



Oregon

Kate Brown, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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Jan. 15, 2016

Proposed Changes to Workers' Compensation Rules

Amendment of rules governing workers' compensation medical services and medical billing and payment

The Workers' Compensation Division proposes changes to OAR:

- [436-009, Oregon Medical Fee and Payment Rules](#)
- [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?

Feb. 22, 2016 9 a.m.

Where is the hearing?

Labor & Industries Building
350 Winter Street NE, Room F (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
Fax – 503-947-7514

The closing date for written comments is Feb. 25, 2016.

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.

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

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Department of Consumer and Business Services, Workers' Compensation Division

436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns

(503) 947-7717

Rules Coordinator

Telephone

Department of Consumer and Business Services, Workers' Compensation Division, PO Box 14480, Salem, OR 97309-0405

Address

RULE CAPTION

Amendment of rules governing workers' compensation medical services and medical billing and payment

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

Hearing Date	Time	Location	Hearings Officer
2-22-16	9:00 a.m.	Room F, Labor & Industries Bldg, 350 Winter St. NE, Salem	Fred Bruyns

RULEMAKING ACTION

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

ADOPT:

AMEND:

OAR 436-009, 436-010

REPEAL:

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.

Statutory Authority:

ORS 656.248, 656.726(4)

Other Authority:

Statutes Implemented:

ORS 656.245, 656.248; 656.252; 656.327; 656.704

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 436-009, "Oregon Medical Fee and Payment Rules," to:

- Adopt updated medical fee schedules (Appendices B, C, D, and E) and resources for the payment of health care providers;
- Increase maximum allowable payment rates by three percent for physician services except for physical therapy services;
- Replace two laboratory HCPCS codes with seven new codes assigned by the Centers for Medicare and Medicaid Services (CMS): replace G0431 with G0480, G0481, G0482, and G0483; replace G0434 with G0477, G0478, and G0479;
- Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
- Specify how providers must complete boxes 32 and 32a on the National Uniform Claim Committee 1500 Claim Form;
- Exclude platelet rich plasma injections from compensability;
- Eliminate the list of hospitals subject to including Medicare Severity Diagnosis Related Group (MS-DRG) codes on their bills, in favor of a general requirement to include the MS-DRG codes, unless the hospital is a critical access hospital or if the bill contains revenue code 002x.
- Replace the requirement for an insurer or insurer's representative to respond to a question from a provider or a worker about reimbursement within 48 hours with a requirement to do so within two days; require that explanations to workers about out-of-pocket expenses and explanations of benefits sent to health care providers specify two days instead of 48 hours to respond to questions;
- Remove a redundant requirement for health care providers to send multidisciplinary treatment programs to insurers - already in OAR 436-010;
- Establish new Oregon Specific (billing) Codes and associated fees for closing medical examinations of three levels of complexity, and for

related closing reports;

- Increase the maximum payable for hearing aids, without approval by the insurer or director, from \$5000 to \$7000 for a pair and from \$2500 to \$3500 for a single hearing aid;
- Allow a worker to upgrade a hearing aid by paying the price difference;
- Require that compounded drugs be billed at the component ingredient level, listing each ingredient national drug code (NDC), and that ingredients without an NDC are not reimbursable;
- Set the maximum allowable fee for a non-sterile compound drug at 83.5% of the average wholesale price (AWP) for each individual component ingredient, plus a compounding fee of \$2.00 for each ingredient;
- Set the maximum allowable fee for a sterile compound drug at 83.5% of the average wholesale price (AWP) for each individual component ingredient, plus a compounding fee of \$4.00 for each ingredient;
- Replace the mileage reimbursement rate payable to interpreters, currently \$0.50 per mile, with the private vehicle mileage rate published in Bulletin 112; and
- Clarify that, in the matrix for health care provider types, when a provider is not, or is no longer, eligible to provide treatment as a Type B attending physician, if care is provided because it is authorized by an attending physician, physician assistants are not required to have a written treatment plan.

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

- Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
- Replace the requirement for an insurer to forward a copy of an independent medical exam report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report with a requirement to do so within three days; and
- Clarify that, in the matrix for health care provider types, when a provider is not, or is no longer, eligible to provide treatment as a Type B attending physician, if care is provided because it is authorized by an attending physician, physician assistants are not required to have a written treatment plan.

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.

02-25-2016 Close of Business	Fred Bruyins	fred.h.bruyins@oregon.gov
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.

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

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

436
Administrative Rules Chapter Number

Amendment of rules governing workers' compensation medical services and medical billing and payment

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 436-009, Oregon Medical Fee and Payment Rules
OAR 436-010, Medical Services

Statutory Authority:

ORS 656.248, 656.726(4)

Other Authority:

Statutes Implemented:

ORS 656.245, 656.248; 656.252; 656.327; 656.704

Need for the Rule(s):

The agency is proposing changes to update the medical fee schedules as required by ORS 656.248, and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

Documents Relied Upon, and where they are available:

Advisory committee meeting records and written advice. This document is available for public inspection in the Administrator's Office, Workers' Compensation Division, 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.

Fiscal and Economic Impact:

The agency projects that proposed rule changes will have no positive or negative fiscal impacts on the agency. Possible economic effects on other state agencies, units of local government, and the public are described below under "Statement of Cost of Compliance."

Statement of Cost of Compliance:

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

- a. State agencies: The agency estimates that proposed rule changes will have no significant effect on costs of state agencies.
- b. Units of local government: The agency projects proposed rule changes would have some impact on units of local government, such as cities and counties that are self-insured. The fiscal effect on cities and counties is included with the impacts on workers' compensation insurers - see "The public" below.
- c. The public: The agency estimates that proposed rule changes will affect costs to the public as follows:
(References to "insurers" include self-insured employers.)
 - The agency estimates that the proposed increase in the maximum allowable payments for physician services will increase payments to health care providers by approximately \$1,535,000, at a corresponding cost to insurers. This will increase the total medical costs by 0.5 percent.
 - The agency projects a potential fiscal impact due to the replacement of two laboratory HCPCS codes with seven new codes assigned by CMS. However, the impact cannot be accurately estimated because it is not known which new codes will be used and how frequently each will be used. CMS used the following multipliers to derive new maximum allowable payments:

<input type="checkbox"/>	Current	New	Multiplier
<input type="checkbox"/>	G0431	G0480	3.25 times CPT® 82542
<input type="checkbox"/>	G0431	G0481	5.00 times CPT® 82542
<input type="checkbox"/>	G0431	G0482	6.75 times CPT® 82542
<input type="checkbox"/>	G0431	G0483	8.75 times CPT® 82542
<input type="checkbox"/>	G0434	G0477	0.75 times G0434
<input type="checkbox"/>	G0434	G0478	1.00 times G0434
<input type="checkbox"/>	G0434	G0479	4.00 times G0434.

- The agency estimates that the proposed creation of Oregon Specific Codes to be used when billing for closing medical examinations and reports may have economic effects on health care providers and insurers. However, the agency cannot project specific impacts because it cannot predict how many closing exams, and related reports, will be billed at level 1, level 2, and level 3.
- The agency estimates that the proposed increase in the maximum amounts payable for hearing aids (without approval by the insurer or the director), from \$5000 to \$7000 for a pair and from \$2500 to \$3500 for a single hearing aid, will increase payments to hearing aid providers at a corresponding cost to insurers. The agency estimates a maximum potential increase of \$223,000 per year. This will increase the total medical costs by 0.07 percent.
- The agency estimates that the proposed requirement that compounded drugs be billed at the ingredient level and at 83.5% of the average wholesale price for each individual component ingredient, plus a compounding fee for each ingredient, may reduce payments to compounding pharmacies, and provide a corresponding savings for insurers. However, the agency does not have enough data on the current costs of compounded drugs to estimate a specific impact.
- The proposed replacement of the \$0.50 per mile reimbursement rate for interpreters with a rate published in Bulletin 112 should produce a small increase in payments to interpreters in the near term, because the rate published in Bulletin 112 is currently \$0.54 per mile. There will be a corresponding cost for insurers. At \$0.54 per mile, an 8 percent increase, the payments for interpreter mileage will rise by approximately \$6,900 per year. This will increase the total medical costs by 0.002 percent. However, the rate in Bulletin 112 is the rate published by the U. S. General Services Administration (applicable to federal employees), and this rate is adjusted from time to time. Given the downward trend in gas prices, the GSA's mileage reimbursement rate may fall as well.
- The agency estimates that additional proposed rule changes will not have significant fiscal or economic impacts.

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 small businesses most affected by proposed rule changes are medical providers, pharmacies, and interpreter firms. The agency estimates that Oregon has at least 12,000 medical providers, 100 independently owned pharmacies, and 200 interpreter firms. Many of these businesses are 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 there will be no increased costs for small businesses for reporting, recordkeeping, or other administrative activities, including costs for professional services, required for compliance.

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

The agency projects that there will be no increased costs for small businesses for equipment, supplies, labor, or increased administration required for compliance.

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

Small business representatives attended the rulemaking advisory committee meetings and provided advice.

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

<u>02-25-2016 Close of Business</u>	<u>Fred Bruyns</u>	<u>fred.h.bruyns@oregon.gov</u>
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address



Oregon Medical Fee and Payment Rules Temporary Oregon Administrative Rules Chapter 436, Division 009

Proposed

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

Historical rules: <http://www.cbs.state.or.us/wcd/policy/rules/history.html>

NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in	Deleted
Added text is underlined, as in	<u>Added</u>

The Workers' Compensation Division (WCD) adopts, by reference, the American Society of Anesthesiologists (ASA) Relative Value Guide and Current Procedural Terminology (CPT®). See OAR 436-009-0004 for details and updated citations.

To order the *ASA Relative Value Guide*, contact:
American Society of Anesthesiologists
520 N. Northwest Highway, Park Ridge, IL 60068-2573
Phone 847-825-5586
<http://www.asahq.org/>

Ask for: 20145 *Relative Value Guide*

To order the **CPT®** 2016, or the *CPT Assistant*, contact:
American Medical Association
515 North State Street, Chicago, IL 60610
Phone 800-621-8335
<http://www.ama-assn.org/ama>

To order the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.2, contact:
National Council for Prescription Drug Programs (NCPDP)
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
Phone: 480.477.1000
www.ncpdp.org

To order the **NUBC UB-04 Data Specifications Manual**, contact:
National Uniform Billing Committee
American Hospital Association
One North Franklin, 29th Floor, Chicago, IL 60606
Phone 312-422-3390
www.nubc.org

Ask to: Become a subscriber of the NUBC UB-04 Specifications Manual

To order the Healthcare Common Procedure Coding System, contact:
National Technical Information Service
Springfield, VA 22161
Phone 800-621- 8335
www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp

436-009-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(2) Authority for Rules.

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.248.

(3) Purpose.

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

(4) Applicability of Rules.

(a) These rules apply to all services rendered on or after the effective date of these rules.

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2015 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2015, contact the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, 847-825-5586, or on the Web at: <http://www.asahq.org>.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT[®] 2015~~6~~), Fourth Edition Revised, 2014~~5~~, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT[®] must be used as guides governing the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's CPT[®] Assistant, Volume 0, Issue 04 1990 through Volume 24~~5~~, Issue 12, 2014~~5~~. If there is a conflict between the CPT[®] manual and CPT[®] Assistant, the CPT[®] manual is the controlling resource.

(4) To get a copy of the CPT[®] 2015~~6~~ or the CPT[®] Assistant, contact the American Medical Association, 515 North State Street, Chicago, IL60610, 800-621-8335, or on the Web at: <http://www.ama-assn.org>.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT[®] codes or that provide more detail than a CPT[®] code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or on the Web at: www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

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Proposed **OREGON MEDICAL FEE AND PAYMENT RULES**

(6) The director adopts, by reference, CDT 2015~~6~~: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or on the Web at: www.ada.org.

(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 1.1 06/13 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, 515 N. State St., Chicago, IL 60654, or on the Web at: www.nucc.org.

(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2015 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, One North Franklin, 29th Floor, Chicago, IL 60606, 312-422-3390, or on the Web at: www.nubc.org.

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.3 and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – 5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or on the Web at: www.ncdp.org.

(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2015, CPT[®] 2015~~6~~, CPT[®] Assistant, HCPCS 2015~~6~~, CDT 2015~~6~~, Dental Procedure Codes, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem OR 97301, 503-947-7606.

Stat Auth: ORS 656.248, 656.726(4)

Stats Implemented: ORS 656.248

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

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0005 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) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

~~(a)~~ ANSI means the American National Standards Institute.

~~(b)~~ ASC means ambulatory surgery center.

~~(e)~~(a) CMS means Centers for Medicare & Medicaid Services.

~~(d)~~(b) CPT[®] means Current Procedural Terminology published by the American Medical Association.

~~(e)~~ DME means durable medical equipment.

~~(f)~~(c) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies.

~~(g)~~(d) EDI means electronic data interchange.

~~(h)~~(e) HCPCS means Healthcare Common Procedure Coding System published by CMS.

~~(i)~~ IAIABC means International Association of Industrial Accident Boards and Commissions.

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

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

~~(l)~~ ICD-10 PCS means International Classification of Diseases, Tenth Revision, Procedure Coding System.

~~(m)~~(h) MCO means managed care organization certified by the director.

~~(n)~~(i) NPI means national provider identifier.

~~(o)~~(j) OSC means Oregon specific code.

~~(p)~~(k) PCE means physical capacity evaluation.

~~(q)~~(l) WCE means work capacity evaluation.

(3) “**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.

(4) “**Ambulatory surgery center**” (ASC) means:

(a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or

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Proposed OREGON MEDICAL FEE AND PAYMENT RULES

(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.

(5) **“Attending physician”** has the same meaning as described in ORS 656.005(12)(b). See Appendix AF, “Matrix for Health Care Provider Types”.

(6) **“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.

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

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

(9) **“Clinic”** means a group practice in which several medical service providers work cooperatively.

(10) **“CMS form 2552”** (Hospital and Hospital Health Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(11) **“Current procedural terminology”** or **“CPT”**[®] means the Current Procedural Terminology codes and terminology published by the American Medical Association unless otherwise specified in these rules.

(12) **“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.

(13) **“Days”** means calendar days.

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

(14) **“Director”** means the director of the Department of Consumer and Business Services or the director’s designee.

~~(14)~~(15) **“Division”** means the Workers’ Compensation Division of the Department of Consumer and Business Services.

~~(15)~~(16) **“Enrolled”** means an eligible worker has received notification from the insurer that the worker is being required to receive treatment 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 MCO’s certified geographical service area.

~~(16)~~(17) **“Fee discount agreement”** means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

~~(17)~~(18) **“Hearings Division”** means the Hearings Division of the Workers’ Compensation Board.

~~(18)~~(19) **“Hospital”** means an institution licensed by the State of Oregon as a hospital.

(a) **“Inpatient”** means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(b) **“Outpatient”** means a patient 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 that do not result in admission are also considered outpatient services.

~~(19)~~(20) **“Initial claim”** means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician 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.

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~~(20)~~(21) **“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 and meets the qualifications of a self-insured employer under ORS 656.407.

~~(21)~~(22) **“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)~~(23) **“Interpreter”** means a person who:

- (a) Provides oral or sign language translation; and
- (b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider’s employee, or a family member or friend of the patient.

~~(23)~~(24) **“Interpreter services”** means the act of orally translating between a medical provider and a patient who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the patient as well as reasonable time spent on necessary paperwork for the provider’s office.

~~(24)~~(25) **“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.

~~(25)~~(26) **“Managed care organization”** or “MCO” means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

~~(26)~~(27) **“Medical provider”** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

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~~(27)~~(28) **“Medical service”** means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

~~(28)~~(29) **“Medical service provider”** means a person duly licensed to practice one or more of the healing arts.

~~(29)~~(30) **“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 conservative care.

~~(30)~~(31) **“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.

~~(31)~~(32) **“Patient”** means the same as worker as defined in ORS 656.005(30).

~~(32)~~(33) **“Physical capacity evaluation”** means an objective, directly observed, measurement of a patient's ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

~~(33)~~(34) **“Provider network”** means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.

~~(34)~~(35) **“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.

~~(35)~~(36) **“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,

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climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

~~(36)~~(37) **“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.

~~(37)~~(38) **“Type A attending physician”** means an attending physician under ORS 656.005(12)(b)(A). See Appendix AF, “Matrix for Health Care Provider Types”.

~~(38)~~(39) **“Type B attending physician”** means an attending physician under ORS 656.005(12)(b)(B). See Appendix AF, “Matrix for Health Care Provider Types”.

~~(39)~~(40) **“Usual fee”** means the medical provider’s fee charged to the general public for a given service.

~~(40)~~(41) **“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.

~~(41)~~(42) **“Work hardening”** means an individualized, medically prescribed and monitored, work-oriented treatment process. The process involves the patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.000 et seq.; 656.005; 656.726(4)
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0008 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) 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.

(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 absent a showing of good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the

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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:

(A) A worker must request administrative review before the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services. If the worker is represented, and the worker's attorney has given 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.

(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee. Rebillings without any relevant changes will not provide a new 90 day period to request administrative review.

(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.

(D) 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) Within 180 days of the date a bill is paid, an insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

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(f) 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.

(A) The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

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

(B) If the request for review is submitted by either the insurer or the medical provider, it must state specific codes of services in dispute and include enough documentation to support the request, including copies of original bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to review the dispute. The insurer or medical provider requesting review must provide all involved parties a copy of:

- (i)** The request for review;
- (ii)** Any attached supporting documentation; and
- (iii)** If known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(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 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, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

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(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 other than 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.

(4) Dispute Resolution by Agreement (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.

(5) 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~~ received by 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.

(6) 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 order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245(3) or 656.247, 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

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issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the 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 division within 60 days after the mailing date of the order or notice of assessment.
- (C) The division will forward the request and other pertinent information to the board.

(7) Other Proceedings.

(a) Director's administrative review of other actions not covered under sections (1) through (6) of this rule: Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party, may request administrative review before the director. Any party may request administrative review as follows:

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

Stat. Auth.: ORS 656.704, 656.726(4); Stats. Implemented: ORS 656.704
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0010 Medical Billing and Payment

(1) General.

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim.

Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner.

Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The ~~department~~ director may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

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(f) When rebilling, medical providers must indicate that the charges have been previously billed.

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)

(a) Medical providers must bill within:

(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

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(3) Billing Forms.

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:

(A) Dental billings, which must be submitted on American Dental Association dental claim forms;

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or

(C) Electronic billing transmissions of medical bills (see OAR 436-008).

(c) Notwithstanding subsection (3)(~~a~~b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.

(d) Medical providers may use computer-generated reproductions of the appropriate forms.

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(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	<p>The provider must use the following codes to accurately describe the services rendered:</p> <ul style="list-style-type: none"> • CPT[®] codes listed in CPT[®] 20156; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT[®] or OSC. <p>If there is no specific code for the medical service:</p> <ul style="list-style-type: none"> • The provider should use an appropriate unlisted code from CPT[®] 20156 (e.g., CPT[®] code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. <p>Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.</p>
24I (shaded area)	See under box 24J shaded area.
24J (non-shaded area)	The rendering provider's NPI.
24J (shaded area)	<p>If the bill includes the rendering provider's NPI in the non-shaded area of box 24J, the shaded area of box 24I and 24J may be left blank.</p> <p>If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.</p>
<u>32</u>	<u>If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.</u>
<u>32a</u>	<u>If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.</u>

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(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT[®] 2015~~6~~ or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

If there is no specific CPT[®] code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service.

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT[®] 2015~~6~~ or the appropriate unlisted HCPCS code, and provide a description of the service provided.

A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT[®] 2015~~6~~, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

- (A) Unusually lengthy procedure;
- (B) Excessive blood loss during the procedure;
- (C) Presence of an excessively large surgical specimen (especially in abdominal surgery);
- (D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

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- (E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or
(F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier “81.”

(7) Chart Notes.

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider’s Bill.

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider’s bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.

(9) Billing the Patient / Patient Liability.

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. However, the patient may be liable, and the provider may bill the patient:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(10) Disputed Claim Settlement (DCS).

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) Payment Limitations.

(a) Insurers do not have to pay providers for the following:

- (A) Completing forms 827 and 4909;
- (B) Providing chart notes with the original bill;
- (C) Preparing a written treatment plan;
- (D) Supplying progress notes that document the services billed;
- (E) Completing a work release form or completion of a PCE form, when no tests are performed;
- (F) A missed appointment “no show” (see exceptions below under section (13) Missed Appointment “No Show”); or
- (G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.

(c) 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 patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) Excluded Treatment.

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

- (a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
- (b) Intradiscal electrothermal therapy (IDET);
- (c) Surface electromyography (EMG) tests;
- (d) Rolfing;
- (e) Prolotherapy;
- (f) Thermography;
- (g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:
 - (A) The single level artificial disc replacement is between L3 and S1;

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- (B) The patient is 16 to 60 years old;
- (C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and
- (D) The procedure is not found inappropriate under OAR 436-010-0230; ~~and~~

(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:

- (A) The single level artificial disc replacement is between C3 and C7;
- (B) The patient is 16 to 60 years old;
- (C) The patient underwent unsuccessful conservative treatment;
- (D) There is intraoperative visualization of the surgical implant level; and
- (E) The procedure is not found inappropriate under OAR 436-010-0230; and

(i) Platelet rich plasma (PRP) injections.

(13) Missed Appointment (No Show).

In general, the insurer does not have to pay for “no show” appointments. However, insurers must pay for “no show” appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

Stat. Auth.: ORS 656.245, 656.252, 656.254; Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 6/13/14 as Admin. Order 14-055, eff. 7/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0018 Discounts and Contracts

(1) Medical Service Providers and Medical Clinics.

For the purpose of this rule:

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

(b) "Clinic" means a group practice in which several medical service providers work cooperatively.

(2) Discounts.

(a) An insurer may only apply the following discounts to a medical service provider's or clinic's fee:

(A) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(B) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(b) If the insurer has multiple contracts with a medical service provider or clinic, and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

(c) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule amount.

(d) An insurer may not apply a fee discount until the medical service provider or clinic and the insurer have signed the fee discount agreement.

(3) Fee Discount Agreements.

(a) The fee discount agreement between the parties must be on the provider's letterhead and contain all the information listed on Form 3659. Bulletin 352 provides further information. The agreement must include the following:

- (A) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;
- (B) The effective and end dates of the agreement;
- (C) The discount rate or rates under the agreement;
- (D) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a patient receives;
- (E) A statement that the agreement only applies to patients who are being treated for Oregon workers' compensation claims;
- (F) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties;
- (G) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;
- (H) The name and address of the singular insurer or self-insured employer that will apply the discounts;
- (I) The national provider identifier (NPI) for the provider or clinic; and
- (J) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(b) Once the fee discount agreement has been signed by the insurer and medical service provider or clinic, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:

- (A) The insurer's name that will apply the discounts under the fee discount agreement;
- (B) The medical service provider's or clinic's name;
- (C) The effective date of the agreement;
- (D) The end date of the agreement;
- (E) The discount rate under the agreement; and
- (F) An indication that all the terms required under section (3)(a) of this rule are included in the signed fee discount agreement.

(4) Fee Discount Agreement Modifications and Terminations.

(a) When the medical service provider or clinic and the insurer agree to modify an existing fee discount agreement, the parties must enter into a new fee discount agreement.

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(b) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice to the other party. The insurer must report the termination to the director prior to the termination taking effect by completing the director's online form. The following information must be reported:

- (A) The insurer's name;
- (B) The medical service provider's or clinic's name; and
- (C) The termination date of the agreement.

(5) Other Medical Providers.

(a) For the purpose of this rule, "other medical providers" means providers such as hospitals, ambulatory surgery centers, or vendors of medical services and does not include medical service providers or clinics.

(b) The insurer may apply a discount to the medical provider's fee if a written or verbal contract exists.

(c) If the insurer and the medical provider have multiple contracts, only one discount may be applied.

(d) If the insurer has multiple contracts with a provider and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0020 Hospitals

(1) Inpatient.

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes;

(B) When applicable, procedural codes;

(C) The hospital's NPI; and

(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code, except for bills: from those hospitals listed in Appendix A.

(i) Bills from critical access hospitals; or

(ii) Bills containing revenue code 002x.

(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio (See Bulletin 290). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.

(2) Outpatient.

(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient bills must, when applicable, include the following:

(A) Revenue codes;

(B) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes,

(C) CPT[®] codes and HCPCS codes; and

(D) The hospital's NPI.

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(c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows:

Revenue Code	Pay Amount:	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or
		The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or
		The amount billed
All other revenue codes	<ul style="list-style-type: none"> • For hospitals listed in Bulletin 290, the amount billed multiplied by the cost-to-charge ratio. • For in-state hospitals not listed in Bulletin 290, 80% of the amount billed. • For out-of-state hospitals, the amount billed multiplied by a cost-to-charge ratio of 1.000. 	

(3) Specific Circumstances.

When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission are considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment is considered part of the hospital services subject to the hospital inpatient fee schedule.

(4) Out-of-State Hospitals.

(a) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.

(b) Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative.

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(c) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.

(d) If the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(5) Calculation of Cost-to-Charge Ratio Published in Bulletin 290.

(a) Each hospital's CMS 2552 form and financial statement is the basis for determining its adjusted cost-to-charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost-to-charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost-to-charge ratio or the hospital's cost-to-charge ratio based on estimated data.

(b) The basic cost-to-charge ratio is developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A is modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the ~~department~~ director to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio is further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost-to-charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.

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

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule ~~is~~are added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost-to-charge ratio. In no event will the adjusted cost-to-charge ratio exceed 1.00.

(g) The adjusted cost-to-charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of its CMS 2552 and financial statements each year within 150 days of the end of the hospital's fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost-to-charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division determines an adjusted cost-to-charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.

(i) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost-to-charge ratio to allow equitable payment.

(j) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost-to-charge ratio to reflect the data developed subsequent to the initial calculation.

(k) Notwithstanding subsections (1)(c), ~~(2)(b)~~, and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural

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hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost-to-charge ratio.

Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248; 656.252; 656.256
Hist: Amended 6/13/14 as Admin. Order 14-055, eff. 7/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0023 Ambulatory Surgery Center (ASC)

(1) Billing Form.

(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.

(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.

(2) ASC Facility Fee.

(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:

- (A)** Nursing, technical, and related services;
- (B)** Use of the facility where the surgical procedure is performed;
- (C)** Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;
- (D)** Radiology services designated as packaged in Appendix D;
- (E)** Administrative, record-keeping, and housekeeping items and services;
- (F)** Materials for anesthesia;
- (G)** Supervision of the services of an anesthetist by the operating surgeon; and
- (H)** Packaged services identified in Appendix C or D.

(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.

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(3) ASC Billing.

(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says “packaged” in Appendices C or D.

(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.

(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC’s cost for an implant is \$100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC’s cost of the implant.

(4) ASC Payment.

(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.

(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:

- (A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or
- (B) The ASC’s usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee.

A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly.

The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an “N” in the “Subject to Multiple Procedure Discounting” column.

(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.

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CPT [®] Code	Maximum Payment Amount	CPT [®] Code	Maximum Payment Amount
23350	\$235.12	36410	\$19.94
25246	\$220.99	36416	80% of billed
27093	\$304.90	36620	80% of billed
27370	\$290.78	62284	\$282.47
27648	\$274.16	62290	\$417.89
36000	\$39.05		

(e) When the ASC's cost of an implant is more than \$100, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.

(f) When the ASC's cost of an implant is less than \$100, insurers are not required to pay separately for the implant.

An implant may consist of several separately billable components, some of which may cost less than \$100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.

(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:

- (A) The ASC is not a contracted facility for the MCO;
- (B) The MCO has not pre-certified the service provided; or
- (C) The surgeon is not an MCO panel provider.

Stat. Auth.: ORS 656.726(4)
 Stats. Implemented: ORS 656.245; 656.248; 656.252
 Hist: Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
 See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0025 Worker Reimbursement

(1) General.

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

- (A) The insurer will reimburse claim-related services paid by the worker; and
- (B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use [Form 3921 – Request for Reimbursement of Expenses](#).

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

- (A) The amount of reimbursement for each type of out-of-pocket expense requested.
- (B) The specific reason for non-payment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;
- (C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within ~~48 hours~~ two days, excluding weekends and legal holidays;
- (D) The following notice, Web link, and phone number:
"To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit www.oregonwcdoc.info or call 503-947-7606.";
- (E) Space for the worker's signature and date; and
- (F) A notice of right to administrative review as follows:

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“If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers’ Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records.”

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(5)(f), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) Timeframes.

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

- (A) Two years from the date the costs were incurred or
- (B) Two years from the date the claim or medical condition is finally determined compensable.

(b) If the worker requests reimbursement after two years as listed in subsection (a), the insurer may disapprove the reimbursement request.

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request:

- (A) Reimburse the worker if the request shows the costs are related to the accepted claim;
- (B) Disapprove the request if unreasonable or if the costs are not related to the accepted claim; or
- (C) Request additional information from the worker to determine if costs are related to the accepted claim. If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement.

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(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, by whichever date is later the insurer must:

(A) Within 30 days of receiving the reimbursement request:

(i) Reimburse the worker if the request shows the costs are related,

(ii) Disapprove the request if unreasonable or if the costs are not related,
or

(iii) Request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement; or

(B) Within 14 days of claim acceptance:

(i) Reimburse the worker if the request shows the costs are related,

(ii) Disapprove the request if unreasonable or if the costs are not related,
or

(iii) Request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 14-day time frame for the insurer to issue reimbursement.

(e) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(f) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) Meal and Lodging Reimbursement.

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(4) Travel Reimbursement.

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer must inform the worker that he or she may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions 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.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112.

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

(5) Other Reimbursements.

(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) 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 either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing 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.

(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) Advancement Request.

If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth: ORS 656.245, 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0030 Insurer's Duties and Responsibilities

(1) General.

(a) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(b) The insurer, or its designated agent, may request from the medical provider any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents under OAR 436-009-0060. If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(c) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills.

The insurer must provide upon the director's request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(2) Bill Processing.

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b) and (2) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill.

The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.

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(b) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(1)(b) and (3)(~~a~~b), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(c) Any service billed with a code number commanding a higher fee than the services provided must be returned to the medical provider for correction or paid at the value of the service provided.

(3) Payment Requirements.

(a) Insurers must pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the bill is submitted in proper form according to OAR 436-009-0010(1)(b), (3)(a) through (7)(c), and clearly shows that the treatment is related to the accepted compensable injury or disease.

(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).

(c) The written EOB must be in 10 point size font or larger. Electronic and written explanations must include:

(A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within ~~48 hours~~ two days, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access information about Oregon's Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.";

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(E) Space for the provider's signature and date; and

(F) A notice of right to administrative review as follows:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(d) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(e) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily applies such a service charge to the general public.

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

(g) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid within 45 days of receipt by the insurer even if the claim is denied.

(h) If an insurer determines that it has made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.

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(4) Communication with Providers.

(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within ~~48 hours~~ two days, not including weekends or legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

(5) EDI Reporting.

For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

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

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0035 Interim Medical Benefits

(1) General.

(a) Interim medical benefits under ORS 656.247 only apply to initial claims when the patient has a health benefit plan, i.e., the patient's private health insurance. For the purpose of this rule the Oregon Health Plan is not a health benefit plan.

(b) Interim medical benefits are not due on claims:

(A) When the patient is enrolled in an MCO prior to claim acceptance or denial under ORS 656.245(4)(b)(B); or

(B) When the insurer denies the claim within 14 days of the employer's notice of the claim.

(c) Interim medical benefits cover services provided from the date of employer's notice or knowledge of the claim to the date the insurer accepts or denies the claim. Interim medical benefits do not include treatments excluded under OAR 436-009-0010(12).

(d) When billing for interim medical benefits, the medical provider must bill the workers' compensation insurer according to these rules, and the health benefit plan according to the plan's requirements. The provider may submit a pre-authorization request to the health benefit plan prior to claim acceptance or denial.

(e) If the medical provider knows that the patient filed a work-related claim, the medical provider may not collect any health benefit plan co-pay, co-insurance, or deductible from the patient during the interim period.

(2) Claim Acceptance.

If the insurer accepts the claim:

(a) The insurer must pay medical providers for services according to these rules; and

(b) The provider, after receiving payment from the insurer, must reimburse the worker and the health benefit plan for any medical expenses, co-pays, co-insurance, or deductibles, paid by the worker or the health benefit plan.

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(3) Claim Denial.

If the insurer denies the claim:

(a) The insurer must notify the medical provider as provided in OAR 436-060-0140 that an initial claim has been denied; and

(b) The medical provider must bill the health benefit plan, unless the medical provider has previously billed the health benefit plan. The provider must forward a copy of the workers' compensation denial letter to the health benefit plan.

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)

Stat. Implemented: ORS 656.247

Hist: Amended 10/17/14 as Admin. Order 14-060, eff. 1/1/15

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0040 Fee Schedule

(1) Fee Schedule Table.

(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table:

Services	Codes	Payment Amount:	
Services billed with CPT [®] codes, HCPCS codes, or Oregon Specific Codes (OSC):	Listed in Appendix B and performed in medical service provider's office	Lesser of:	Amount in non-facility column in Appendix B, or Provider's usual fee
	Listed in Appendix B and not performed in medical service provider's office	Lesser of:	Amount in facility column in Appendix B*, or Provider's usual fee
Dental Services billed with dental procedure codes:	D0000 through D9999	90% of provider's usual fee	
Ambulance Services billed with HCPCS codes:	A0425, A0426, A0427, A0428, A0429, A0433, and A0434	100% of provider's usual fee	
Services billed with HCPCS codes:	Not listed in the fee schedule	80% of provider's usual fee	
Services not described above:		80% of provider's usual fee	
* However, for all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Non-Facility Maximum column.			

(b) The global period is listed in the column 'Global Days' of Appendix B.

(2) Anesthesia.

(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total

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anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.

(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.

(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier 'NT' (no time) must be on the bill.

(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.

(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of \$58.00.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

- (A) The maximum allowable payment amount for anesthesia codes; or
- (B) The provider's usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

(3) Surgery.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:

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(a) One surgeon

Procedures	Appendix B lists:	The payment amount is:	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The billed amount
	80% of billed amount	80% of billed amount	
Any additional procedures* including: <ul style="list-style-type: none"> • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure 	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The billed amount
	80% of billed amount	40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of <i>ZZZ</i> .			

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(b) Two or more surgeons

Procedures	Appendix B lists:	The payment amount for each surgeon is:	
Each surgeon performs a principal procedure (and any additional procedures) Any additional procedures including:	A dollar amount	The lesser of:	75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or
			The billed amount
<ul style="list-style-type: none"> • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure 	80% of billed amount		60% of the billed amount (and 30% of the billed amount for any additional procedures*) (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(c) Assistant surgeons

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures	A dollar amount	The lesser of:	20% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount		20% of the surgeon(s) fee calculated in subsections (a) or (b)

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(d) Nurse practitioners or physician assistants

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures as the primary surgical provider, billed without modifier "81."	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	85% of the surgeon(s) fee calculated in subsections (a) or (b)	
One or more surgical procedures as the surgical assistant*	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	15% of the surgeon(s) fee calculated in subsections (a) or (b)	

*Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.

(e) Self-employed surgical assistants who work under the direct control and supervision of a physician

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures	A dollar amount	The lesser of:	10% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	10% of the surgeon(s) fee calculated in subsections (a) or (b)	

(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(g) If the surgery is non-elective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.

(4) Radiology Services.

(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component.

The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.

(5) Pathology and Laboratory Services.

(a) The payment amounts in Appendix B apply only when there is direct physician involvement.

(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.

(6) Physical Medicine and Rehabilitation Services.

(a) Time-based CPT[®] codes must be billed and paid according to this table:

Treatment Time	Bill and Pay As
0 to 7 minutes	0
8 to 22 minutes	1 unit
23 to 37 minutes	2 units
38 to 52 minutes	3 units
53 to 67 minutes	4 units
68 to 82 minutes	5 units

(b) Except for CPT[®] codes 97001, 97002, 97003, or 97004, payment for modalities and therapeutic procedures is limited to a total of three separate CPT[®]-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT[®] code does not count as a separate code.

(c) CPT[®] codes 97032, 97033, 97034, 97035, 97036, and 97039 are time-based codes and require constant attendance. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day or the amount of time spent providing the treatment.

(d) CPT[®] codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.

(7) Reports.

(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review

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of the records using CPT[®] codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.

(8) Nurse Practitioners and Physician Assistants.

Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248

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

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0060 Oregon Specific Codes

(1) Multidisciplinary Services.

(a) Services provided by multidisciplinary programs not otherwise described by CPT[®] codes must be billed under Oregon specific codes.

~~(b) When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for a patient, he or she must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.~~

(eb) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:

- (A) The type of service rendered,
- (B) The medical provider who provided the service,
- (C) Whether treatment was individualized or provided in a group session, and
- (D) The amount of time treatment was rendered for each service billed.

(2) Table of all Oregon Specific Codes (For OSC fees, [see Appendix B.](#))

Service	OSC
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR004
Arbiter file review - level 1: A file review of a limited record.	AR021
Arbiter file review - level 2: A file review of an average record.	AR022

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Service	OSC
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
<u>Closing exam by AP– level 1:</u> <u>A history and exam by the attending physician to measure impairment after the worker's condition is medically stationary. Involves one body part.</u>	<u>CE011</u>
<u>Closing exam by AP– level 2:</u> <u>A history and exam by the attending physician to measure impairment after the worker's condition is medically stationary. Involves two to three body parts.</u>	<u>CE012</u>
<u>Closing exam by AP– level 3:</u> <u>A history and exam by the attending physician to measure impairment after the worker's condition is medically stationary. Involves at least one of the following:</u> <ul style="list-style-type: none"> • <u>More than three body parts;</u> • <u>Conditions involving the eyes or head;</u> • <u>Conditions related to hearing; or</u> • <u>Vascular or dermatological conditions.</u> 	<u>CE013</u>
<u>Closing exam by non-AP – level 1:</u> <u>A history and exam by a provider other than attending physician to measure impairment after the worker's condition is medically stationary. Involves one body part.</u>	<u>CE021</u>

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Service	OSC
<p><u>Closing exam by non-AP – level 2:</u> <u>A history and exam by a provider other than attending physician to measure impairment after the worker's condition is medically stationary. Involves two to three body parts.</u></p>	<u>CE022</u>
<p><u>Closing exam by non-AP – level 3:</u> <u>A history and exam by a provider other than attending to measure impairment after the worker's condition is medically stationary. Involves at least one of the following:</u></p> <ul style="list-style-type: none"> • <u>More than three body parts;</u> • <u>Conditions involving the eyes or head;</u> • <u>Conditions related to hearing; or</u> • <u>Vascular or dermatological conditions.</u> 	<u>CE023</u>
<p><u>Closing report – level 1:</u> <u>A closing report that captures the findings of a level 1 closing exam.</u></p>	<u>CR011</u>
<p><u>Closing report – level 2:</u> <u>A closing report that captures the findings of a level 2 closing exam.</u></p>	<u>CR012</u>
<p><u>Closing report – level 3:</u> <u>A closing report that captures the findings of a level 3 closing exam.</u></p>	<u>CR013</u>
<p>Consultation – attorney: Time spent consulting with an insurer's attorney.</p>	D0001
<p>Consultation – insurer: Time spent consulting with an insurer.</p>	D0030
<p>Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.</p>	R0001
<p>Copies of medical records electronically: Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.</p>	R0002
<p>Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.</p>	D0002
<p>Director required medical exam or review time: Services by a physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate up to 6 hours for record review and exam.</p>	P0001
<p>Director required medical report: Preparation and submission of the report.</p>	P0003
<p>Director required review - complex case fee: Preauthorized fee by the director for an extensive review in a complex case.</p>	P0004
<p>Director required exam – failure to appear: Patient fails to appear for a director required exam.</p>	P0005

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Service	OSC
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003
IME – review and response: Insurer requested review and response by treating physician; document time spent.	D0019
Interdisciplinary rehabilitation conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – other than American Sign Language (ASL)	D0004
Interpreter services – American Sign Language (ASL)	D0005
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001

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Service	OSC
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645

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Service	OSC
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual - each additional 30 minutes	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
Vocational evaluation - each additional 15 minutes	97663
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: <ul style="list-style-type: none"> • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings. 	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647

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Service	OSC
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam and report.	W0001

(3) CARF / JCAHO Accredited Programs.

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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

(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.

Stat. Auth.: ORS 656.726(4) Stats. Implemented: ORS 656.248
 Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
 Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
 See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0080 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(1) **Durable medical equipment** (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:

- (a) Is primarily and customarily used to serve a medical purpose,
- (b) Can withstand repeated use,
- (c) Could normally be rented and used by successive patients,
- (d) Is appropriate for use in the home, and
- (e) Is not generally useful to a person in the absence of an illness or injury.

~~Examples: Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc.~~

(2) A **prosthetic** is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc.

The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged.

If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An **orthosis** is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.

(4) **Supplies** are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

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(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

- (a) NU for purchased, new equipment
- (b) UE for purchased, used equipment
- (c) RR for rented equipment

(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table:

If DMEPOS is:	And HCPCS is:	Then payment amount is:	
New	Listed in Appendix E	The lesser of	Amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Used	Listed in Appendix E	The lesser of	75% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Rented (monthly rate)	Listed in Appendix E	The lesser of	10% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	

(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes):

Code	Monthly Rate	Code	Monthly Rate
E0163	\$26.33	E0849	\$98.40
E0165	\$30.24	E0900	\$93.68
E0168	\$27.28	E0935	\$996.97
E0194	\$3643.05	E0940	\$52.20
E0261	\$259.66	E0971	\$5.68
E0277	\$1135.64	E0990	\$25.52

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E0434	\$35.31		E1800	\$262.29
E0441	\$86.85		E1815	\$276.15
E0650	\$1423.50		E2402	\$2487.86

(8) For items rented, unless otherwise provided by contract:

- (a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.
- (b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.
- (c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.

(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:

- (a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or
- (b) The provider may offer a service agreement at an additional cost.

(10) **Hearing aids** must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist.

The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

Unless otherwise provided by contract, insurers must pay the provider's usual fee for **hearing services** billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed \$57000 for a pair of hearing aids, or \$23500 for a single hearing aid.

If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.

(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for **vision services** billed with HCPCS codes V0000 through V2999.

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(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.

(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0090 Pharmaceutical

(1) General.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.

(2) Pharmaceutical Billing and Payment.

(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed. This includes compounded drugs, which must be billed at the component ingredient level, listing each ingredient NDC. Ingredients without an NDC are not reimbursable.

(b) All bills from pharmacies must include the prescribing provider's NPI or license number.

(c) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

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(d) Unless directly purchased by the worker (see 009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

If the drug dispensed is:	Then the maximum allowable fee is:
A generic drug	83.5 % of the dispensed drug's AWP plus a \$2.00 dispensing fee
A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent	83.5 % of the dispensed drug's AWP plus a \$2.00 dispensing fee
A brand name drug with a generic equivalent and the prescribing provider has not prohibited substitution	83.5 % of the average AWP for the class of generic drugs plus a \$2.00 dispensing fee
<u>A non-sterile compound drug</u>	<u>83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$2.00 for each ingredient</u>
<u>A sterile compound drug</u>	<u>83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$4.00 for each ingredient</u>

(Note: "AWP" means the Average Wholesale Price effective on the date the drug was dispensed.)

(e) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., First DataBank, RED BOOK, or Medi-Span.

(3) Clinical Justification Form 4909.

(a) The prescribing provider must fill out Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, and submit it to the insurer when prescribing more than a five day supply of the following drugs:

- (A) Celebrex[®],
- (B) Cymbalta[®],
- (C) Fentora[®],
- (D) Kadian[®],
- (E) Lidoderm[®],
- (F) Lyrica[®], or

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(G) OxyContin[®].

(b) Insurers may not challenge the adequacy of the clinical justification. However, they may challenge whether or not the medication is excessive, inappropriate, or ineffectual under ORS 656.327.

(c) The prescribing provider is not required to fill out Form 4909 for refills of medications listed on that form.

(d) If a prescribing provider does not submit Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, to the insurer, the insurer may file a complaint with the director.

(4) Dispensing by Medical Service Providers.

(a) 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 patient, up to a maximum of 10 days.

(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248, 656.252, 656.254

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

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0110 Interpreters

(1) Choosing an Interpreter.

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

(2) Billing.

(a) Interpreters must charge the usual fee they charge to the general public for the same service.

(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the patient.

(c) Interpreters may bill for interpreter services and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule, "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location and back to the interpreter's starting point.

(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:

- (A)** The patient fails to attend the appointment; or
- (B)** The provider has to cancel or reschedule the appointment.

(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the Department of Consumer and Business Services², Workers' Compensation Division at 503-947-7814. They may also access insurance policy information at <http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm>.

(3) Billing and Payment Limitations.

(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if:

- (A) The patient fails to attend the appointment: or
- (B) The provider cancels or reschedules the appointment.

(b) The insurer is not required to pay for interpreter services or mileage when the services are provided by:

- (A) A family member or friend of the patient; or
- (B) A medical provider's employee.

(4) Billing Timelines.

(a) Interpreters must bill within:

- (A) 60 days of the date of service;
- (B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or
- (C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.

(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the interpreter may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause. Good cause may include, but is not limited to, extenuating circumstances or circumstances considered outside the control of the interpreter.

(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.

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(5) Billing Form.

(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:

- (A) D0004 for interpreter services except American Sign Language,
- (B) D0005 for American Sign Language interpreter services, and
- (C) D0041 for mileage.

(b) An interpreter's invoice must include:

- (A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;
- (B) The patient's name;
- (C) The patient's workers' compensation claim number, if known;
- (D) The correct Oregon specific codes for the billed services (D0004, D0005, or D0041);
- (E) The workers' compensation insurer's name and address;
- (F) The date interpreter services were provided;
- (G) The name and address of the medical provider that conducted the exam or provided treatment;
- (H) The total amount of time interpreter services were provided; and
- (I) The mileage, if the round trip was 15 or more miles.

(6) Payment Calculations.

(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.

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(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters:

For:	The maximum payment is:
Interpreter services of an hour or less	\$60.00
American sign language (ASL) interpreter services of an hour or less	\$70.00
Interpreter services of more than one hour	\$15.00 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language (ASL) interpreter services of more than one hour	\$17.50 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	\$0.50 per mile <u>The private vehicle mileage rate published in Bulletin 112</u>
An examination required by the director or insurer that the patient fails to attend or when the provider cancels or reschedules	\$60.00 no-show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage

(7) Payment Requirements.

(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.

(b) When the patient fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay the no-show fee and mileage if the round-trip mileage is 15 or more miles.

(c) The insurer must pay the interpreter within:

(A) 14 days of the date of claim acceptance or any action causing the service to be payable, or 45 days of receiving the invoice, whichever is later; or

(B) 45 days of receiving the invoice for an exam required by the insurer or director.

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(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.

(f) If the insurer does not receive all the information to process the invoice, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.

(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each service billed.

(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.

(i) Electronic and written explanations must include:

(A) The payment amount for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within ~~48 hours~~ two days, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";

(E) Space for a signature and date; and

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(F) A notice of the right to administrative review as follows:

“If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers’ Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records.”

(j) The insurer or its representative must respond to an interpreter’s inquiry about payment within ~~48 hours~~two days, not including weekends or legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.

(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.248

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

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-009-0998 Sanctions and Civil Penalties

(1) The director may impose sanctions upon a medical provider or insurer for violation of these rules in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider's bill that is incorrect, the insurer must pay the provider's bill at the provider's usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty.

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provision of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS chapter 656.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.254, 656.745

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

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Appendix A

Oregon hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills under OAR 436-009-0020

	HOSPITAL NAME	NPI	ALT NPI	SECOND-ALT NPI
1	Adventist Medical Center	1801887658		
2	Asante Ashland Community Hospital*	1386644029	-	-
3	Asante Rogue Regional Medical Center Hospital	1770587107	1427277086	-
4	Asante Three Rivers Medical Center	1801891809	1598895690	-
5	Bay Area Hospital—Coos Bay	1225016561	-	-
6	Good Samaritan Regional Medical Center—Corvallis	1962453134	-	-
7	Kaiser Sunnyside Medical Center	1124182902	-	-
8	Kaiser Westside Medical Center	1891048807		
9	Legacy Emanuel Medical Center	1831112358	1295756898	-
10	Legacy Good Samaritan Medical Center	1780608216	-	-
11	Legacy Meridian Park Medical Center	1184647620	-	-
12	Legacy Mt. Hood Medical Center	1255354700	-	-
13	McKenzie Willamette Medical Center—Springfield	1568413573	1528006301	-
14	Mercy Medical Center—Roseburg*	1477590198	1134161391	-
15	Mid-Columbia Medical Center—The Dalles*	1306842752	-	-
16	Oregon Health & Science University Hospital	1609824010	1376873570	1548272511
17	Providence Medford Medical Center	1689755670	-	-
18	Providence Milwaukie Medical Center	1366536963	-	-
19	Providence Newberg Medical Center*	1952482275	-	-
20	Providence Portland Medical Center	1003991845	-	-
21	Providence St. Vincent Hospital & Medical Center	1114015971	1083866933	-
22	Providence Willamette Falls Medical Center	1639108434	-	-
23	Sacred Heart Medical Center Riverbend—Springfield	1083888515	1881928067	-
24	Sacred Heart Medical Center University Dist.—Springfield	1346237971	1164595617	-
25	Salem Hospital	1265431829	1114197894	-
26	Samaritan Albany General Hospital	1154372340	-	-
27	Santiam Hospital—Stayton*	1154302214	-	-
28	Silverton Hospital	1669424354	-	-
29	Sky Lakes Medical Center—Klamath Falls	1811130149	1659340370	-
30	St. Alphonsus Medical Center—Ontario*	1891891792	-	-
31	St. Charles Medical Center—Bend	1982621447	1598839789	-
32	St. Charles Medical Center—Redmond*	1225056146	-	-
33	Tuality Community Hospital—Hillsboro	1275591984	1336228659	-
34	Willamette Valley Medical Center—McMinnville*	1346269982	-	-

*Denotes hospital as rural. All of the 25 OR Critical Access Hospitals are intentionally excluded from this list.

Appendix FA - Matrix for health care provider types*

See OAR 436-009-0005

	Attending physician status (primarily responsible for treatment of a patient)	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. <u>(Note: physician assistants are not required to have a written treatment plan)</u>	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

Appendices B through E
Oregon Workers' Compensation Maximum Allowable Payment Amounts

The Workers' Compensation Division no longer adopts the Federal Register that publishes Centers for Medicare and Medicaid Services' (CMS) relative value units (RVUs). The division publishes the following Appendices to the division 009 of chapter 436.

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers.

[Effective April 1, 2015~~6~~]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective April 1, 2015~~6~~]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective April 1, 2015~~6~~]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, 2015~~6~~]

Note: If the above links do not connect you to the ~~department's~~ division's website, click:

<http://www.cbs.state.or.us/external/wcd/policy/rules/disclaimer.html>

If you have questions, call the Workers' Compensation Division, 503-947-7606.

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright 2014~~5~~ by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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Link to the Maximum Allowable Payment Tables: <http://www.cbs.state.or.us/wcd/policy/rules/disclaimer.html>

Or, contact the division for a paper copy, 503-947-7717



Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Proposed

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NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in
 Added text is underlined, as in

~~Deleted~~
Added

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Oregon Administrative rules OAR chapter 436

436-010-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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.

(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.)

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(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.

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(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.

(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.

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(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.

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(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 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

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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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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:

(A) 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 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.

(B) 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.

(C) 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.

(b) 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 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)~~(e), 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).

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(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 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

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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.

(6) Director Order and Reconsideration.

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(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~~received by 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, 656.247, 656.260(15) 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.

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(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.

(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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

436-010-0210 Attending Physician, Authorized Nurse Practitioner, and 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.

(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:

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- (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
- (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

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(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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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;

(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;

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(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

(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

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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

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of the 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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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.

(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.

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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 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.

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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.

(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 pre-authorized or not pre-authorized 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;
- (I) Prior fusion, laminectomy that involves any part of the facet joint, or

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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;

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- (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;
- (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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 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

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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.

(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;

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- (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.

(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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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.

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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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

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.

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(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 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.

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Stat. Auth: ORS 656.726(4)

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

Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 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’

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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.

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(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.

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(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 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.

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(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.

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(b) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within ~~72 hours~~ three days, excluding weekends and legal holidays, 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.

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(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 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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 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 pre-authorized or not pre-authorized.

(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;

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(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 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:

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- (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;
 - (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

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See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 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.

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(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.

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(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.

(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

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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.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)

Stats. Implemented: ORS 656.245, 656.252

Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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

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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 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:

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- (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;
- (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

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(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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the Index to Rule History: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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

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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 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.

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(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 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf.

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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. <u>(Note: physician assistants are not required to have a written treatment plan)</u>	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, while providing for access to adequate representation for injured workers.
 - 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?

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- 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.

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- 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.