physician, the worker or worker's representative may request approval from the director under OAR 436-010-0220.

Stat. Auth: ORS 656.726(4)

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

Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14

436-010-0220 Choosing and Changing Medical Providers

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment he or she considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:

(a) Emergency services;

(b) Insurer or director requested examinations;

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

(c) A Worker Requested Medical Examination;

(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and

(e) Diagnostic studies provided by radiologists and pathologists upon referral.

(2) Changing Attending Physician or Authorized Nurse Practitioner. The worker may choose to change his or her attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;

(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or

(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:

(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;

(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;

(D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");

(E) When the authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;

(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or

ORDER NO. 15-XXX

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

(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(3) Insurer Notice to the Worker. When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change his or her attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.

(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:

(A) Send the worker a written explanation of the reasons;

(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and

(C) Inform the worker that he or she may request director approval by sending Form 2332 to the director.

(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.

(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:

(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the

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

order.

(5) Managed Care Organization (MCO) Enrolled Workers. An MCO enrolled worker must choose:

(a) A panel provider unless the MCO approves a non-panel provider, or

(b) A “come-along provider” who provides medical services subject to the terms and conditions of the governing MCO.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.252, 656.260

Hist: Amended 12/14/07 as Admin. Order 07-070, eff. 1/2/08 (temporary)
 Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

436-010-0225 Choosing a Person to Provide Interpreter Services

A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245

Adopted 5/27/10, as Admin. Order 10-053, eff. 7/1/10

436-010-0230 Medical Services and Treatment Guidelines

(1) Medical services provided to the worker must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.

(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize time loss. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.

(4) Consent to Attend a Medical Appointment.

(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.

(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.

(B) The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(C) The insurer must keep a copy of the signed consent form in the claim file.

(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.

(5) Request for Records at a Medical Appointment. The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.

(6) Requesting a Medical Provider Consultation. The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.

(7) Ancillary Services – Treatment Plan.

(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.

(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.

(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes.

(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")

(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.

(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants directed by the attending physician do not have to provide a written treatment plan as prescribed in this section.

(8) Massage Therapy. Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services provided by a massage therapist licensed by the Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by

ORDER NO. 15-XXX

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

massage therapists must follow the same requirements as those for ancillary providers in section (5) of this rule.

(9) Therapy Guidelines and Requirements.

(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.

(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:

- (A) Subjective status of the patient;
- (B) Objective data from tests and measurements conducted;
- (C) Functional status of the patient;
- (D) Interpretation of above data; and
- (E) Any change in the treatment plan.

(10) Physical Capacity Evaluation. The attending physician or authorized nurse practitioner must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician or authorized nurse practitioner must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.

(11) Prescription Medication.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.

ORDER NO. 15-XXX

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

(b) Providers should review and are encouraged to adhere to the workers' compensation division's opioid guidelines. See <http://www.cbs.state.or.us/wcd/rdrs/mru/ogandcal.html>.

(12) Diagnostics. Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is approved or denied within 14 days of receipt of the request.

(13) Articles. Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices are not compensable unless a report by the attending physician or authorized nurse practitioner clearly justifies the need. The report must:

(a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and

(b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.

(14) Physical Restorative Services.

(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:

(A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and

(B) A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.

(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(15) Lumbar Artificial Disc Replacement Guidelines.

(a) Lumbar artificial disc replacement is always inappropriate for patients with the following conditions (absolute contraindications):

(A) Metabolic bone disease – for example, osteoporosis;

(B) Known spondyloarthropathy (seropositive and seronegative);

(C) Posttraumatic vertebral body deformity at the level of the proposed surgery;

(D) Malignancy of the spine;

(E) Implant allergy to the materials involved in the artificial disc;

(F) Pregnancy – currently;

(G) Active infection, local or systemic;

(H) Lumbar spondylolisthesis or lumbar spondylolysis;

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

(I) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or

(J) Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

(b) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients with the following conditions, depending on severity, location, etc. (relative contraindications):

(A) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(B) Arachnoiditis;

(C) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);

(D) Facet arthropathy – lumbar – moderate to severe, as shown radiographically;

(E) Morbid obesity – BMI greater than 40;

(F) Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;

(G) Osteopenia – based on bone density test;

(H) Prior lumbar fusion at a different level than the proposed artificial disc replacement;
or

(I) Psychosocial disorders – diagnosed as significant to severe.

(16) Cervical Artificial Disc Replacement Guidelines.

(a) Cervical artificial disc replacement is always inappropriate for patients with any of the following conditions (absolute contraindications):

(A) Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;

(B) Significantly abnormal facets;

(C) Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g., -2.7);

(D) Allergy to metal implant;

(E) Bone disorders (any disease that affects the density of the bone);

(F) Uncontrolled diabetes mellitus;

(G) Active infection, local or systemic;

(H) Active malignancy, primary or metastatic;

(I) Bridging osteophytes (severe degenerative disease);

(J) A loss of disc height greater than 75 percent relative to the normal disc above;

(K) Chronic indefinite corticosteroid use;

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

(L) Prior cervical fusion at two or more levels; or

(M) Pseudo-arthritis at the level of the proposed artificial disc replacement.

(b) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) may be inappropriate for patients with any of the following conditions, depending on severity, location, etc. (relative contraindications):

(A) A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(B) Multilevel degenerative disc disease – cervical – moderate to severe, as shown radiographically;

(C) Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;

(D) Prior cervical fusion at one level;

(E) A loss of disc height of 50 percent to 75 percent relative to the normal disc above; or

(F) Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252

Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

(1) Medical Records and Reports.

(a) Medical providers must maintain records necessary to document the extent of medical services provided.

(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).

(2) Diagnostic Studies. When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs. When an attending physician or authorized nurse

ORDER NO. 15-XXX

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

practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and

(B) HIV-related information protected by ORS 433.045(3).

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

(A) Psychotherapy notes;

(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(f) A medical provider may charge the patient or his or her representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of his or her medical records because of inability to pay.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

(6) Time Loss and Medically Stationary.

(a) When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

(A) The anticipated date of release to work;

(B) The anticipated date the patient will become medically stationary;

(C) The next appointment date; and

(D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

(7) Consultations. When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245, 656.252, 656.254

Hist: Amended 12-1-2009 as Admin. Order 09-055, eff. 1-1-2010

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0241 Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims

(1) First Visit.

(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit (Saturdays, Sundays, and holidays are not counted in the 72-hour period).

(b) Form 3283 ("A Guide for Workers Recently Hurt on the Job") is included with Form 827. All medical service providers must give a copy of Form 3283 and Form 827 to the patient.

(2) New or Omitted Medical Condition. A patient may use Form 827 to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.

(3) Change of Attending Physician. When the patient changes attending physician or authorized nurse practitioner, the patient and the new medical service provider must complete and sign Form 827. The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician or authorized nurse practitioner. The new attending physician or authorized nurse practitioner is responsible for requesting all available medical records from the previous attending physician, authorized nurse practitioner, or insurer. Anyone failing to forward the requested information to the new attending physician or authorized nurse practitioner within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.

(4) Aggravation. After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign Form 827. The physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:

(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and

(b) Whether the patient is unable to work as a result of the compensable worsening.

Stat. Auth: ORS 656.726(4)

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273

Hist:

436-010-0250 Elective Surgery

(1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health.

(2) Except as otherwise provided by the MCO, the attending physician, authorized nurse practitioner, or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.

(3) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

(4) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery:

(a) Is approved;

(b) Is not approved and a consultation is requested by using Form 3228 (Elective Surgery Notification); or

(c) Is disapproved by using Form 3228.

(5) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(6) If the insurer requests a consultation, it must be completed within 28 days after sending Form 3228 to the physician.

(7) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.

(8) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.

(9) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must either send the signed and dated Form 3228 or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before

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

the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(10) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

(11) Surgery that must be performed before seven 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 or authorized nurse practitioner should try to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

436-010-0260 Monitoring and Auditing Medical Providers [Renumbered to rule 0335]

436-010-0265 Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs)

(1) General.

(a) Except as provided in section (12) of this rule, “independent medical exam” (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325. A “worker-requested medical exam” (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker’s attending physician or authorized nurse practitioner. The insurer may obtain three IMEs for each opening of the claim. These exams may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as a statutory IME. A claim for aggravation, Board’s Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 allows a new series of three IMEs. A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a physician of the insurer’s choice. The insurer must choose the medical service providers from the director’s list of authorized IME providers under ORS 656.328. The IME may be conducted by one or more providers of different specialties, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the IME must be completed within a 72-hour period and at locations reasonably convenient to the worker.

(b) The provider will determine the conditions under which the exam will be conducted.

(c) IMEs must be at times and intervals reasonably convenient to the worker and must not delay or interrupt treatment of the worker.

(d) When the insurer requires a worker to attend an IME, the insurer must comply with

ORDER NO. 15-XXX

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

the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(e) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.

(f) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the Workers' Compensation Division's website. If the worker does not have access to the Internet, the worker may call the Workers' Compensation Division at 503-947-7606.

(2) IME/WRME Authorization.

(a) Medical service providers can perform IMEs, WRMEs, or both once they complete a director-approved training and are placed on the director's list of authorized IME providers.

(A) To be on the director's list to perform IMEs or WRMEs, a medical service provider must complete the online application at www.oregonwcdoc.info, hold a current license, be in good standing with the provider's regulatory board, and must have:

(i) Reviewed IME training materials provided or approved by the director found at www.oregonwcdoc.info; or

(ii) Completed a director-approved training course regarding IMEs. The training curriculum must include all topics listed in Appendix B.

(B) By submitting the application to the director, the medical service provider agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or standards published in Appendix C if the provider's regulatory board does not have standards; and

(ii) All relevant workers' compensation laws and rules.

(C) A provider may be sanctioned or removed from the director's list of authorized IME providers after the director finds that the provider:

(i) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C;

(ii) Has a current restriction on his or her license or is under a current disciplinary action from their professional regulatory board;

(iii) Has entered into a voluntary agreement with his or her regulatory board that the director determines is detrimental to performing IMEs;

(iv) Violated workers' compensation laws or rules; or

(v) Has failed to complete training required by the director.

(D) A provider may appeal the director's decision to exclude or remove the provider from the director's list within 60 days under ORS 656.704(2) and OAR 436-001-0019.

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

(b) If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

(3) IME Training.

(a) The IME provider training curriculum must be approved by the director before the training is given. Any party may submit a curriculum to the director for approval. The curriculum must include:

- (A) A training outline,
- (B) Goals,
- (C) Objectives,
- (D) The method of training, and
- (E) All topics addressed in Appendix B.

(b) Within 21 days of the IME training, the training vendor must send the director the date of the training and a list of all medical providers who completed the training, including names and license numbers.

(c) Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

(4) IME Related Forms.

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

(A) Form 3923, "Important Information about Independent Medical Exams," available to the worker before the exam; and

(B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.

(5) IME Observer.

(a) A worker may choose to have an observer present during the IME, however, an observer may not participate in or obstruct the IME. An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must sign Form 3923A, "IME Observer Form," acknowledging that the worker understands the IME provider may ask sensitive questions during the exam in the presence of the observer. An observer must not participate in or obstruct the exam. If the worker does not sign Form 3923A, the provider may exclude the observer. The IME provider must verify that the worker signed the "IME Observer Form" acknowledging that the worker understands:

(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;

ORDER NO. 15-XXX

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

(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and

(C) The observer must not be paid to attend the exam.

(c) A person receiving any compensation for attending the exam may not be a worker's observer. The worker's attorney or any representative of the worker's attorney may not be an observer.

(6) Invasive Procedure. For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form.

(7) Record the Exam. With the IME provider's approval, the worker may use a video camera or other recorder to record the exam.

(8) Objection to the IME Location. When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, fax, email, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if travel is medically contraindicated or unreasonable because:

(A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;

(B) Alternative methods of travel will not overcome the limitations; or

(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

(9) Failure to Attend an IME. If the worker fails to attend an IME and does not notify the insurer before the date of the exam or does not have sufficient reason for not attending the exam, the director may impose a monetary penalty against the worker for failure to attend.

(10) IME Report.

(a) Upon completion of the exam, the IME provider must:

(A) Send the insurer a copy of the report and, if applicable, the observer Form 3923A, the invasive procedure Form 3227, or both.

(B) Sign a statement at the end of the report acknowledging that any false statements may

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

result in sanctions by the director and verifying:

- (i) Who performed the exam;
- (ii) Who dictated the report; and
- (iii) The accuracy of the report content.

(b) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt of the report.

(11) Request for Additional Exams.

(a) When the insurer has obtained the three IMEs allowed under this rule and wants to require the worker to attend an additional IME, the insurer must first request authorization from the director. Insurers that fail to request authorization from the director may be assessed a civil penalty. The process for requesting authorization is:

(A) The insurer must submit a request for authorization to the director by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if any; and

(B) The director will review the request and determine if additional information from the insurer or the worker is necessary. Upon receiving a written request for additional information from the director, the parties 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.

(b) To determine whether to approve or deny the request for an additional IME, the director may consider, but is not limited to, whether:

(A) An IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(B) There has been a significant change in the worker's condition.

(C) There is a new condition or compensable aspect introduced to the claim.

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits.

(E) The IME is requested to establish preponderance for medically stationary status.

(F) The IME is medically harmful to the worker.

(G) The IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(c) Any party who disagrees with the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.283 and OAR chapter 438.

ORDER NO. 15-XXX

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

(12) Other Exams – Not Considered IMEs. The following exams are not considered IMEs and do not require approval as outlined in section (11) of this rule:

- (a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;
- (b) An exam requested by the director;
- (c) An elective surgery consultation requested under OAR 436-010-0250(3);
- (d) An exam of a permanently totally disabled worker required under ORS 656.206(5);
- (e) A closing exam that has been arranged by the insurer at the attending physician's or authorized nurse practitioner's request; and
- (f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/1/11 as Admin. Order 11-051, eff. 4/1/11
Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13

436-010-0270 Insurer's Rights and Duties

(1) Notifications.

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical

ORDER NO. 15-XXX

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

information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) Pre-authorization. Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is approved or disapproved.

(4) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

- (A)** The names and addresses of all MCO panel providers within the employer's geographical service area(s);
- (B)** How workers can receive compensable medical services within the MCO;
- (C)** How workers can receive compensable medical services by non-panel providers; and
- (D)** The geographical service area governed by the MCO.

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

- (i)** Provide a telephone number the worker may call to ask for a written list; and
- (ii)** Tell the worker that he or she has seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

- (i)** Must to change attending physician or authorized nurse practitioner to an MCO panel provider, or
- (ii)** May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-

ORDER NO. 15-XXX

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

along” provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker’s employer, except when the employer provides a coordinated health care program. For the purpose of this rule, “coordinated health care program” means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers’ compensation coverage, for some or all of the employer’s workers, which provides the worker with health care benefits even if a worker’s compensation claim is denied; and

(F) Notify the worker of his or her right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

(g) If, at the time of MCO enrollment, the worker’s medical service providers are not members of the MCO and do not qualify as “come-along providers,” the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0035(4).

(h) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(i) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) Any changes to the worker’s or worker’s attorney’s name, address, or telephone number;

(B) Any requests for medical services from the worker or the worker’s medical provider;
or

(C) Any request by the worker to continue treating with a “come-along” provider.

(j) Insurers under contract with MCOs must maintain records including, but not limited to:

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

- (A) A listing of all employers covered by MCO contracts;
- (B) The employers' WCD employer numbers;
- (C) The estimated number of employees governed by each MCO contract;
- (D) A list of all workers enrolled in the MCO; and
- (E) The effective dates of such enrollments.

(k) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(l) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

Stat. Auth: ORS 656.726(4)

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

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0275 Insurer's Duties under MCO Contracts [Repealed/combined with rule 0270]

436-010-0280 Determination of Impairment / Closing Exams

(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)

(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.

(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven

ORDER NO. 15-XXX

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

days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.

(5) The attending physician must specify the worker's residual functional capacity if:

(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and

(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.

(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:

(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or

(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.

(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:

(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or

(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician for a closing exam.

(8) The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

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

(b) Findings documenting permanent work restrictions.

(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.

(c) A statement regarding the validity of an impairment finding is required in the following circumstances:

(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252
Hist: Amended 11/17/11 as WCD Admin. Order 11-056, eff. 1/1/12
 Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0290 Medical Care After Medically Stationary

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:

- (a) Palliative care under section (2) of this rule;
- (b) Curative care under sections (3) and (4) of this rule;
- (c) Provided to a worker who has been determined permanently and totally disabled;
- (d) Prescription medications;
- (e) Necessary to administer or monitor administration of prescription medications;
- (f) Prosthetic devices, braces, or supports;
- (g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;
- (h) Provided under an accepted claim for aggravation;
- (i) Provided under Board's Own Motion;
- (j) Necessary to diagnose the worker's condition; or
- (k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

(2) Palliative Care.

(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

- (A) Describe any objective findings;
- (B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;
- (C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;
- (D) Explain how the requested care is related to the compensable condition; and
- (E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care

ORDER NO. 15-XXX

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

is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice to the attending physician, worker, and worker's attorney approving or disapproving the request.

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

- (A) The palliative care services are not related to the accepted condition(s);
- (B) The palliative care services are excessive, inappropriate, or ineffectual; or
- (C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

- (A) A copy of the original request to the insurer; and
- (B) A copy of the insurer's response.

(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.

(g) Subsequent requests for palliative care are 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.

(3) **Curative Care.** Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(4) **Advances in Medical Science.** The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

- (a) Describe any objective findings;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);

(c) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;

(d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and

(e) Describe why the care is otherwise justified by the circumstances of the claim.

Stat. Auth: ORS 656.726

Stats. Implemented: ORS 656.245

Hist: Amended 3/1/11 as Admin. Order 11-051, eff. 4/1/11

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0300 Requesting Exclusion of Medical Treatment from Compensability

If a worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. The director will request advice from the licensing boards of practitioners that might be affected and the Medical Advisory Committee. The director will issue an order and may adopt a rule declaring the treatment to be noncompensable. The decision of the director is appealable under ORS 656.704. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process. Excluded treatments are listed in OAR 436-009-0010.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

436-010-0330 Medical Arbiters and Physician Reviewers

(1) The director will establish and maintain a list of arbiters. The director will appoint a medical arbiter or a panel of medical arbiters from this list under ORS 656.268.

(2) The director will establish and maintain a list of physician reviewers. The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245, 656.260, and 656.327.

(3) When a worker is required to attend an examination under this rule, the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location, and purpose of the examination. Examinations will be at a place reasonably convenient to the worker, if possible.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.268, 656.325, 656.327

Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0335 Monitoring and Auditing Medical Providers

(1) The director may monitor and conduct periodic audits of medical providers to ensure

ORDER NO. 15-XXX

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

compliance with ORS chapter 656 and chapter 436 of the administrative rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist:

436-010-0340 Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), or 656.325, or OAR 436-009 or 436-010, the director may impose one or more of the following sanctions:

- (a) Reprimand by the director;
- (b) Non-payment, reduction, or recovery of fees in part or whole for medical services provided;
- (c) Referral to the appropriate licensing board;
- (d) Civil penalty not to exceed \$1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will 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; or
- (e) A penalty of \$100 for each violation of ORS 656.325(1)(c)(C).

(2) If the medical provider fails to provide information under OAR 436-010-0240 within fourteen days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.

(3) The director may impose a penalty of forfeiture of fees and a fine not to exceed \$1,000 for each occurrence on any medical service provider who, under ORS 656.254, and 656.327, has been found to:

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

(4) If the conduct as described in section (3) of this rule is found to be repeated and willful, the director may declare the medical provider ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years.

(5) A medical provider 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 patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for

ORDER NO. 15-XXX

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

the director's order.

(6) If a financial penalty is imposed on the medical provider for violation of these rules, the provider may not seek recovery of the penalty fees from the worker.

(7) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are not appropriate, either may submit a complaint in writing to the director.

(8) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical providers for services provided until the insurer complies with the notification requirement. Any penalty will be limited to the amounts listed in section (9) of this rule.

(9) If the director finds any insurer in violation of statute, OAR 436-009, OAR 436-010, or an order of the director, the insurer may be subject to penalties under ORS 656.745 of not more than \$2,000 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, will be considered a separate violation.

(10) The director may subject a worker who fails to meet the requirements in OAR 436-010-0265(9) to a \$100 penalty per occurrence under ORS 656.325, to be deducted from future benefits.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245, 656.254, 656.745

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

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

Appendix A - Matrix for health care provider types *

See OAR 436-010-0005

	Attending physician status (primarily responsible for treatment of a patient's injury)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathy Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician Physician assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No Unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No if patient referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No Unless authorized by the attending physician
Other health care providers e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any other health care providers. Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

**Appendix B
Independent Medical Examination (IME)
Medical Service Provider
Training Curriculum Requirements**

A. Overview

WCD will provide the overview portion of the curriculum to vendors for use in their approved training program.

1. Why the IME training is required.

- a) The Workers' Compensation Management-Labor Advisory Committee requested a study after hearing anecdotal injured worker complaints.
- b) The Workers' Compensation Division (WCD) study found there was perceived bias in the IME system.
- c) There was no process to handle complaints about IMEs.
- d) There was concern about IME report quality.
- e) The 2005 Legislature passed Senate Bill 311 unanimously.

2. Workers' compensation system:

- a) Public policy: workers' compensation law [ORS 656.012 (2)] identifies four objectives:
 - 1) Provide, regardless of fault, sure, prompt and complete medical treatment for injured workers, and fair, adequate, and reasonable income benefits to injured workers and their dependents.
 - 2) Provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent possible.
 - 3) Restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.
 - 4) Encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents.

Additional items to discuss:

- Exclusive remedy.
 - The Legislature found that common law is expensive without proportionate benefit.
 - No fault versus tort.
 - The economy and the costs of injuries.
- b) Causation of work related injuries.
 - Is the injury work related?
 - What are pre-existing conditions?
 - What is major contributing cause?
 - What is material contributing cause?
 - c) The IME provider role

- Unbiased, neutral third-party
- Independent

- d) The difference between IMEs and
- Worker Requested Medical Exams (Causation)
 - Arbitrator Exams (Reconsideration)
 - Physician Reviews (Medical disputes)

B. Provider Code of Professional Conduct

IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:

1. The guidelines adopted by the appropriate health professional regulatory board, OR
2. The “Guidelines of Conduct” published in Appendix C, if the appropriate regulatory board hasn’t adopted standards for professional conduct regarding IMEs.

C. Report writing

1. The statement of accuracy must be in compliance with OAR 436-010-0265.
2. Report content: what comprises a good IME report?

D. Communication

What is appropriate communication between claims examiners and medical providers?

E. Training specific to the requirements of ORS 656.325, OAR 436-010, and 436-060 concerning:

1. Observers
2. Recording of exams
3. Invasive procedures
4. Sanctions and civil penalties
5. Worker penalties and suspension
6. Exam location disputes
7. Forms
8. Complaints.

F. Sanctions of providers, up to and including removal from the list:

1. Provider has restrictions on its license or current disciplinary actions from its health professional regulatory board.
2. Provider has entered into a voluntary agreement with the licensing board that the director has determined to be detrimental to performing IMEs.
3. Provider has violated the standards of professional conduct for IMEs.
4. Provider has violated workers’ compensation laws or rules.
5. Provider has failed to attend training required by the director.

G. If the director removes a provider's name from the director's list, providers may appeal.

H. Workers’ Compensation Division’s complaint process:

1. Use of injured workers surveys about IMEs

2. Complaints received by the Workers' Compensation Division.
 - I. Impairment findings: The purpose of measuring impairment is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job at injury being performed, etc.
 - J. Other necessary information as determined by the director.

OAR 436-010-0265

Appendix C
INDEPENDENT MEDICAL EXAMINATION STANDARDS
As developed by the Independent Medical Examination Association

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
 - a. Remind the examinee of the party who requested the examination.
 - b. Explain to the examinee that a physician-patient relationship will not be sought or established.
 - c. Tell the examinee the information provided during the examination will be documented in a report.
 - d. Review the procedures that will be used during the examination.
 - e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
 - f. Answer the examinee's questions about the examination process.
6. During the examination:
 - a. Ensure the examinee has privacy to disrobe.
 - b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
 - c. Examine the condition being evaluated sufficient to answer the requesting party's questions.
 - d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

|

Blank page for two-sided printing

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

**Oregon Administrative Rules
chapter 436, division 010**

Changes are marked as follows:

Additions
Deletions

436-010-0001 Authority for Rules Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and OAR chapter 436, are considered orders of the director.

(2) Authority for Rules. These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.

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

(4) Applicability of Rules.

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794
Hist: Amended 12/17//01 as Admin. Order 01-065, eff 1/1/02
Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0002 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.~~

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794
Hist: Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Repealed xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0003 Applicability of Rules

~~(1) These rules shall be applicable on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268,~~

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

~~656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service pursuant to ORS chapter 656.~~

~~(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.~~

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

Hist: Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04

Repealed xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0005 Definitions

~~(1) For the purpose of Unless a term is specifically defined elsewhere in these rules, OAR 436-009, and OAR 436-015, unless or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.~~

~~(1)(2) "Administrative Review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.~~

~~(2)(3) "Attending Physician," unless otherwise provided by a Managed Care Organization contract, physician has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider types" Appendix A.Types."~~

~~(3)(4) "Authorized nurse practitioner" means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and who has been assigned an authorized nurse practitioner number by the director.~~

~~(4)(5) "Board" means the Workers' Compensation Board and includes its Hearings Division.~~

~~(5)(6) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records information such ~~things~~ as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return-to-work goals and status.~~

~~(6) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied.~~

~~(7) "Current Procedural Terminology" or "CPT"® means the Current Procedural Terminology codes and terminology most recently published by the American Medical Association unless otherwise specified in these rules.~~

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

~~(7) "Come-along provider" means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider~~

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

and who continues to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)

(8) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(9) "Days" means calendar days.

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

(11) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela."

(12) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(13) "Eligible worker" means an injured a worker who has filed a claim or who has an accepted claim and is employed by an whose employer who is located in an MCO's authorized geographical service area, covered by an insurer who that has a contract with that MCO. ~~"Eligible" also includes a worker with an accepted claim having a date of injury prior to contract when that worker's employer later becomes covered by an MCO contract.~~

(14) "Enrolled" means an eligible ~~injured~~ worker has received notification from the insurer that the worker is being required to treat under the ~~auspices~~ provisions of the a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

(15) "Health Care Practitioner, care practitioner or Health Care Provider health care provider" has the same meaning as a "medical service provider."

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

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

(18) "Home Health Care health care" means ~~medically-necessary~~ medical and medically related services provided in the ~~injured worker's~~ patient's home environment. These services ~~might~~ may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

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

(20) ICD-9-CM means ~~International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(21)~~ ICD-10 CM means International Classification of Diseases, Tenth Revision, Clinical Modification.

~~(22)~~**(19)** “**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 or authorized nurse practitioner. For nondisabling claims, the “initial claim” means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

~~(23)~~ “Inpatient” means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

~~(24)~~**(20)** “**Insurer**” means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 ~~meeting that meets~~ the qualifications of a self-insured employer under ORS 656.407.

~~(25)~~**(21)** “**Interim Medical Benefits**~~medical benefits~~” means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer’s notice of the claim.

~~(26)~~**(22)** “**Mailed or Mailing Date,**” for the purposes of determining timeliness under these rules, **mailing date**” means the date a document is postmarked. Requests submitted by facsimile or “fax” are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped ~~or punched in~~ by the Workers’ Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

~~(27)~~**(23)** “**Managed Care Organization**~~care organization~~” or “**MCO**” means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

~~(28)~~**(24)** “**Medical Evidence**” includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, ~~X~~-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material ~~utilized~~**used**, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

~~(25)~~ “**Medical provider**” means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

~~(29)~~**(26)** “**Medical Service**” means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, ~~and~~ or other related services, ~~and~~; drugs, medicine, crutches ~~and~~, prosthetic appliances, braces, and supports; and where necessary, physical restorative services.

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(30)~~**(27)** “~~Medical Sservice Pprovider~~” means a person duly licensed to practice one or more of the healing arts.

~~(31)~~ “~~Medical Provider~~” means a medical service provider, a hospital, medical clinic, or vendor of medical services.

~~(32)~~**(28)** “~~Medical Ttreatment~~” means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker’s condition through conservative care.

~~(33)~~ “~~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 considered outpatient services.

~~(34)~~**(29)** “~~Parties~~” mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(30) “**Patient**” means the same as worker as defined in ORS 656.005(30).

~~(35)~~**(31)** “~~Physical Capacity Evaluation~~**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 Capacity Evaluation, and Functional Capacity Assessment will be considered to have the same meaning as Physical Capacity Evaluation.

~~(36)~~**(32)** “~~Physical Restorative Services~~**restorative services**” means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia, or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the patient’s highest functional ability consistent with the worker’s patient’s condition. ~~Physical restorative services are not services to replace medical services usually prescribed during the course of recovery.~~

~~(37)~~**(33)** “**Report**” means medical information transmitted in written form containing relevant subjective or 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.

~~(38)~~**(34)** “~~Residual Functional Capacity~~**functional capacity**” means an individual’s patient’s remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker patient can perform each activity.

~~(39)~~**(35)** “~~Specialist Pphysician~~” means a licensed physician who qualifies as an attending physician and who examines a worker patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a ~~workers'~~patient's compensable injury.

~~(40)~~ “Usual Fee” means the medical provider’s fee charged the general public for a given service.

~~(41)~~(36) “~~Work Capacity Evaluation~~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 ~~will be considered to have~~has the same meaning as Work Capacity Evaluation.

~~(42)~~ “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.~~

Stat. Auth.: ORS 656.726(4)
 Stats. Implemented: ORS 656.000 et seq.; 656.005
 Hist: Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
 Amended 1/29/15 as Admin. Order 15-051, eff. 3/1/15
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0006 Administration of Rules

~~Any orders issued by the division in carrying out the director’s authority to administer, regulate, and enforce ORS chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.~~

Stat. Auth.: ORS 656.726(4)
 Stats. Implemented: ORS 656.726
 Hist: Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
 Repealed xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0008 Administrative Request for Review before the Director

(1) General.

(a) Administrative review before the director:

~~(a)~~(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all ~~matters~~disputes concerning medical ~~services~~fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327.

~~(b)~~ Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(B) A party does not need not to be represented to participate in the administrative review before the director.

~~(c)~~(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed. ~~When a dispute is~~

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

~~resolved by agreement of the parties to the satisfaction of the director, any agreement must be in writing and be approved by the director. Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the claimant's attorney. If the dispute does not resolve through mediation or alternative dispute resolution, a director's order will be issued.~~

~~(2) Administrative review and hearing processes for change of attending physician or authorized nurse practitioner issues are in OAR 436-010-0220; additional independent 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) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.~~

~~(4)(b) All issues pertaining to disagreements about medical services within a Managed Care Organization 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 administrative review of the matter by before the director.~~

~~(5)(c) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.~~

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

~~(e) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.~~

(2) Time Frames and Conditions.

~~(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:~~

~~(a)(b) For all disputes subject to For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution within a Managed Care Organization, upon completion of the MCO process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision unless the party can show good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.~~

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

(c) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review ~~by~~before the director within 60 days of the ~~date the MCO issues its final decision.~~ MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to ~~an~~the MCO internal-dispute resolution 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. If the MCO does not have a process for resolving ~~the~~a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review ~~by~~before the director.

~~(b)~~(d) For ~~all~~ claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review ~~by~~before 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.~~ When the aggrieved party ~~other than the insurer is~~ a represented worker, and the worker's attorney has given written notice ~~that they have~~of representation to the insurer, the ~~90 days in which to request administrative review by the director.~~ 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, ~~which ever~~whichever occurs last. ~~Filing a~~A request for administrative review under this rule may also be ~~accomplished in the manner~~ filed as prescribed in OAR 438-chapter 438, division 005.

~~(e)~~ Disputes regarding elective surgery must be processed in accordance with OAR 436-010-0250.

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

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

~~(6)~~ Parties must submit requests for administrative review to the director ~~in~~ are not payable during the ~~form~~review.

(3) Form and format provided in Bulletins Required Information.

(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or ~~the~~a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ~~seek~~ask the director for help from the director to meet in meeting the filing requirements. The requesting party must simultaneously notify ~~at the same time~~ all other interested parties ~~of the~~

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

~~dispute~~, and their representatives, if known, as follows of the dispute. The notice must:

~~(a)~~**(A)** Identify the worker's name, date of injury, insurer, and claim number;

~~(b)~~**(B)** Specify ~~what~~ the issues are in dispute and ~~specify with particularity~~ the relief sought; and

~~(c)~~**(C)** Provide the specific dates of the unpaid disputed treatment or services.

~~(7)~~**(b)** In addition to medical evidence relating to the ~~medical~~ 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 additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

~~(8)~~**(c)** When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327;~~(3)~~**(c)**, the insurer must provide a record packet, ~~without cost~~ at no charge, to the director and all other parties or their representatives as follows:

~~(a)~~ Except for disputes regarding interim medical benefits, the packet must include certification that there is no issue of compensability of the underlying claim or condition. ~~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)~~**(A)** The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document ~~ten~~**10** must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

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

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

~~(d)~~**(C)** If the requesting party is ~~other than~~ not the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request ~~in the form and format~~ as described in this rule.

~~(e)~~**(D)** 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.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(9)~~**(E)** Except for disputes regarding interim medical benefits, the packet must include certification stating that there is an issue of compensability of the underlying claim or condition or stating that there is not an issue of compensability of the underlying claim or condition. If the insurer issued a denial that has been reversed by the Hearings Division, the Board, or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

(4) Physician Review (E.g., appropriateness). If the director determines a review by a physician is indicated to resolve the dispute, the director, ~~in accordance with~~under 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~~exam as ~~a step in part of~~ the administrative review process, the worker may refuse an invasive test without sanction.

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

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

(c) When such an ~~examination~~exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the ~~examination-exam~~. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel must not be contacted directly by any party except as unless it relates to the examination-exam date, time, location, and/or attendance. If the parties wish to have special questions they want addressed by the physician or panel, these questions must be submitted to the director for screening 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-exam 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) The director will review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).~~

(5) Dispute Resolution by Agreement (E.g., Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. ~~When the parties agree, the~~The agreement must be in writing and approved by the director. The director may issue a letter of agreement in lieu instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

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

- (A) A party fails to honor the agreement;
- (B) The agreement was based on misrepresentation;
- (C) Implementation of the agreement is not feasible because of unforeseen circumstances; or
- (D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order.

~~(b)~~ If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical 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.

~~(e) If the director issues an administrative order resolving a bona fide dispute:~~

(6) Director Order and Reconsideration.

~~(A) For disputes arising under ORS 656.245, 656.260, or 656.327, a party may file a request for hearing within 30 days of the mailing date of the order.~~

~~(B) For disputes arising under ORS 656.247, a party may file a request for hearing within 60 days of the mailing date of the order.~~

~~(C)~~(a) The director may, on the director's own motion, reconsider or withdraw 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 information that 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 must be mailed to the director before the administrative order becomes final.

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

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

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

~~(12)~~(d) Attorney fees in administrative review will be awarded as provided in ORS

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

656.385(1) and OAR 436-001-0400 through 436-001-0440.

(13)(7) Hearings.

~~(a)~~ Any party ~~who~~that disagrees with an action or administrative order under these rules may ~~request a hearing~~obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of ~~an~~the action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.

~~(a)(b)~~ In the review of orders issued under ORS 656.327(2), ~~ORS 245(3), 656.247,~~ 656.260(14) ~~and~~or (16), ~~and ORS~~or 656.247, ~~327(2),~~ no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order 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.

~~(b)~~ 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 hearing is subject to the “no new medical evidence or issues rule” in subsection (13)(a) of this rule. However, if the disputed medical service or medical treatment 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 hearing.

~~(14)(c)~~ Contested case hearings of sanctions 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 under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the ~~board~~Workers’ Compensation Board as follows:

~~(a)(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)(B)~~ The request must be mailed to the ~~division~~administrator within 60 days after the mailing date of the order or notice of assessment.

~~(c)(C)~~ The ~~division~~administrator will forward the request and other pertinent information to the ~~board~~Workers’ Compensation Board.

~~(15)(d)~~ If the director’s order is appealed, ~~Director’s administrative review of other actions:~~ at hearing is subject to the “no new medical evidence or issues rule” in subsection (7)(b) of this rule. However, if the disputed medical service or medical treatment 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 hearing.

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

(8) Other Proceedings.

(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by ~~any other~~ another party; not covered under sections (1) through (147) of this rule; ~~under these rules~~, may request administrative review ~~by~~ before the director. ~~Any party may request administrative review as follows:~~

~~(a)~~ (b) 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)~~ (c) The ~~division~~ administrator 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 (13) of this rule.

Stat. Auth.: ORS 656.726(4)

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

Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

Amended 12-1-2009 as Admin. Order 09-055, eff. 1-1-2010

Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0200 Medical Advisory Committee on Medical Care

The Medical Advisory Committee on Medical Care ~~will be~~ members are appointed by the director ~~of the Department of Consumer and Business Services~~. The committee ~~will~~ must include one insurer representative of insurers, one employer representative of employers, one worker representative of workers, one managed care organization representative of managed care organizations, ~~and~~ and a diverse group of health care providers representative of those providing medical care to injured or ill workers; ~~and~~. The director may appoint other persons as ~~the director may determine are~~ be determined necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. ~~The selection of~~ When appointing members, the director should select health care providers who will consider the perspective of specialty care, primary care, and ancillary care providers; ~~and~~ consider the ability of members to represent the interests of the community at large.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.794

Hist: Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0210 Who May Provide Medical Services Attending Physician and Authorize Authorized Nurse Practitioner/Time--Loss Authorization

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes time loss, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

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

(b) Type A and B attending physicians may and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of ORS chapter 656- or a managed care organization contract. (See Appendix A "Matrix for health care provider types" Appendix A) Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

(2) Emergency Room Physicians. Emergency room physicians may authorize time loss for not more than 14 days when they refer the worker/patient to a primary care physician. However, if an emergency room physician also sees a patient in his or her private practice, apart from their duties of as an emergency room physician, the physician may qualify as a type A be the attending physician. For the purpose of this rule, private practice means a physician who treats individuals on an established patient basis.

(3) Authorized primary care physicians, chiropractic physicians, Nurse Practitioners.

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioners/practitioner number.

(b) An authorized nurse practitioner may provide:

(A) Provide compensable medical services to an injured workers subject to the terms and conditions of the governing MCO. An MCO may allow greater latitude for the provider types to treat a worker enrolled under ORS 656.260 for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Attending physicians and authorized nurse practitioners may prescribe treatment or services to be carried out by persons licensed to provide a medical service. Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

(4) Unlicensed to Provide Medical Services. Attending physicians may prescribe treatment or services to be carried out by persons not licensed to provide a medical service or treat independently only when such. These services or treatment is must be rendered under the physician's direct control and supervision. Reimbursement to a worker for home/Home health care provided by a worker's/patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(5) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants working within the scope of their license and as directed by the attending physician,

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~need not be working under a written treatment plan as prescribed in OAR 436-010-0230(5)(a), nor under the direct control and supervision of the attending physician.~~

~~(6) In order to provide any compensable medical service under ORS chapter 656, a nurse practitioner licensed under ORS 678.375 to 678.390 must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request and must have been assigned an authorized nurse practitioner number by the director. An authorized nurse practitioner may:~~

~~(a) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first nurse practitioner visit on the initial claim. Thereafter, medical services an authorized nurse practitioner provides are not compensable without the attending physician's authorization; and~~

~~(b) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.~~

~~(7)(5) **Out-of-State Attending Physicians.** 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 with the approval of the insurer. When the insurer receives the worker's request, or the insurer's knowledge becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or denial/disapproval 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 must clearly state the reason(s) for the 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, and identify at least two other physicians of the same healing art and specialty whom it would approve. The notice must 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)(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the medical service provider/physician in writing of the following:~~

~~(A) The Oregon medical fee schedule requirements and payment rules, OAR 436-009;~~

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

~~(C) The That the insurer may not/cannot pay billings for compensable services in excess of the maximum allowed under/above the Oregon fee schedule.~~

~~(8) After giving prior approval, if the~~

~~(b) If the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:~~

~~(A) Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,~~

~~(B) Identify at least two other physicians of the same healing art and specialty in the same~~

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

area that the insurer would approve, and

(C) Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.

(6) If an approved out-of-state attending physician does not comply with these rules OAR 436-009 or 436-010, the insurer may object to withdraw approval of the worker's choice of attending physician and. The insurer must notify the worker and the physician in writing of the reason for the objection, that payment for:

(a) The reasons for withdrawing the approval,

(b) That any future services rendered provided by that physician after notification will not be reimbursable paid by the insurer, and that

(c) That the worker may be liable for payment of services rendered provided after the date of notification.

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

Stat. Auth: ORS 656.726(4)
 Stats. Implemented: ORS 656.005(12), 656.245, 656.260
 Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
 Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0220 Choosing and Changing Medical Providers

(1) A newly selected attending physician, authorized nurse practitioner, or a specialist physician who becomes primarily responsible for the worker's care, must notify the insurer not later than five days after the date of change or first treatment, using Form 827. An attending physician or authorized nurse practitioner:

(a) Is primarily responsible for the worker's care,

(b) Authorizes time loss,

(c) Monitors ancillary care and specialized care, and

(d) Is determined by the facts of the case and the actions of the physician, not whether a Form 827 is filed.

(2)(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent Concurrent treatment or services by other medical service providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based upon a written request of referral by the attending physician or authorized nurse practitioner, with. The referral must specify any limitations and a copy of the request must be sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable. When the attending physician or authorized nurse practitioner refers the worker to

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

~~a~~ A specialist physician, the referral must be written. An attending physician must specify any limitations regarding the referral within such document. Unless the documented referral limits the referral to consultation only, the referral is deemed to include attending physician authorization for the specialist physician- is authorized to provide or order all compensable medical services and treatment he or she determinesconsiders appropriate. Nothing in this rule diminishes, unless the referral is for a consultation only. The attending physician's responsibility physician or authorized nurse practitioner continues to fulfill all their duties under ORS chapter 656, including be responsible for authorizing temporary disability. Fees for services by more than one physician at the same time are payable only when the service is sufficiently different that separate medical skills are needed for proper care, even if the specialist physician is providing or authorizing medical services and treatment.

~~(3) The worker is allowed to change his or her attending physician or authorized nurse practitioner by choice two times after the initial choice. Referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, initiated by the worker, will count in this calculation. The limitations of the worker's right to choose physicians or authorized nurse practitioners under 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 by choice of the worker:~~

Physicians who provide the following services are not considered attending physicians:

- ~~(a) Emergency services by a physician;~~
- ~~(b) Examinations at the request of the insurer;~~
- ~~(e)(b) Insurer or director requested examinations;~~
- ~~(c) A Worker Requested Medical Examination;~~
- ~~(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and~~
- ~~(d)(e) Referrals to Diagnostic studies provided by radiologists and pathologists for diagnostic studies; upon referral.~~

(2) Changing Attending Physician or Authorized Nurse Practitioner.

~~(e) When workers are required to change medical service providers 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 authorized to continue providing compensable medical services;~~

~~(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:~~

- ~~(A) When the physician terminates practice or leaves the area;~~
- ~~(B) When a physician is no longer willing to treat an injured worker;~~
- ~~(C) When the worker moves out of the area requiring more than a 50 mile commute to the physician;~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(D)~~ When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired; (See "Matrix for health care provider types" Appendix A);

~~(E)~~ When the nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

~~(F)~~ When a worker is subject to managed care and compelled to be treated inside an MCO; and

~~(G)~~ When the worker is disenrolled from an MCO because the worker was not subject to the MCO contract and the enrollment into the MCO compelled a change of attending physician or authorized nurse practitioner at the time of enrollment;

~~(g)~~ A Worker Requested Medical Examination;

The worker may choose to change his or her attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

~~(h)(a)~~ Whether a When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines; ~~or~~

~~(i)(b)~~ When a the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; ~~or~~

~~(4)(c)~~ When a the worker has made an initial choice ~~of~~ is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:

(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;

(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;

(D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");

(E) When the authorized nurse practitioner is required to refer the worker to an attending

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;

(F) When the worker becomes subject to a managed care organization (MCO) contract and subsequently must change to an attending physician or authorized nurse practitioner on the MCO's panel;

(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or

(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(3) Insurer Notice to the Worker. When the worker has changed two times attending physicians or authorized nurse practitioners twice by choice or reaches has reached the maximum number of changes established by the MCO, the insurer must inform notify the worker by certified mail that any subsequent additional changes by choice must have the approval of be approved by the insurer or the director. If the insurer fails to provide such notice and the worker subsequently later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to notice to the worker. If an attending physician or authorized nurse practitioner begins treatment without being informed that the worker has been given the required notification, the insurer must pay for appropriate services rendered prior to the time the insurer notifies the medical service The insurer must notify the newly selected provider that further payment will not be made and informs the worker of the right to seek approval of the director the worker was not allowed to change his or her attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

(5)(a) If a worker not enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner 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 medical service provider or a Form 827 indicating the worker is choosing to change his or her attending physician or authorized nurse practitioner, the insurer must notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer must advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.

(b)(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO If a worker enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the changes allowed in the MCO contract or certified plan workers, the maximum allowed by the

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

MCO) and wants to change again, the worker must request approval from the insurer. Within~~The~~ worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request, the insurer must notify the worker in writing whether the change is approved. If the insurer denies~~objects to the change, the insurer must provide:~~

(A) Send the worker a written explanation of the reasons and give notification that;

(B) Send the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician or authorized nurse practitioner issues, the insurer shall give notification that Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and

(C) Inform the worker that he or she may request director approval and provide by sending Form 2332 to the director.

(b) When the worker withsubmits a copy of Form 2332.

(6) Upon receipt of a worker's request to the director for an additional change of attending physician or authorized nurse practitioner, the director may notify the parties and request, in writing, additional information. Upon receipt of a written request from the director for requests additional information, the parties will have 14 days to must respond in writing within 14 days of the director's request.

(7)(c) After receipt and review, theThe director will issue an order advising whether the change request for change of attending physician or authorized nurse practitioner is approved. The change of attending physician or authorized nurse practitioner will be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case-by-case basis consideration may be given, but is not limited to, the followingthe director will consider circumstances, such as:

(a)(A) Whether there is medical justification for a change, includinge.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(b)(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(c) Whether such a change will cause unnecessary travel costs or lost time from work.

(8)(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing.

(5) Managed Care Organization (MCO) Enrolled Workers. An MCO enrolled worker must choose:

(a) A panel provider unless the MCO approves a non-panel provider, or

(b) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.

Stat. Auth: ORS 656.726(4)

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

Stats. Implemented: ORS 656.245, 656.252, 656.260
 Hist: Amended 12/14/07 as Admin. Order 07-070, eff. 1/2/08 (temporary)
 Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0225 Choosing a Person to Provide Interpreter Services

A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
 Adopted 5/27/10, as Admin. Order 10-053, eff. 7/1/10

436-010-0230 Medical Services and Treatment Guidelines

(1) Medical services provided to the worker must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.

(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize time loss. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.

(4) Consent to Attend a Medical Appointment.

(a) An employer or insurer representative, such as a nurse case manager, may not attend a worker's patient's medical appointment without written consent of the worker's patient. The worker's patient has the right to refuse such attendance.

(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.

(B) The consent form must state that the worker's patient's benefits cannot be suspended if the worker's patient refuses to have an employer or insurer representative present.

(b) The consent form must be written in a way that allows the worker to understand it and to overcome language or cultural differences.

(C) The insurer must keep a copy of the signed consent form in the claim file.

(b) At any time, the worker's patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the worker's patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(a) The medical provider may refuse to meet with the employer or insurer representative.~~

~~(b)~~ **(5) Request for Records at a Medical Appointment.** The medical provider may refuse to provide copies of the ~~worker's~~ patient's medical records to the insurer representative without proof that the ~~representative person~~ is attending the appointment on behalf of representing the insurer. The provider may charge for any copies that are provided.

~~(4) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services.~~

~~(5)(a)~~ **(6) Requesting a Medical Provider Consultation.** ~~Except as otherwise provided by an MCO, when an~~ The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.

(7) Ancillary Services – Treatment Plan.

(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services such as physical or occupational therapy, unless an MCO contract specifies other requirements, the ancillary medical service provider must prepare a treatment plan before beginning treatment.

(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. The treatment plan must 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 under ORS 656.245(2)(b)(A). If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.

(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes.

(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")

(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.

(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants directed by the attending physician do not have to provide a written treatment plan as prescribed in this section.

(8) Massage Therapy.

~~(b)~~ Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services to be provided

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

by a massage therapist licensed by the Oregon State Board of Massage Therapists for the state of Oregon under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. ~~The massage therapist must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. The treatment plan must 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. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided.~~ Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician.

~~(e) The attending physician, authorized nurse practitioner, or specialist physician must sign a copy of the treatment plan within 30 days of the commencement of treatment and send it to the insurer. Failure of the physician or authorized nurse practitioner to sign or mail the treatment plan may subject the attending physician or authorized nurse practitioner to sanctions under OAR 436-010-0340, but shall not affect payment to the ancillary provider.~~

~~(d) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and Treatment plans provided by a chiropractic physician, naturopathic physician, or acupuncturist, are subject to the treatment plan massage therapists must follow the same requirements as those for ancillary providers in subsection (5)(a) and (e) of this rule.~~

(e)(9) Therapy Guidelines and Requirements.

~~(a) Unless otherwise provided for within by an MCO's utilization and treatment standards under an MCO contract, the usual range for therapy visits does not exceed is up to 20 visits in the first 60 days, and 4four visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services, but is a guideline for reviewing treatment or services. The attending physician or authorized nurse practitioner must document the need for medical services in excess of exceed these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when. When an insurer believes the treatment plan is inappropriate, or excessive, the insurer may request director review as outlined in OAR 436-010-0008.~~

~~(f)(b) Unless otherwise provided for within utilization and treatment standards under an MCO contract by an MCO, a physical therapist must simultaneously submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer each every 30 days or after every visit, if the workerpatient is seen less frequently, after every visit. The progress report may be included in part of the provider's physical therapist's chart notes. The progress report and must include:~~

- ~~(A) Subjective status of the workerpatient;~~
- ~~(B) Objective data from tests and measurements conducted;~~
- ~~(C) Functional status of the workerpatient;~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(D) Interpretation of above data; and

(E) Any change in the treatment plan.

~~(6)~~**(10) Physical Capacity Evaluation.** The attending physician or authorized nurse practitioner, ~~when requested by the insurer or the director through the insurer to complete~~ must complete a physical capacity or work capacity evaluation, ~~must complete within 20 days after the insurer or director requests the evaluation.~~ must complete within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner ~~does not wish to perform the evaluation within 20 days, or, they must refer the worker for such evaluation patient to a different provider within seven days, of the request.~~ does not wish to perform the evaluation within 20 days, or, they must refer the worker for such evaluation patient to a different provider within seven days, of the request. The attending physician or authorized nurse practitioner must notify the insurer and the ~~worker~~ worker/patient in writing if the ~~worker/patient~~ worker/patient is incapable of participating in ~~such~~ such the evaluation.

~~(7)~~**(11) Prescription Medication.**

(a) ~~Unless otherwise provided by an MCO contract, 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, dispensing physician, or authorized nurse practitioner even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drugs to injured workers in accordance with and under drug (if available) according to ORS 689.515. For the purposes of this rule When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker will be deemed the "purchaser" and may object to the substitution of a must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic drug. However, payment for and brand-name drugs are subject drug, the insurer only has to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs and medicine for oral consumption supplied dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication, up to a maximum of 10 days, subject. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.~~

(b) ~~Providers should review and are encouraged to the requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090 adhere to the workers' compensation division's opioid guidelines. See <http://www.cbs.state.or.us/wcd/rdrs/mru/ogandcal.html>.~~

~~(8)~~**(12) Diagnostics.**

~~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.~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(9) X-ray films must be of diagnostic quality and accompanied by a report. 14" x 36" lateral views are not reimbursable.~~

~~(10) Upon request of either the director or the insurer, original diagnostic studies, including but not limited to actual films, must be forwarded to the director, the insurer, or the insurer's designee, within 14 days of receipt of a written request.~~

~~(a) Diagnostic studies, including films must be returned to the medical provider within a reasonable time.~~

~~(b) The insurer must pay for a reasonable charge made by the provider for the costs of delivery of diagnostic studies, including films.~~

~~(c) If a medical provider does not forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.~~

~~(11) A~~Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. Pre-authorization is not a guarantee of payment. The insurer must respond in writing to the provider's request in writing whether the service is approved or denied within seven14 days of receipt of the provider's request.

~~(12)~~(13) Articles. Articles, including but not limited to, beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a ~~need is~~report by the attending physician or authorized nurse practitioner clearly justified by a report which establishes justifies the need. The report must:

~~(a) Establish that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth, and~~

~~(b) Specifically explain why the worker requires an~~the item not usually considered necessary inwhen the great majority of workers with similar impairments: do not.

(14) Physical Restorative Services.

~~(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:~~

~~(A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and~~

~~(B) A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.~~

~~(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.~~

~~(13) Physical restorative services may include but are not limited to a regular exercise program or swim therapy. Such services are not compensable unless the nature of the worker's~~

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

limitations requires specialized services to allow the worker a reasonable level of social or functional activity. The attending physician or authorized nurse practitioner must justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

~~(14)~~ 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 that aids the performance of a natural function, including but not limited to hearing aids and eyeglasses.

(15) Lumbar Artificial Disc Replacement Guidelines.

~~(a)~~ Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) is always inappropriate for injured workerspatients with the following conditions (absolute contraindications):

- ~~(a)~~**(A)** Metabolic bone disease – for example, osteoporosis;
- ~~(b)~~**(B)** Known spondyloarthropathy (seropositive and seronegative);
- ~~(c)~~**(C)** Posttraumatic vertebral body deformity at the level of the proposed surgery;
- ~~(d)~~**(D)** Malignancy of the spine;
- ~~(e)~~**(E)** Implant allergy to the materials involved in the artificial disc;
- ~~(f)~~**(F)** Pregnancy – currently;
- ~~(g)~~**(G)** Active infection, local or systemic;
- ~~(h)~~**(H)** Lumbar spondylolisthesis or lumbar spondylolysis;
- ~~(i)~~**(I)** Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or
- ~~(j)~~**(J)** Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

~~(16)~~**(b)** Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for injured workerspatients with the following conditions, depending on severity, location, etc. (relative contraindications):

- ~~(a)~~**(A)** A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;
- ~~(b)~~**(B)** Arachnoiditis;
- ~~(c)~~**(C)** Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);
- ~~(d)~~**(D)** Facet arthropathy – lumbar – moderate to severe, as shown radiographically;
- ~~(e)~~**(E)** Morbid obesity – BMI greater than 40;
- ~~(f)~~**(F)** Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

~~(g)~~**(G)** Osteopenia – based on bone density test;

~~(h)~~**(H)** Prior lumbar fusion at a different level than the proposed artificial disc replacement; or

~~(i)~~**(I)** Psychosocial disorders – diagnosed as significant to severe.

~~(17)~~**(16) Cervical Artificial Disc Replacement Guidelines.**

~~(a)~~**(a)** Cervical artificial disc replacement ~~that is not excluded from compensability under OAR 436-009-0010(12)(h)~~ is always inappropriate for ~~injured workers~~patients with any of the following conditions (absolute contraindications):

~~(a)~~**(A)** Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;

~~(b)~~**(B)** Significantly abnormal facets;

~~(c)~~**(C)** Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g., -2.7);

~~(d)~~**(D)** Allergy to metal implant;

~~(e)~~**(E)** Bone disorders (any disease that affects the density of the bone);

~~(f)~~**(F)** Uncontrolled diabetes mellitus;

~~(g)~~**(G)** Active infection, local or systemic;

~~(h)~~**(H)** Active malignancy, primary or metastatic;

~~(i)~~**(I)** Bridging osteophytes (severe degenerative disease);

~~(j)~~**(J)** A loss of disc height greater than 75 percent relative to the normal disc above;

~~(k)~~**(K)** Chronic indefinite corticosteroid use;

~~(l)~~**(L)** Prior cervical fusion at two or more levels; or

~~(m)~~**(M)** Pseudo-arthrosis at the level of the proposed artificial disc replacement.

~~(18)~~**(b)** Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) may be inappropriate for ~~injured workers~~patients with any of the following conditions, depending on severity, location, etc. (relative contraindications):

~~(a)~~**(A)** A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

~~(b)~~**(B)** Multilevel degenerative disc disease – cervical – moderate to severe, as shown radiographically;

~~(c)~~**(C)** Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;

~~(d)~~**(D)** Prior cervical fusion at one level;

~~(e)~~**(E)** A loss of disc height of 50 percent to 75 percent relative to the normal disc above;

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

or

~~(F)~~**(F)** Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)
 Stats. Implemented: ORS 656.245, 656.248, 656.252; [OL 2011, ch. 117]
 Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
 Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

~~(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records under ORS 656.252 and diagnostic records required under ORS 656.325. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. 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. However, separate authorization is required for release of information regarding:~~

~~(a) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, or~~

~~(b) HIV related information protected by ORS 433.045(3).~~

~~(2) Any physician, hospital, clinic, or other medical service provider, must provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, or 2476 (Release of Information). "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the director, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule prevents a medical provider from requiring a signed authorized Release of Information.~~

~~(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim must complete the "Worker's and Health Care Provider's Report for Workers' Compensation Claims" (Form 827). Information that must be provided on the form includes, but is not limited to the worker's name, address, and Social Security number if available. For an initial claim, the medical service provider must send Form 827 to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period). Diagnoses stated on Form 827 and all subsequent reports must conform to terminology found in the appropriate International Classification of Disease (ICD) or taught in accredited institutions of the licentiate's profession.~~

~~(4) All medical service providers must 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. Providers must also notify workers that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the worker's medical record.~~

~~(5) All medical service providers must give a copy of "A Guide for Workers Recently~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

Hurt on the Job" (Form 3283) to the worker when they give the worker a copy of Form 827.

~~(6) Attending physicians or authorized nurse practitioners must, 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. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return to work form, the insurer must use Form 3245.~~

~~(7)~~**(1) Medical Records and Reports.**

~~(a) Medical providers must maintain records necessary to document the extent of medical services provided to injured workers.~~

~~(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.~~

~~(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.~~

~~(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).~~

(2) Diagnostic Studies. When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs. When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation,

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

and

(B) HIV-related information protected by ORS 433.045(3).

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

(A) Psychotherapy notes;

(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or his or her representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of his or her medical records because of inability to pay.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

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

(6) Time Loss and Medically Stationary.

~~(8)(a) Progress reports are essential. When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports must be in accordance with OAR 436-009-0040 (7)(a), 436-009-0060, and Appendix B of division 009, whichever applies.~~

~~(9) Reports may be handwritten and must include all relevant or requested information.~~

~~(10) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.~~

~~(11) The medical provider must respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, original diagnostic studies, including, but not limited to, actual films, and any or all necessary records needed to review the efficacy of medical treatment or medical services, frequency, and necessity of care. The medical provider must be reimbursed for copying documents in accordance with OAR 436-009-0060 and Appendix B of division 009. If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.~~

~~(12) The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request.~~

~~(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer and the worker of the of the following and include it in each progress report:~~

~~(A) The anticipated date of release to work, the;~~

~~(B) The anticipated date the worker/patient will become medically stationary, the;~~

~~(C) The next appointment date,; and the worker's~~

~~(D) The patient's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report.~~

~~(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.~~

~~(13)(d) The attending physician or authorized nurse practitioner must notify the worker/patient, insurer, and all other health care/medical providers involved in the worker's/patient's treatment when the worker/patient is determined medically stationary, and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam, and not a projected date. The notice must provide:~~

~~(a) The medically stationary date; and~~

~~(b) Whether the worker is released to any kind of work.~~

~~(14) The attending physician or authorized nurse practitioner must advise the worker, and~~

ORDER NO. 15-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

within five days provide the insurer with written notice, of the date the injured worker is released to return to regular or modified work.

(15)(7) Consultations.

When an injured worker files a claim for aggravation, the claim must be filed on Form 827 and must be signed by the worker or the worker's representative and the attending physician. The attending physician, on the worker's behalf, must submit the aggravation form to the insurer within five days of the examination where aggravation is identified. When an insurer or self-insured employer receives a completed aggravation form, it must process the claim. Within 14 days of the examination the attending physician must also send a written report to the insurer that includes objective findings that document:

~~(a) Whether the worker is unable to work as a result of the compensable worsening; and~~

~~(b) Whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273.~~

~~(16) A worker may use the Form 827 to request the insurer to formally accept a new or omitted medical condition in writing. If the worker uses the form to request acceptance of a new or omitted medical condition during a medical visit, the health care provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the worker in the space provided on the form. If the injured worker signs the form and gives it to the provider, the provider must send the form to the insurer within five days of the day the worker signs the form.~~

~~(17) When the attending physician, authorized nurse practitioner, or the MCO may request requests a consultation with a medical provider regarding conditions related to an accepted claim.:~~

~~(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation. This requirement does not apply to and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists and/or pathologists. The attending physician, authorized nurse practitioner, or MCO must provide the consultant with all relevant clinical information., no such notification is required.~~

~~(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, the or MCO, and the insurer within 10 days of the date of the examination exam or chart review. No additional The consultation fee beyond includes the consultation fee is allowed for this report. MCO requested consultations that are initiated by the insurer, which include examination of the worker, must be considered independent medical examinations subject to the provisions of OAR 436-010-0265. for this report.~~

~~(18) A medical service provider must not unreasonably interfere with the right of the insurer, under OAR 436-010-0265(1), to obtain a medical examination of the worker by a physician of the insurer's choice.~~

~~(19) Any time an injured worker changes his or her attending physician or authorized~~

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

nurse practitioner:

~~(a) The new provider is responsible for:~~

~~(A) Submitting Form 827 to the insurer not later than five days after the change or the date of first treatment; and~~

~~(B) Requesting all available medical information, including information concerning previous temporary disability periods, from the previous attending physician, authorized nurse practitioner, or from the insurer.~~

~~(b) The requirements of paragraphs (A) and (B) also apply anytime a worker is referred to a new physician qualified to be an attending physician or to a new authorized nurse practitioner primarily responsible for the worker's care.~~

~~(c) Anyone failing to forward requested information within 14 days to the new physician or nurse will be subject to penalties under OAR 436-010-0340.~~

~~(20) Injured workers, or their representatives, are entitled to copies of all protected health information in the medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers under the following conditions:~~

~~(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0060, but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.~~

~~(b) For the purpose of this rule, "protected health information in the medical record" means any oral or written information in any form or medium that is created or received and relates to:~~

~~(A) The past, present, or future physical or mental health of the patient;~~

~~(B) The provision of health care to the patient; and~~

~~(C) The past, present, or future payment for the provision of health care to the patient.~~

~~(e) A worker or the worker's representative may request all or part of the record. A summary may substitute for the actual record only if the patient agrees to the substitution. Upon request, the entire health information record in the possession of the medical provider will be provided to the worker or the worker's representative. This includes records from other health care providers, except that the following may be withheld:~~

~~(A) Information that was obtained from someone other than a health care provider when the health care provider promised confidentiality, and release of the information would likely reveal the source of the information;~~

~~(B) Psychotherapy notes;~~

~~(C) Information compiled for use in a civil, criminal, or administrative action or proceeding; and~~

~~(D) Other reasons specified by federal regulation.~~

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273

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

Hist: Amended 12-1-2009 as Admin. Order 09-055, eff. 1-1-2010
 Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0241 Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims

(1) First Visit.

(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit (Saturdays, Sundays, and holidays are not counted in the 72-hour period).

(b) Form 3283 ("A Guide for Workers Recently Hurt on the Job") is included with Form 827. All medical service providers must give a copy of Form 3283 and Form 827 to the patient.

(2) New or Omitted Medical Condition. A patient may use Form 827 to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.

(3) Change of Attending Physician. When the patient changes attending physician or authorized nurse practitioner, the patient and the new medical service provider must complete and sign Form 827. The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician or authorized nurse practitioner. The new attending physician or authorized nurse practitioner is responsible for requesting all available medical records from the previous attending physician, authorized nurse practitioner, or insurer. Anyone failing to forward the requested information to the new attending physician or authorized nurse practitioner within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.

(4) Aggravation. After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign Form 827. The physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:

(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and

(b) Whether the patient is unable to work as a result of the compensable worsening.

Stat. Auth: ORS 656.726(4)
 Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273
 Hist: Adopted xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

436-010-0250 Elective Surgery

(1) "Elective ~~§~~surgery" is surgery ~~which~~that may be required in the process of recovery to recover from an injury or illness, but ~~need~~is not be done as an emergency surgery to preserve life, function, or health.

(2) Except as otherwise provided by the MCO, ~~when the attending physician or surgeon upon referral by the attending physician or~~ authorized nurse practitioner, ~~believes elective surgery is needed to treat a compensable injury or illness, the attending physician, authorized nurse practitioner, or the surgeon or specialist physician~~ must give the insurer ~~notice~~ at least seven days ~~prior to~~notice before the date of the proposed surgery. ~~Notification~~elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.

(3) When elective surgery is ~~recommended~~proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

~~(a)~~(4) The insurer must ~~notify~~respond to the recommending physician, the worker, and the worker's representative, within seven days of ~~receipt of~~receiving the notice of intent to perform surgery, ~~whether or~~ that the proposed surgery:

(a) Is approved;

(b) Is not approved and a consultation is desired.

~~(A)~~ The insurer's notice must either communicate approval to the physician or,

~~(B)~~ If approval is not given, the insurer must submit a completed Form 440 requested by using Form 3228 (Elective Surgery Notification) to the recommending physician; or

~~(b)~~ If the form is not completed or insurer approval is not communicated to the physician, the physician is not required to respond.

(c) Is disapproved by using Form 3228.

(5) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

~~(e)~~(6) When requested, the If the insurer requests a consultation, it must be completed within 28 days after ~~notice~~ sending Form 3228 to the physician.

~~(4)~~(a)(7) Within seven days of the consultation, the The insurer must notify the recommending physician of the insurer's consultant's findings: within seven days of the consultation.

~~(b)~~(8) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer should endeavorattempt to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, thedisagreement. The insurer and recommending physician, with the insurer's agreement to pay, may agree to obtain additional

ORDER NO. 15-XXX

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

diagnostic testing, ~~clarification reports~~ or other medical information designed, such as asking for clarification from the consultant, to assist them in their attempt to reach reaching an agreement regarding the proposed surgery.

~~(e)(9) When~~ If the recommending physician determines that agreement cannot be reached reach an agreement with the insurer and that further attempts continues to resolve the matter would be futile, recommend the recommending proposed surgery, the physician must notify the insurer, either send the worker signed and the worker's representative of such by signing dated Form 440-3228 or providing other written notification:

~~(5)~~ to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or ~~is in violation of these medical rules and cannot resolve the dispute with the recommending physician,~~ the insurer must request an administrative review ~~by~~ before the director within 21 days of ~~the notice provided in subsection (4)(c) of this rule.~~ Failure of the insurer to timely respond to the physician's elective surgery request either by communicating the insurer's approval of the surgery or by submitting a completed Form 440-3228, or to receiving the notification. If the insurer fails to timely request administrative review ~~under this rule shall bar the insurer is barred~~ from later disputing challenging whether the surgery is or was excessive, inappropriate, or ineffectual.

~~(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform~~ The attending physician and the worker of the consultant's opinion. The decision may decide whether to proceed with surgery ~~remains with the attending physician and the worker.~~

~~(7)(10)~~ A recommending physician who prescribes or ~~proceeds to perform~~ performs elective surgery and fails to ~~comply with~~ give the notification requirements in section (2) of this rule, insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

~~(8)(11)~~ Surgery ~~which that~~ must be performed before seven 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 or authorized nurse practitioner should ~~endeavor~~ try to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327
Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0260 Monitoring and Auditing Medical Providers [Renumbered to rule 0335]

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

~~(2) All records maintained or required to be maintained must be disclosed upon request of the director.~~

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252
Hist: Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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

Amended and renumbered to OAR 436-010-0335 xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0265 Independent Medical Examinations Exams -(IMEs) and Worker Requested Medical Exams (WRMEs)

(1) General.

(a) Except as provided in section (12) of this rule, “independent medical exam” (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325. A “worker-requested medical exam” (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker’s attending physician or authorized nurse practitioner. The insurer may obtain three medical examinations of the worker by medical service providers of its choice IMEs for each opening of the claim. These examinations may be obtained prior to before or after claim closure. Effective July 1, 2006, For the insurer must choose a provider to perform purpose of determining the independent medical examination from the director’s list described in section (13) of this rule. number of IMEs, any IME scheduled but not completed does not count as a statutory IME. 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 under ORS 656.340 and 656.726 permits allows a new series of three medical examinations. For purposes of this rule, “independent 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 IMEs. A medical service provider, other than the worker’s attending, must not unreasonably interfere with the right of the insurer to obtain an IME by a physician or of the insurer’s choice. The insurer must choose the medical service providers from the director’s list of authorized nurse practitioner. The examination IME providers under ORS 656.328. The IME may be conducted by one or more providers with of different specialty qualifications specialties, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the examination is to IME must 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 must 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 will be as follows:

(a) The insurer must submit a request for such authorization to the director in a form and format as prescribed by the director in Bulletin 252 including, but not limited to, the reasons for an additional IME, the conditions to be evaluated, dates, times, places, and purposes of previous examinations, copies of previous IME notification letters to the worker, and any other information requested by the director. A copy of the request must 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

ORDER NO. 15-XXX

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

~~written request for additional information from the director, the parties 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.~~

~~(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) 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 medical treatment or medical services, 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 services, or the condition has been included in the compensable claim.~~

~~(4) Any party aggrieved by the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the board under ORS 656.283 and OAR chapter 438.~~

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

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

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

~~(c) An elective surgery 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);~~

~~(e) A closing examination by a consulting physician that has been arranged by the insurer, the worker's attending physician or authorized nurse practitioner in accordance with OAR 436-010-0280;~~

~~(f) A consultation requested by the Managed Care Organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under its contract.~~

~~(6) Examinations~~

~~(b) The provider will determine the conditions under which the exam will be conducted.~~

ORDER NO. 15-XXX

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

~~(c)~~ **(c)** IMEs must be at times and intervals reasonably convenient to the worker and must not delay or interrupt proper treatment of the worker.

~~(7)~~ **(d)** When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

~~(8)~~ **(e)** A medical provider who unreasonably fails to timely provide diagnostic records required for an IME in accordance with under OAR 436-010-0230(10) and 436-010-0240(11) may be assessed a penalty under ORS 656.325.

~~(9)~~ When a worker objects to the location of an IME, the worker may request review by the director within six business days of the mailing date of the appointment notice.

~~(a)~~ The request may be made in person, by telephone, facsimile, or mail.

~~(b)~~ The director may facilitate an agreement between the parties regarding location.

~~(c)~~ If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

~~(d)~~ The director will determine if there is substantial evidence to support a finding that the travel is medically contraindicated, or unreasonable based on a showing of good cause.

~~(A)~~ For the purposes of this rule, "medically contraindicated" means that the travel required to attend the IME exceeds the travel or other limitations imposed by the attending physician, authorized nurse practitioner or other persuasive medical evidence, and alternative methods of travel will not overcome the limitations.

~~(B)~~ For the purposes of this rule, "good cause" means the travel would impose a hardship for the worker that outweighs the right of the insurer or self-insured employer to select an IME location of its choice.

~~(10)~~ If a worker fails to attend an IME without notifying the insurer or self-insured employer before the date of the examination or without sufficient reason for not attending, the director may impose a monetary penalty against the worker for such failure under OAR 436-010-0340.

~~(11)~~ When scheduling an IME, the insurer must ensure the medical service provider has:

~~(a)~~ An Invasive Medical Procedure Authorization (Form 440-3227), if applicable; and

~~(b)~~ The Form 440-3923, "Important Information about Independent Medical Exams," available to the injured worker before the exam.

~~(12)~~ If a medical service provider intends to perform an invasive procedure as part of an IME, the provider must explain the risks involved in the procedure to the worker and the worker's right to refuse the procedure. The worker then must check the applicable box on Form 440-3227 either agreeing to the procedure or declining the procedure, and sign the form. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

~~(13)~~ Any medical service provider wishing to perform an IME or a Worker Requested

ORDER NO. 15-XXX

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

~~Medical Exam (WRME) under ORS 656.325(1)(e) and OAR 436-060-0147 for a workers' compensation claim must meet the director's criteria and be included on the list of authorized providers maintained by the Director of the Department of Consumer and Business Services under ORS 656.328.~~

~~(a) To be on the director's list to perform IMEs or WRMEs, a medical service provider must hold a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon Medical Board, and must:~~

~~(A) Complete a director approved training course regarding IMEs. The training curriculum must include all topics listed in Appendix B;~~

~~(B) Review IME training materials provided by the director at www.oregonwedoc.info;~~
or

~~(C) IME training materials approved by the director.~~

~~(b) To be included on the list of authorized IME providers, the provider must complete the online certification form. Providers may access the certification form at www.oregonwedoc.info. The provider must supply his or her license number, the name of the training vendor, and certify to the director that the provider completed at least one of the training requirements under OAR 436-010-0265(13)(a). Any provider that completes the certification agrees to abide by the following:~~

~~(A) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board, or the independent medical examination standards published in Appendix C, which apply if the provider's regulatory board does not adopt standards of conduct for IMEs; and~~

~~(B) All relevant workers' compensation laws and rules.~~

~~(c) Providers on the director's list of authorized IME providers as of March 31, 2011, remain authorized to perform IMEs and do not need to reapply.~~

~~(d) A provider may be sanctioned or excluded from the director's list of providers authorized to perform IMEs after a finding by the director that the provider:~~

~~(A) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C;~~

~~(B) Failed to comply with the requirements of this rule;~~

~~(C) Has a current restriction on their license or is under a current disciplinary action from their professional regulatory board;~~

~~(D) Has entered into a voluntary agreement with his or her regulatory board which the director determines is detrimental to performing IMEs;~~

~~(E) Violated workers' compensation laws or rules; or~~

~~(F) Has failed to complete training required by the director.~~

~~(e) Within 60 days of the director's decision to exclude a provider from the director's list,~~

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

~~the provider may appeal the decision under ORS 656.704(2) and OAR 436-001-0019.~~

~~(14) The medical service provider conducting the examination will determine the conditions under which the examination will be conducted. Subject to the provider's approval, the worker may use a video camera or tape recorder to record the examination.~~

~~(15) If there is a finding by the director, an administrative law judge, the Workers' Compensation Board, or the court, that the IME was performed by a provider who was not on the director's list of authorized IME providers at the time of the examination, the insurer shall not use the IME report nor shall the report be used in any subsequent proceeding.~~

~~(16) Except as provided in subsection (a) of this section, a worker may elect to have an observer present during the IME.~~

~~(a) An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.~~

~~(b) The worker must submit a signed observer form (440-3923A) to the examining provider acknowledging that the worker understands the worker may be asked sensitive questions during the examination in the presence of the observer. If the worker does not sign form 440-3923A, the provider may exclude the observer.~~

~~(c) An observer cannot participate in or obstruct the examination.~~

~~(d) The worker's attorney or any representative of the worker's attorney shall not be an observer. Only a person who does not receive compensation in any way for attending the examination can be an injured worker's observer.~~

~~(e) The IME provider must verify that the worker and any observer have been notified of the requirement in sub-section (b).~~

~~(17) The IME provider must make Form 440-3923, "Important Information about Independent Medical Exams," available to the worker upon request by the worker or when needed to complete the observer form (440-3923A).~~

~~(18) Upon completion of the examination, the examining medical service provider must:~~

~~(a) Send the insurer a copy of the report and, if applicable, the observer form (440-3923A) or the invasive procedure form (440-3227), or both.~~

~~(b) Sign a statement at the end of the report verifying who performed the examination and dictated the report, the accuracy of the content of the report, and acknowledging that any false statements may result in sanction by the director.~~

~~(19) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.~~

~~(20)(f) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the Workers' Compensation Division's website. If the worker does not have access to the Internet, the worker may call the Workers' Compensation Division at 503-947-7606.~~

~~(21)(2) IME/WRME Authorization.~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(a) Medical service providers can perform IMEs, WRMEs, or both once they complete a director-approved training and are placed on the director's list of authorized IME providers.

(A) To be on the director's list to perform IMEs or WRMEs, a medical service provider must complete the online application at www.oregonwcdoc.info, hold a current license, be in good standing with the provider's regulatory board, and must have:

(i) Reviewed IME training materials provided or approved by the director found at www.oregonwcdoc.info; or

(ii) Completed a director-approved training course regarding IMEs. The training curriculum must include all topics listed in Appendix B.

(B) By submitting the application to the director, the medical service provider agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or standards published in Appendix C if the provider's regulatory board does not have standards; and

(ii) All relevant workers' compensation laws and rules.

(C) A provider may be sanctioned or removed from the director's list of authorized IME providers after the director finds that the provider:

(i) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C;

(ii) Has a current restriction on his or her license or is under a current disciplinary action from their professional regulatory board;

(iii) Has entered into a voluntary agreement with his or her regulatory board that the director determines is detrimental to performing IMEs;

(iv) Violated workers' compensation laws or rules; or

(v) Has failed to complete training required by the director.

(D) A provider may appeal the director's decision to exclude or remove the provider from the director's list within 60 days under ORS 656.704(2) and OAR 436-001-0019.

(b) If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

(3) IME Training.

(a) The IME provider training curriculum must be approved by the director before the training is given. Any party may submit ~~medical service provider IME training~~ a curriculum to the director for approval. The curriculum must include:

(A) A training outline, goals, objectives, specify the

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(B) Goals.**(C) Objectives.**

(D) The method of training, and the number of training hours, and must include all

(E) All topics addressed in Appendix B.

~~(22)~~**(b)** Within 21 days of the IME training, the training ~~supplier~~ vendor must send the director the date of the training and a list of all medical providers who completed the training, including names, and license numbers, ~~and~~ addresses.

~~(23)~~**(c)** Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

(4) IME Related Forms.

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

(A) Form 3923, "Important Information about Independent Medical Exams," available to the worker before the exam; and

(B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.

(5) IME Observer.

(a) A worker may choose to have an observer present during the IME, however, an observer may not participate in or obstruct the IME. An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must sign Form 3923A, "IME Observer Form," acknowledging that the worker understands the IME provider may ask sensitive questions during the exam in the presence of the observer. An observer must not participate in or obstruct the exam. If the worker does not sign Form 3923A, the provider may exclude the observer. The IME provider must verify that the worker signed the "IME Observer Form" acknowledging that the worker understands:

(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;

(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and

(C) The observer must not be paid to attend the exam.

(c) A person receiving any compensation for attending the exam may not be a worker's observer. The worker's attorney or any representative of the worker's attorney may not be an observer.

(6) Invasive Procedure. For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory

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

procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form.

(7) Record the Exam. With the IME provider's approval, the worker may use a video camera or other recorder to record the exam.

(8) Objection to the IME Location. When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, fax, email, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if travel is medically contraindicated or unreasonable because:

(A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;

(B) Alternative methods of travel will not overcome the limitations; or

(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

(9) Failure to Attend an IME. If the worker fails to attend an IME and does not notify the insurer before the date of the exam or does not have sufficient reason for not attending the exam, the director may impose a monetary penalty against the worker for failure to attend.

(10) IME Report.

(a) Upon completion of the exam, the IME provider must:

(A) Send the insurer a copy of the report and, if applicable, the observer Form 3923A, the invasive procedure Form 3227, or both.

(B) Sign a statement at the end of the report acknowledging that any false statements may result in sanctions by the director and verifying:

(i) Who performed the exam;

(ii) Who dictated the report; and

(iii) The accuracy of the report content.

(b) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt of the report.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

(11) Request for Additional Exams.

(a) When the insurer has obtained the three IMEs allowed under this rule and wants to require the worker to attend an additional IME, the insurer must first request authorization from the director. Insurers that fail to request authorization from the director may be assessed a civil penalty. The process for requesting authorization is:

(A) The insurer must submit a request for authorization to the director by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if any; and

(B) The director will review the request and determine if additional information from the insurer or the worker is necessary. Upon receiving a written request for additional information from the director, the parties 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.

(b) To determine whether to approve or deny the request for an additional IME, the director may consider, but is not limited to, whether:

(A) An IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(B) There has been a significant change in the worker's condition.

(C) There is a new condition or compensable aspect introduced to the claim.

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits.

(E) The IME is requested to establish preponderance for medically stationary status.

(F) The IME is medically harmful to the worker.

(G) The IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(c) Any party who disagrees with the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.283 and OAR chapter 438.

(12) Other Exams – Not Considered IMEs. The following exams are not considered IMEs and do not require approval as outlined in section (11) of this rule:

(a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;

(b) An exam requested by the director;

(c) An elective surgery consultation requested under OAR 436-010-0250(3);

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

(e) A closing exam that has been arranged by the insurer at the attending physician's or

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

authorized nurse practitioner's request; and

(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

Stat. Auth: ORS 656.726(4)
 Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
 Hist: Amended 3/1/11 as Admin. Order 11-051, eff. 4/1/11
 Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0270 Insurer's Rights and Duties

~~(1) Insurers must notify the injured worker in writing, immediately~~ **Notifications.**

~~(a) Immediately~~ following receipt of notice or knowledge of a claim, ~~of the manner~~ **insurer must notify the worker in which they may writing about how to receive medical services for compensable injuries.**

~~(2) Insurers may obtain relevant medical records, using a computer generated equivalent of Form 2476 (Release of Information), with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker signed original of the release form.~~

~~(3)~~ **(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim. In claims which have been denied, the insurer shall notify the medical service provider and MCO, if any, within ten days of any change of status of the claim.**

~~(4) Upon request, the insurer must forward all relevant medical information to return to work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner within 14 days.~~

~~(5) When an insurer receives a written request for pre-authorization of diagnostic studies from a provider the insurer must respond in writing to the provider's request within seven days of receipt of the provider's request. If the insurer fails to respond within seven days of receiving a written request, penalties under OAR 436-010-0340 may be imposed.~~

~~(6)~~ **(c) In disabling and non-disabling/nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers/the insurer must notify the injured worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).**

~~(7)~~ **(d) When the insurer establishes a medically stationary date is established by the insurer and that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer will be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician or authorized nurse practitioner.**

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

~~(8) Insurers must 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)(e), 656.325, and 656.327.~~

~~(a) Reimbursement by the insurer to the worker for transportation costs to visit his or her 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. If a worker seeks medical services from an authorized nurse practitioner, reimbursement by the insurer to the worker for transportation costs to visit his or her authorized nurse practitioner may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate nurse practitioner 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 or authorized nurse practitioner and be reimbursed transportation costs.~~

~~(c) Prior to limiting reimbursement under subsection (7)(a) of this rule, the insurer must provide the worker a written explanation and a list of providers who can timely provide similar medical services within a reasonable traveling distance for the worker. The insurer must inform the worker that medical services may continue with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited as described.~~

~~(d) When the director decides travel reimbursement disputes 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.~~

For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) Pre-authorization. Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization

ORDER NO. 15-XXX

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

of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is approved or disapproved.

(4) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);

(B) How workers can receive compensable medical services within the MCO;

(C) How workers can receive compensable medical services by non-panel providers; and

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

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

(i) Provide a telephone number the worker may call to ask for a written list; and

(ii) Tell the worker that he or she has seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

(i) Must to change attending physician or authorized nurse practitioner to an MCO panel provider, or

(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an

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

employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied; and

(F) Notify the worker of his or her right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

(g) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0035(4).

(h) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(i) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) Any changes to the worker's or worker's attorney's name, address, or telephone number;

(B) Any requests for medical services from the worker or the worker's medical provider;
or

(C) Any request by the worker to continue treating with a "come-along" provider.

(j) Insurers under contract with MCOs must maintain records including, but not limited to:

(A) A listing of all employers covered by MCO contracts;

(B) The employers' WCD employer numbers;

(C) The estimated number of employees governed by each MCO contract;

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

(D) A list of all workers enrolled in the MCO; and

(E) The effective dates of such enrollments.

(k) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(l) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

Stat. Auth: ORS 656.726(4)

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

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0275 Insurer's Duties under MCO Contracts

~~(1) Insurers who enter into an MCO contract in accordance with OAR 436-015, must notify the affected insured employers of the following:~~

~~(a) The names and addresses of the complete panel of MCO medical providers within the employer's geographical service area(s);~~

~~(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; and~~

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

~~(2) Insurers under contract with an MCO must notify all newly insured employers in accordance with section (1) of this rule, prior to or on the effective date of coverage.~~

~~(3) At least 30 days prior to any significant changes to an MCO contract affecting injured worker benefits, the insurer must notify in accordance with OAR 436-015-0035 all affected insured employers and injured workers of the manner in which injured workers will receive medical services.~~

~~(4) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO of enrollment. The notice must:~~

~~(a) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:~~

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

- ~~(A) Provide a telephone number the worker may call to ask for a written list; and~~
- ~~(B) Tell the worker that he or she has seven days from the mailing date of the notice to request the list.~~
- ~~(b) Describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;~~
- ~~(c) Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;~~
- ~~(d) Describe how the worker can receive compensable medical treatment from a primary care physician, chiropractic physician, or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician, chiropractic physician, or authorized nurse practitioner;~~
- ~~(e) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(6);~~
- ~~(f) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;~~
- ~~(g) Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and~~
- ~~(h) Notify the MCO of any request by the worker for qualification of a primary care physician, chiropractic physician, or authorized nurse practitioner.~~
- ~~(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance must inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever occurs first.~~
- ~~(6) Insurers enrolling a worker who is not yet medically stationary and is required to change medical providers, must notify the worker of the right to request review by the MCO if the worker believes the change would be medically detrimental.~~
- ~~(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not meet the requirements for qualification as a primary care physician, chiropractic physician, or authorized nurse practitioner, the insurer must notify the worker and medical service provider regarding provision of care under the MCO contract, including the provisions for continuity of care.~~
- ~~(8) An enrollment notice is complete:~~
- ~~(a) On the date the notice is mailed when the notice includes all required information and~~

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

a written list of eligible attending physicians;

~~(b) On the date the notice is mailed when the notice includes all required information and a Web address to access the list of eligible attending physicians, and the worker does not request a written list within seven days; or~~

~~(c) On the date the written list is mailed when the insurer includes all required information and a Web address to access the list of eligible attending physicians, and the worker requests a written list within seven days of the notice.~~

~~(9) When an insurer under contract with an MCO receives a dispute regarding a matter that is to be resolved through the MCO dispute resolution process and that dispute has not been simultaneously provided to the MCO, the insurer must within 14 days:~~

~~(a) Send a copy of the dispute to the MCO; or~~

~~(b) If the MCO does not have a dispute resolution process for that issue, the insurer must notify the parties in writing to seek administrative review before the director.~~

~~(10) The insurer must also notify the MCO of:~~

~~(a) The name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, any changes in this information; and~~

~~(b) Any requests for medical services received from the worker or the worker's medical provider.~~

~~(11) Insurers under contract with MCOs must maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.~~

~~(12) When the insurer is dis-enrolling a worker from an MCO, the insurer must simultaneously provide written notice of the dis-enrollment to the worker, the worker's representative, all medical service providers, and the MCO. The notice must be mailed no later than seven days prior to the date the worker is no longer subject to the contract. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer enrolled.~~

~~(13) When a managed care contract expires or terminates without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO, that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days prior to the date of the contract's expiration or termination. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer subject.~~

Stat. Auth: ORS 656.726(4)

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

Hist: Amended 5/21/09 as Admin. Order 09-051, eff. 7/1/09

Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14

Repealed xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

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

436-010-0280 Determination of Impairment / Closing Exams

~~(1) On disabling claims, when the worker~~(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. For workers under the care of an authorized nurse practitioner or a type B attending physician other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam if there is a likelihood the worker has permanent impairment. The closing exam must be completed under OAR 436-030 and OAR 436-035. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)

~~(3) When the attending physician or authorized nurse practitioner completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. Within eight days of the medically stationary date, When the attending physician may does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician. This exam does not count as an IME or a change of attending physician. within seven days of the medically stationary date.~~

~~(3)(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for the concurrence or objections. Within seven days of receiving the closing exam report, the attending physician. The attending physician must also state, in writing, whether they agree or disagree the physician concurs with or objects to all or part of the findings of the exam. Within seven days of receiving the report, the attending physician must make any comments in writing, and send the concurrence or objections with the report to the insurer. (See "Matrix for Health Care Provider types" Appendix A)~~

~~(4)(5) The attending physician must specify the worker's residual functional capacity or if:~~

~~(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and~~

~~(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.~~

~~(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for completion of:~~

~~(a) A second-level physical capacities exam or work capacities exam (as described in evaluation (see OAR 436-009-0060) pursuant to the following:~~

~~(a) A physical capacities exam when the worker has not been released to return to regular work the job held at the time of injury, has not returned to regular work the job held at the time of injury, has returned to modified work, or has refused an offer of modified work;~~ or

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

(b) A work capacities ~~exam~~ evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. ~~The provider~~ may also be required to specify the worker's ability to perform specific job tasks.

~~(5)(7) If~~ When the insurer issues a major contributing cause denial on ~~the~~ an accepted claim and the worker is not medically stationary, ~~the~~:

(a) ~~The attending physician must do a closing exam; or refer the worker to a consulting physician for all or part of the closing exam; or~~

(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician ~~for a closing exam.~~ (See "Matrix for Health Care Provider types" Appendix A) a closing exam.

~~(6)(8)~~ The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) ~~In initial injury claims.~~ In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(B) ~~In new or omitted condition claims.~~ In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) ~~In aggravation claims.~~ In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(D) ~~In occupational disease claims.~~ In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(b) Findings documenting permanent work restrictions.

(A) ~~Release to regular work.~~ If the worker has no permanent work restriction, the closing report must include a statement indicating that:

(i) The worker has no permanent work restriction; or

(ii) The worker is released, without restriction, to the job held at the time of injury.

(B) ~~In initial injury claims.~~ In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

(i) Prevents the worker from returning to the job held at the time of injury; and

(ii) Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

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

(C) ~~In new or omitted condition claims.~~ In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

- (i) Prevents the worker from returning to the job held at the time of injury; and
- (ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(D) ~~In aggravation claims.~~ In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

- (i) Prevents the worker from returning to the job held at the time of injury; and
- (ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

(E) ~~In occupational disease claims.~~ In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

- (i) Prevents the worker from returning to the job held at the time of injury; and
- (ii) Is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

(c) ~~Statements regarding the validity of impairment findings.~~ A statement regarding the validity of an impairment finding is required in the following circumstances:

(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

~~**(7)** 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 reporting format or form to be used as a supplement to the narrative report.~~

Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252
Hist: Amended 11/17/11 as WCD Admin. Order 11-056, eff. 1/1/12
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
Amended 1/29/15 as Admin. Order 15-051, eff. 3/1/15
Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0290 Medical Care After Medically Stationary

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a

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

worker's condition is medically stationary are compensable only when services are:

- (a) Palliative care under section (2) of this rule;
- (b) Curative care under sections (3) and (4) of this rule;
- (c) Provided to a worker who has been determined permanently and totally disabled;
- (d) Prescription medications;
- (e) Necessary to administer or monitor administration of prescription medications;
- (f) Prosthetic devices, braces, or supports;
- (g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and

supports;

- (h) Provided under an accepted claim for aggravation;
- (i) Provided under Board's Own Motion;
- (j) Necessary to diagnose the worker's condition; or
- (k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

(2) Palliative Care.

(a) Palliative care means that medical services ~~rendered~~ are provided to temporarily reduce or moderate temporarily the intensity of an otherwise stable medical condition, but. It does not include those medical services ~~rendered~~ provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when it is prescribed by the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. When the worker's attending physician believes that ~~Before palliative care is appropriate to enable the worker to continue current employment or a current vocational training program can begin,~~ the attending physician must first submit a written palliative care request to the insurer for approval to the insurer. The request must:

(a) The request must:

- (A) Describe any objective findings;
- (B) Identify by the appropriate ICD diagnosis, the medical condition for which palliative care is requested by the appropriate ICD diagnosis;
- (C) Detail a treatment plan which includes the name of the provider who will ~~render~~ provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;
- (D) Explain how the requested care is related to the compensable condition; and
- (E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date

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

service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receipt receiving the request, the insurer must send written notification notice to the attending physician, worker, and worker's attorney approving or disapproving the request as prescribed.

~~(A) Palliative care may begin following submission of the request to the insurer. If approved, services are payable from the date the approved medical service begins. If the requested care is ultimately disapproved, the insurer is not liable for payment of the medical service.~~

~~(B)(d)~~ If the insurer disapproves the requested care request, the insurer must explain, the reason why in writing. Reasons to disapprove a palliative care request may include:

~~(i)(A) Any disagreement with~~ The palliative care services are not related to the medical accepted condition for which the care is requested;(s);

~~(ii) Why the requested care is not acceptable; or~~

~~(iii)(B) Why the requested~~ The palliative care services are excessive, inappropriate, or ineffectual; or

(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

(A) A copy of the original request to the insurer; and

(B) A copy of the insurer's response.

~~(e)(f)~~ If the insurer fails to respond to the request in writing within 30 days, the attending physician or injured worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. If the request is from a physician, it must include a copy of the original request and may include any other supporting information.

~~(d)~~ When the attending physician or requests approval from the injured worker disagrees with director, the insurer's disapproval, the attending physician or the injured worker may request administrative review by the director in accordance with OAR 436-010-0008, within 90 days from the date of insurer's notice of disapproval. In addition to information required by OAR 436-010-0008(6), if the request is from a physician, it must include:

~~(A) A~~ a copy of the original request to the insurer; and and may include any other supporting information.

~~(B)~~ A copy of the insurer's response.

~~(e)~~ When the worker, insurer, or director believes palliative care, compensable under

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

~~ORS 656.245(1)(c)(J), is excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services, the dispute will be resolved in accordance with ORS 656.327 and OAR 436-010-0008.~~

~~(f)(g)~~ Subsequent requests for palliative care are 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.

~~(2)~~**(3) Curative Care.**

Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

~~(a)~~**(4) Advances in Medical Science.** The director must approve curative care arising from a generally recognized, ~~non-experimental~~nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

~~(A)~~**(a)** Describe any objective findings;:

~~(B)~~**(b)** Identify ~~by the appropriate ICD diagnosis,~~ (the medical condition for which the care is requested-);

~~(C)~~**(c)** Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;:

~~(D)~~**(d)** Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition;: and

~~(E)~~**(e)** Describe why the care is otherwise justified by the circumstances of the claim.

~~(3)~~ In addition to sections (1) and (2) of this rule, medical services after a worker's condition is medically stationary are compensable when they are:

~~(a)~~ Provided to a worker who has been determined permanently and totally disabled.

~~(b)~~ Prescription medications.

~~(c)~~ Services necessary to administer or monitor administration of prescription medications.

~~(d)~~ Prosthetic devices, braces, and supports.

~~(e)~~ Services to monitor the status, replacement or repair of prosthetic devices, braces, and supports.

~~(f)~~ Services provided under an accepted claim for aggravation.

~~(g)~~ Services provided under Board's Own Motion.

~~(h)~~ Services necessary to diagnose the worker's condition.

~~(i)~~ Life preserving modalities similar to insulin therapy, dialysis, and transfusions.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed MEDICAL SERVICES RULES

Stat. Auth: ORS 656.726
 Stats. Implemented: ORS 656.245
 Hist: Amended 3/1/11 as Admin. Order 11-051, eff. 4/1/11
 Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

**436-010-0300 ~~Process for Requesting Exclusion of Medical Treatment from~~
 Compensability**

~~(1) If an injured~~ worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. The director will request advice from the licensing boards of practitioners that might be affected and the Medical Advisory Committee. The director will issue an order and may adopt a rule declaring the treatment to be noncompensable. The decision of the director is appealable under ORS 656.704. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process.

~~(2) The investigation will include a request for advice from the licensing boards of practitioners who might be affected and the Medical Advisory Committee.~~

~~(3) The director will issue an order and may adopt a rule declaring the treatment to be non-compensable. The decision of the director is appealable under ORS 656.704. Excluded treatments are listed in OAR 436-009-0010.~~

Stat. Auth: ORS 656.726(4)
 Stats. Implemented: ORS 656.245
 Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0330 ~~Medical Arbiters and Panels of Physicians~~Physician Reviewers

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

~~(a) To arbiters.~~ The director will appoint a medical arbiter or a panel of medical arbiters from this list under ORS 656.268.

~~(2) The director will establish and to select~~maintain a list of physician under ORS 656.325 (1)(b).

~~(b) To reviewers.~~ The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245, 656.260, and 656.327.

~~(2) Arbiters, panels of arbiters, physicians, and panels of physicians will be selected by the director.~~

(3) When a worker is required to attend an examination under this rule, the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location, and purpose of the examination. Examinations will be at a

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

place reasonably convenient to the worker, if possible.

~~(4) The arbiters, the panels of arbiters, the physicians and the panels of physicians selected under this rule must be paid by the insurer in accordance with OAR 436-009-0060 and Appendix B of division 009.~~

~~(5) The insurer must pay the worker for all necessary related services in accordance with ORS 656.325(1).~~

Stat. Auth: ORS 656.726(4)
 Stats. Implemented: ORS 656.268, 656.325, 656.327
 Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
 Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
 Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0335 Monitoring and Auditing Medical Providers

(1) The director may monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and chapter 436 of the administrative rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth: ORS 656.726(4)
 Stat. Implemented: ORS 656.245, 656.254, 656.745
 Hist: Amended and renumbered from OAR 436-010-0260 as WCD Admin. Order 15-xxx, eff. xx/xx/xx

436-010-0340 Sanctions and Civil Penalties

~~(1) If the director finds any medical-service provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), and/or 656.325, and/or OAR 436-009 and/or 436-010, the director may impose one or more of the following sanctions:~~

~~(a) Reprimand by the director;~~

~~(b) Non-payment, reduction, or recovery of fees in part, or whole, for medical services rendered provided;~~

~~(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 will 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; or~~

~~(e) A penalty of \$100 for each violation of ORS 656.325(1)(c)(C).~~

(2) If the medical provider fails to provide information under OAR 436-010-0240 within fourteen days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.

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

~~(2)~~**(3)** The director may impose a penalty of forfeiture of fees and a fine not to exceed \$1,000 for each occurrence on any ~~health care practitioner~~medical service provider who, under ORS 656.254, and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(b) Provide medical services that are excessive, inappropriate, or ineffectual; or

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

~~(b)~~ Provide medical services that are excessive, inappropriate or ineffectual; or

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

~~(3)~~**(4)** If the conduct as described in section ~~(2)~~**(3)** of this rule is found to be repeated and willful, the director may declare the medical ~~service~~provider ineligible for reimbursement for treating workers' compensation ~~patients~~patients for a period not to exceed three years.

~~(4)~~**(5)** A ~~medical service~~ provider 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 ~~patients~~patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

~~(5)~~**(6)** If a financial penalty is imposed on the ~~attending physician or authorized nurse practitioner~~medical provider for violation of these rules, ~~ne~~the provider may not seek recovery of the ~~penalty fees may be sought~~ from the worker.

~~(6)~~**(7)** If an insurer or worker believes sanctions under sections (1) or (2) of this rule are not appropriate, either may submit a complaint in writing to the director.

~~(7)~~**(8)** If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected ~~medical service providers~~medical service providers for services ~~rendered~~provided until the insurer complies with the notification requirement. Any penalty will be limited to the amounts listed in section ~~(8)~~**(9)** of this rule.

~~(8)~~**(9)** If the director finds any insurer in violation of statute, OAR 436-009 ~~or~~, OAR 436-010, or an order of the director, the insurer may be subject to penalties under ORS 656.745 of not more than ~~\$2000~~\$2,000 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, will be considered a separate violation.

~~(9)~~**(10)** The ~~D~~director may subject a worker who fails to meet the requirements in OAR 436-010-0265~~(10)~~ to a \$100 penalty per occurrence under ORS 656.325, to be deducted from future benefits.

Stat. Auth: ORS 656.726~~(4)~~;

Stat. Implemented: ORS 656.245, 656.254, 656.745

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

Amended xx/xx/xx as Admin. Order 15-xxx, eff. xx/xx/xx

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

Appendix A - Matrix for health care provider types *

See OAR 436-010-0005

	Attending physician status (primarily responsible for treatment of a <u>worker's/patient's</u> injury)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the <u>worker/patient</u> to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of Osteopathy Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic Pphysician Naturopathic Pphysician Physician Assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No Unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency Room Physiciansroom physicians	No, if the physician refers the <u>worker/patient</u> to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No if <u>worker/patient</u> referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No Unless authorized by the attending physician
Other Health Care Providershealth care providers e.g., acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim <u>with any other health care providers</u> . Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

Appendix B
Independent Medical Examination (IME)
Medical Service Provider
Training Curriculum Requirements

A. Overview

WCD will provide the overview portion of the curriculum to vendors for use in their approved training program.

1. Why the IME training is required.

- a) The Workers' Compensation Management-Labor Advisory Committee requested a study after hearing anecdotal injured worker complaints.
- b) The Workers' Compensation Division (WCD) study found there was perceived bias in the IME system.
- c) There was no process to handle complaints about IMEs.
- d) There was concern about IME report quality.
- e) The 2005 Legislature passed Senate Bill 311 unanimously.

2. Workers' Compensation system:

- a) Public policy: ~~Workers' Compensation Law~~ workers' compensation law [ORS 656.012 (2)] identifies four objectives:
 - 1) Provide, regardless of fault, sure, prompt and complete medical treatment for injured workers, and fair, adequate, and reasonable income benefits to injured workers and their dependents.
 - 2) Provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent possible.
 - 3) ~~To restore~~ Restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.
 - 4) ~~To encourage~~ Encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents.

Additional items to discuss:

- Exclusive remedy.
- The Legislature found that common law is expensive without proportionate benefit.
- No fault versus tort.
- The economy and the costs of injuries.

b) Causation of work related injuries.

- Is the injury work related?
- What are pre-existing conditions?
- What is major contributing cause?
- What is material contributing cause?

- c) The IME provider role
 - Unbiased, neutral third-party
 - Independent

- d) The difference between IMEs and
 - Worker Requested Medical Exams (Causation)
 - Arbitrator Exams (Reconsideration)
 - Physician Reviews (Medical Disputes)

B. Provider Code of Professional Conduct

IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:

- 1. The guidelines adopted by the appropriate health professional regulatory board, OR
- 2. The “Guidelines of Conduct” published in Appendix C, if the appropriate regulatory board hasn’t adopted standards for professional conduct regarding IMEs.

C. Report writing

- 1. The statement of accuracy must be in compliance with OAR 436-010-0265.
- 2. Report content: what comprises a good IME report?

D. Communication

What is appropriate communication between claims examiners and medical providers?

E. Training specific to the requirements of ORS 656.325, OAR 436-010, and 436-060 concerning:

- 1. Observers
- 2. Recording of exams
- 3. Invasive procedures
- 4. Sanctions and civil penalties
- 5. Worker penalties and suspension
- 6. Exam location disputes
- 7. Forms
- 8. Complaints.

F. Sanctions of providers, up to and including removal from the list:

- 1. Provider has restrictions on ~~their~~its license or current disciplinary actions from ~~their~~its health professional regulatory board.
- 2. Provider has entered into a voluntary agreement with the licensing board ~~which~~that the director has ~~been~~determined by the director to be detrimental to performing IMEs.
- 3. Provider has violated the standards of professional conduct for IMEs.
- 4. Provider has violated workers’ compensation laws or rules.
- 5. Provider has failed to attend training required by the director.

G. If the director removes a provider's name from the director's list, providers may appeal.

H. Workers’ Compensation Division’s complaint process:

1. ~~u~~Use of injured workers surveys about IMEs
 2. ~~e~~Complaints received by the Workers' Compensation Division.
-
- I. Impairment findings: ~~t~~The purpose of measuring impairment—~~It~~ is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job -at -injury being performed, etc.
 - J. Other necessary information as determined by the director.

OAR 436-010-0265

Appendix C
INDEPENDENT MEDICAL EXAMINATION STANDARDS
As developed by the Independent Medical Examination Association

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
 - a. Remind the examinee of the party who requested the examination.
 - b. Explain to the examinee that a physician-patient relationship will not be sought or established.
 - c. Tell the examinee the information provided during the examination will be documented in a report.
 - d. Review the procedures that will be used during the examination.
 - e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
 - f. Answer the examinee's questions about the examination process.
6. During the examination:
 - a. Ensure the examinee has privacy to disrobe.
 - b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
 - c. Examine the condition being evaluated sufficient to answer the requesting party's questions.
 - d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

BRUYNS Fred H * DCBS

From: Krishna Balasubramani <kbalas@sbhlegal.com>
Sent: Friday, June 12, 2015 4:55 AM
To: BRUYNS Fred H * DCBS
Subject: Thoughts on new rules

Fred:

A couple of quick thoughts.

First, under 436-10-240 why "must" an insurer use that specific form? Why not that form or something similar/

(5) Release to Return to Work. (a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner

Second, why not have attending physicians also review the training materials? I assume it doesn't take much time and it would really help with the communication and confirm that the attending physicians knows that he or she is signing up for. Perhaps follow the language that exists for IME doctors – "(i) Reviewed IME training materials provided or approved by the director found at www.oregonwcdoc.info"

Krishna Balasubramani, Attorney at Law kbalas@sbhlegal.com

Sather Byerly Holloway LLP * 111 SW Fifth Avenue, Suite 1200 * Portland, Oregon 97204
ph 503.412.3104 * fx 503.721.9272 * mo 503.310.1075

Sign up for our blog at www.sbhlegal.com

PRIVILEGED AND CONFIDENTIAL. If you are not the designated recipient or employee or agent, any dissemination, copying, or publication of this transmittal is strictly prohibited. If you have received this transmittal in error, please call us immediately.

DIANA E. GODWIN
ATTORNEY AT LAW
1500 NE IRVING, SUITE 430
PORTLAND, OREGON 97232
TELEPHONE 503-224-0019 • FAX 503-229-0614
EMAIL:dianagodwin@earthlink.net

Admitted to practice in
Oregon and Washington

July 10, 2015

TO THE WORKERS' COMPENSATION DIVISION and INSURANCE DIVISION

Via e-mail to: fred.h.bruyns@state.or.us

RE: PROPOSED CHANGES TO OAR 436-010

FROM: Diana Godwin on behalf of OREGON PHYSICAL THERAPISTS IN
INDEPENDENT PRACTICE

Thank you for the opportunity to provide testimony to the Workers' Compensation Division and the Insurance Division on the proposed changes to OAR 436-010, Medical Services rules.

I represent Oregon Physical Therapists in Independent Practice (OPTIP), a trade association of 165 physical therapist-owned out-patient clinics located throughout Oregon. These out-patient physical therapy clinics provide substantial rehabilitation services to Oregon injured workers.

Proposed Amendment to OAR 436-010-0005 Definitions

We support the addition of the definition of "date stamp."

Proposed Amendment to OAR 436-010-0230 Medical Services and Treatment Guidelines

We strongly support the proposed revisions in re-numbered subsection (7) of OAR 436-010-0230 regarding preparation and submission of a treatment plan to the workers' compensation insurer and the patient's attending provider. The new language provides that in the circumstance where a provider fails to send the treatment plan within seven days the insurer is not required to pay those dates of service that occurred prior to the date the provider sends the plan, but will pay for the dates of service that occur after the provider sends the plan. This change addresses a long-standing problem.

Under the current wording of this rule, the insurer can decline to pay for all dates of service if the provider fails to send the treatment plan within seven days, even those dates of service that occur after the provider does send the plan. This has resulted in unwarranted denials of payment and friction between insurers and providers. A provider may send the treatment plan by postal mail within seven days but the insurer does not receive it within the seven days. Under these circumstances if the insurer does not retain the envelope with the postmark date, but rather date

stamps the plan as of the date it's received, the insurer will deny payment based on the date stamp.

Also, under the current wording of this rule, if the provider – or more likely, the provider's staff – makes an inadvertent mistake and fails to send the treatment plan within the seven days, the insurer will deny all payment, not just payment for the services provided before the date the plan is sent, even if the plan is sent just a day or two late. Under these circumstances, the provider may not even realize that the plan was sent after the seven day period and will not know that all payment is being denied until after the provider receives the EOBs. This could be 45 days after submission of the billings, or even later if the work comp claim is in deferred status up to 60 days. By the time the provider is informed that payment for all services is being denied, the patient may well have completed all of the prescribed visits. If the provider is aware at the time that the treatment plan was not sent within seven days, the provider is faced with the choice of discharging the patient to a new physical therapist for a new initial evaluation and preparation of a new treatment plan or continuing to treat the patient for free. This does not serve anyone's interests.

We appreciate the Division's attention to this issue. Thank you for the opportunity to comment.

Diana E. Godwin

**BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON**

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR: 436-010, Medical Services))))))	TRANSCRIPT OF TESTIMONY
---	----------------------------	----------------------------

The proposed amendment to the rules was announced in the Secretary of State's Oregon Bulletin dated July 2015. On July 21, 2015, a public rulemaking hearing was held as announced at 9 a.m. in Room B of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers' Compensation Division was the hearing officer. The record will be held open for written comment through July 27, 2015.

INDEX OF WITNESSES

No testimony was given at the hearing.

TRANSCRIPT OF PROCEEDINGS

Fred Bruyns:

Good morning and welcome. This is a public rulemaking hearing. My name is Fred Bruyns, and I'll be the presiding officer for the hearing.

The time is now 9:01 a.m. on Tuesday, July 21, 2015. We are in Room B of the Labor & Industries Building, at 350 Winter Street NE, in Salem, Oregon.

We are making an audio recording of today's hearing.

If you wish to present oral testimony today, please sign in on the "Testimony Sign-In Sheet." It's on the table near the entrance. If you plan to testify over the telephone, I will sign-in for you.

The Department of Consumer & Business Services, Workers' Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically, division 010, Medical Services. The department has summarized the proposed rule changes in the Notice of Proposed Rulemaking Hearing. This hearing notice, a Statement of Need and Fiscal Impact, and proposed rules, are on the table by the entrance. You may also pick up an information page that explains how to access testimony that we post to our website.

Transcript of public rulemaking hearing
July 21, 2015

The Workers' Compensation Division filed the Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact with the Oregon Secretary of State on June 11, 2015; and subsequently:

- Mailed the Notice and Statement to its postal and electronic mailing lists;
- Notified Oregon Legislators as required by ORS chapter 183; and
- Posted public notice and the proposed rules to its website.

The Oregon Secretary of State published the hearing notice in its July 2015 *Oregon Bulletin*.

This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including July 27, 2015, and will make no decisions until all of the testimony is considered.

We are ready to receive testimony. If you are reading from written testimony and give the agency a copy of that testimony, we will add it to the rulemaking record.

No one has signed the sign-in sheet as far as I know, and would anyone here like to testify? Is there anyone on the telephone with us who would like to testify?

It is our policy to keep our hearings open a minimum of one half an hour, so if someone arrives late they may still testify, so I will go ahead and recess the hearing. And, with that I'm going to recess the hearing at 10:06 a.m.

This hearing is resumed at 10:30 a.m. There is no one here in person to testify. Is there anyone on the telephone with us? Hearing nothing, the time is now, still 10:30.
This hearing is adjourned.

Transcribed from a digital audio recording by Fred Bruyns, July 21, 2015.



July 27, 2015

Fred Bruyns, Rules Coordinator
Workers' Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

Re: SAIF Corporation comments on proposed division 010 revision

Dear Fred:

SAIF Corporation submits the following comments for the Workers' Compensation Division's proposed medical services rules, Oregon Administrative Rules 436-010. As always, SAIF appreciates the opportunity to provide feedback to the Workers' Compensation Division. The significant effort made to clarify these rules for system users is apparent. We hope our comments will assist the Division in its endeavor.

1. OAR 436-010-0005:

(7) "Come along provider." The definition for "come along provider" appears incomplete and thus potentially misleading. SAIF suggests the definition should either clarify that the treatment is under the terms of ORS 656.260(4)(g) and ORS 656.245(5), or, rather than referring the reader to "see OAR 436-015-0070, the rule could state that the definition is "subject to" OAR 436-015-0070.

(30) "Patient." SAIF is somewhat mystified at this new addition to the administrative scheme. Perhaps using "patient" rather than "worker" or "injured worker" is an attempt to use a word more commonly employed by medical providers. SAIF is not aware the current terminology causes confusion for medical providers. Moreover, "patient" it not consistently used throughout the administrative scheme or even in this rule division, and may create potential confusion rather than clarity.

2. OAR 436-010-0008:

(1)(e) States that when the director declares a medical treatment or service inappropriate or in violation of rules, the worker is not obligated to pay for such. While generally true, there are circumstances when the worker is required to pay for such services. The worker may be liable to pay for a variety services rendered in violation of rules, as delineated in OAR 436-009-0010(9). In addition, using "such" as the end of the sentence is unclear.

(2)(c) SAIF suggests retaining the deleted reference to section 0250 for elective surgery disputes; the reference to OAR 436-010-0250 was helpful. SAIF also noticed that Section 2's number series seems incorrect. Section (2)(a) ends with a colon, and the next section is (2)(b). It seems proposed subsection (2)(a) should not be numbered, and the proposed (2)(b) should be (2)(a).

(3)(c)(E) This provision requires a statement from the insurer that there either is, or is not, an issue of compensability of the "underlying claim or condition". The phrase "underlying claim or condition" does not appear in ORS Chapter 656 and as such, its meaning is unclear.

(7) SAIF finds the order of this rule's paragraphs confusing. In particular, paragraph (d) refers to "the director's order" but the kind of order to which it refers, is unclear. SAIF suggests moving this sentence to (7)(b) rather than referencing it in (7)(d). SAIF finds the second sentence of paragraph (d) relating to the standard of review of an administrative order redundant and confusing. Simply stating that in any hearing on review of a director's order concerning a medical service under ORS 656.245, ORS 656.327, or ORS 656.260, the record is closed, and the ALJ will review the order for substantial evidence or errors of law, would be clear. See, *Liberty Northwest Insurance Corporation v. Kraft*, 205 Or App 59 (2006); *Liberty Northwest Ins. Corp. v. Mundell*, 219 Or App 358 (2008). Also see OAR 436-001-0225(2) ("In medical service and medical treatment disputes under ORS 656.245, 656.247(3)(a), and 656.327, and managed care disputes under ORS 656.260(16), the administrative law judge may modify the director's order only if it is not supported by substantial evidence in the record or if it reflects an error of law. New evidence or issues may not be admitted or considered.")

3. OAR 436-010-0210:

Title: SAIF finds this section's current title more descriptive than the proposed title for anyone searching the rules for information. The proposed title does not capture the rule's references to treatments by other providers on referral from an attending physician. In addition, using a slash instead of words may be unclear. If reverting to the current title is unsatisfactory, SAIF suggests the title read, "Attending Physicians, Authorized Nurse Practitioners, and Time-Loss Authorizations."

(3) Nurse Practitioners: This section details compensable medical services a nurse practitioner may and may not provide, but does not mention closing exams. SAIF suggests this section add language stating that nurse practitioners must refer the worker to a type A physician for closing exams.

(4) Unlicensed to Provide Medical Services: SAIF suggests this section on unlicensed providers belongs in OAR 436-010-0230, Medical services and treatment guidelines.

4. OAR 436-010-0230:

(4) SAIF does not understand or agree with the proposed language stating "A medical provider may refuse to meet with an employer or insurer representative." This blanket statement may discourage good working relationships between medical providers and insurance carriers and may hamper the insurer's ability to discuss a plan of care or show the provider evidence relating to the worker's condition or care.

(6) Ancillary services. The rule does not specify whether it also applies to closed claims. In closed claims, there are additional requirements under ORS 656.245(1)(c)(J).

(12) Diagnostics. This rule is ambiguous; it states pre-authorization is not a guarantee of payment, but requires the insurer to respond whether the service is "approved or denied." In addition, the utility of this action is unclear and the terms "approved or

denied" are different than the term "pre-authorized." Thus, it is unclear whether an approval will be a guarantee of payment. When a claims adjuster is obtaining evidence to evaluate the compensability of a new condition in an accepted claim, this rule forces them to approve or deny a service that may later turn out to be either compensable or not compensable. Some "diagnostic" services involve invasive procedures; participants should not be misled into thinking that an insurer will pay for a service when it may not.

5. OAR 436-010-0241:

(4)(a) Aggravation. SAIF suggests this rule would be clearer if it stated that the physician's report must document the worker's inability to work due to an actual worsening of a compensable condition.

6. OAR 436-010-0250:

(10) This rule provides notice of penalties to physicians who fail to comply with the rule requiring sufficient notice of a proposed elective surgery to the insurer. However, it also tells the physician the insurer may still be liable for the surgery, which may make the rule's notice provisions ineffectual. SAIF recommends removing the last sentence of this section.

7. OAR 436-010-0270:

(1)(d) The second sentence of this rule is worded very broadly and, as written, is not authorized by statute.

(3) Preauthorization. This rule is inconsistent with OAR 436-010-0230(12) in that it omits the provision stating that preauthorization is not a guarantee of payment. SAIF's concerns regarding OAR 436-010-023(12) set out above also apply here.

SAIF is always available to answer any questions.

Sincerely,



Jaye Caroline Fraser, J. D., Assistant Counsel
400 High Street SE
Salem, Oregon 97312
P: 503.373.8026 or 800.285.8525 ext. 8026
jayfra@saif.com