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

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

EFFECTIVE JANUARY 1, 2002

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010

NOTE: Only adopted, amended, and repealed rules are included in this document:

RULE **PAGE**

436-010-0001 Authority For Rules

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(**4**[3]) 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)].

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
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436-010-0003 Applicability Of Rules

(1) These rules shall be applicable on or after the effective date to carry out the provisions of ORS 656.245, 656.248, 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 pursuant to ORS [C]**c**hapter 656.

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794
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436-010-0005 Definitions

For the purpose of these rules, OAR 436-009, and OAR 436-015, unless the context otherwise requires:

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

(2) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

(a) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or a**n** [board certified] oral surgeon licensed by the Oregon Board of Dentistry; [or]

(b) A medical doctor, doctor of osteopathy, or oral surgeon practicing in and licensed under the laws of another state; [or]

(c) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits, during that 30 day period, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon; [or]

(d) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician of chiropractic practicing and licensed under the laws of another state; or

(e) Any medical service provider authorized to be an attending physician in accordance with a managed care organization contract.

(3) "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.

(4) "Contested Case" means a proceeding as defined in ORS 183.310(2) pursuant to OAR 436-001.

(5) ["Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in evaluation of disability, diagnosis and/or treatment. A consulting physician may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensation injury.]

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

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

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

(8) [(9)] "Days" means calendar days.

(9) [(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.

(10) [(11)] "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

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

(12) [(13)] "Enrolled" means an eligible injured worker has received notification from the insurer that the worker is being required to treat under the auspices of the 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.

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

(14) [(15)] "Health Care Practitioner" has the same meaning as a "medical service provider."

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

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

(17) "Home Health Care" means medically necessary medical and medically related services provided in the injured worker's home environment. These services might 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. 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 does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(20) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(21) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS [C]**c**hapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(22) "Interim Medical Benefits" means those services provided pursuant to section 14, chapter 865, Oregon Laws 2001 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.

(23) [(22)] "Mailed or Mailing Date" means the date a document is postmarked **or an electronic record is sent pursuant to section 15 (1), chapter 535, Oregon Laws 2001,** for the purposes of determining timeliness pursuant to these rules. [A telephonic facsimile copy of a document will be accepted provided the document transmitted indicates at the top that it has been delivered by FAX to the division or other recipient's facsimile transmission number. If the document is submitted for filing, the original signed document must be simultaneously mailed addressed to the Division. The complete facsimile copy must be received by the Division by 5 p.m. on the filing deadline. When reception of a document begins after 5 p.m., the date of filing of that document, for purposes of these rules, shall be the date of the next regular workday. Persons transmitting or filing documents by facsimile copy accept all responsibility to timely filings. Delays in transmission shall not extend filing deadlines. Hand-delivered requests shall be considered mailed as of the date received by the Workers' Compensation Division or other recipient.]

(24) [(23)] "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR **chapter** 436, [D]**d**ivision 015.

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

(26) [(25)] "Medical Service" means 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.

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

(28) [(27)] "Medical Provider" means a medical service provider, a hospital, medical clinic**,** or vendor of medical services.

(29) [(28)] "Medical Treatment" means **the management and care of a patient for the purpose of combating disease, injury, or disorder.** [services that include but are not limited to those defined in (25) of this rule; ancillary services prescribed by an attending physician pursuant to OAR 436-010-0230(3); or any services which require a physician's prescription.] 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) [(29)] "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician pursuant to ORS 656.005 and subsections [1] **(2)**(c) and [1] **(2)**(d) of this rule.

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

(32) [(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.

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

(34) "Physical Restorative Services" means those services prescribed by the attending physician to address permanent loss of physical function due to hemiplegia, a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the highest functional ability consistent with the worker's condition. Physical restorative services are not services to replace medical services usually prescribed during the course of recovery.

(35) [(33)] "Report" means medical information transmitted in written form containing relevant subjective and/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.

(36) [(34)] "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

(37) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A

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

(38) [(35)] "Usual Fee" means the fee charged the general public for a given service.

(39) [(36)] "Work Capacity Evaluation" or "WCE" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening shall be considered to have the same meaning as Work Capacity Evaluation.

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

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436-010-0006 Administration of Rules

Any orders issued by the division in carrying out the director's authority to administer, regulate, and enforce ORS [C]**c**hapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

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436-010-0008 Administrative Review and Contested Cases

(1) Administrative [R]**r**eview [B]**b**efore the [D]**d**irector:

(a) Except as otherwise provided in ORS 656.704 [(3)(b)], the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.260**,** [and] 656.327**, and section 14, chapter 865, Oregon Laws 2001.**

(b) A party need not be represented to participate in the administrative review before the director except as provided in ORS [C]**c**hapter 183 and OAR [C]**c**hapter 436, [D]**d**ivision 001**.**

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

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

(3) **Except for disputes regarding interim medical benefits, w**[W]hen there is a formal denial of the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. After the compensability of the underlying claim is finally decided, any party may request director's review of appropriate medical issues within 30 days after the date the decision becomes final by operation of law.

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

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

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

(a) For all MCO enrolled claims, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision under the MCO's internal dispute resolution process. If a party has been denied access to an MCO internal dispute process or the

process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. **For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, which ever occurs last**. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438 **chapter**, [D]**d**ivision 005.

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

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

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

(7) Parties shall submit requests for administrative review to the director in the form and format **provided in Bulletin 293** [prescribed by the director]. The requesting party shall simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

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

(b) Specify what issues are in dispute and specify with particularity the relief sought[.]**;**

(c) Provide the specific dates of the unpaid disputed treatment.

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

(9) When a request for administrative review is filed pursuant to ORS 656.260**,** [or] 656.327, **or section 14, chapter 865, Oregon Laws 2001,** the insurer shall provide a record packet, without cost, to the director and all other parties or their representatives as follows:

(a) **Except for disputes regarding interim medical benefits, t**[T]he packet shall include certification that there is no issue of compensability of the underlying claim or condition**.** [; and,] **I**f there is

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

(b) The packet shall include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical service in 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 shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages, and date of the document. The packet shall include the following notice in bold [face] type:

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

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

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

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

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

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

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

(c) When such an examination of the worker is required, the director shall notify the appropriate parties of the date, time, and location of the examination. The physician or panel shall not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted to the director for screening as to the appropriateness of the questions. Matters not related to

the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination 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.

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

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

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

(A) The parties will have 30 days from the issuance of [the] **an** order **pursuant to ORS 656.245, 656.260, or 656.327, or 60 days from the issuance of an order pursuant to section 14, chapter 865, Oregon Laws 2001,** to request a contested case hearing before the director.

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

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

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

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

(13) Contested [C]**c**ases [B]**b**efore the [D]**d**irector: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

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

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

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

(d) In the review of orders issued pursuant to ORS 656.327(2)**,** [and] ORS 656.260(14) and (16), **and section 14, chapter 865, Oregon Laws 2001,** no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, **an** administrative order[s] may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

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

(14) Contested [C]**c**ase [H]**h**earings of [S]**s**anction and [C]**c**ivil [P]**p**enalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

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

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

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

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

(15) Director's [A]**a**dministrative [R]**r**eview of [O]**o**ther [A]**a**ctions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (14) of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

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

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

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704
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436-010-0200 Advisory Committee on Medical Care

The Advisory Committee on Medical Care shall be appointed by the director. The [C]**c**ommittee shall include one representative of insurers, one representative of employers, one representative of workers, one representative of managed care organizations, a diverse group of health care providers representative of those providing medical care to injured workers, and other persons as the director may determine are necessary to carry out the purpose of the committee. Health care providers shall comprise a majority of the [C]**c**ommittee at all times. The selection of health care providers shall consider the perspective of specialty care, primary care, and ancillary care providers, and the ability of members to represent the interests of the community at large.

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

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

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

(3) Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service or by persons not licensed to provide a medical service. Those persons not licensed to treat independently or not licensed to provide a medical service, may only provide treatment prescribed by the attending physician which is rendered under the physician's direct control and supervision. **Reimbursement to a worker for home health care provided by a worker'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.**

(4) Nurse practitioners and physician assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits [during that 30 day period]on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those nurse practitioners and physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are contained in ORS 442.470.

(5) Nurse practitioners and physician assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(**4**[3])(a), nor under the direct control and supervision of the attending physician.

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

(7) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer shall give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

(a) If the insurer does not approve the worker's out-of-state physician, notice to the worker shall clearly state the reason(s) for the denial **which may include, but are not limited to, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010, and** identify at least two

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

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

(A) The Oregon fee schedule requirements;

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

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

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

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

Stat. Auth: ORS 656.726(4)
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436-010-0220 Choosing and Changing Medical Providers

(1) A newly selected attending physician or a **specialist** [referral] physician who becomes primarily responsible for the worker's care, shall notify the insurer not later than five days after the date of change or first treatment, using Form 827. [(Change of Attending Physician). This form should be completed and

submitted only when the previous attending physician is no longer primarily responsible for the worker's care.] **An attending physician:**

(a) is primarily responsible for the worker's care,

(b) authorizes time loss,

(c) monitors ancillary care and specialized care, and

(d) is determined by the facts of the case and the actions of the physician, not whether a Form 827 is filed.

(2) The worker may have only one attending physician at a time. Simultaneous or concurrent treatment by other medical service providers shall be based upon a written request of the attending physician, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for **by statute or** [in] these rules, all treatments **and medical services** must be authorized by the injured worker's attending physician to be reimbursable. Fees for treatment by more than one physician at the same time are payable only when treatment is sufficiently different that separate medical skills are needed for proper treatment.

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

(a) Emergency services by a physician;

(b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment initiated by the attending physician;

(d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change physicians to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician; [or]

(f) Changes of attending physician required due to conditions beyond the worker's control. This could include, but not be limited to, when the physician terminates practice or leaves the area, when a physician is no longer willing to treat an injured worker, **when the worker moves out of the area requiring more than a 50 mile commute to the physician,** and when a worker is subject to managed care and compelled to be treated inside an MCO[.]**;**

(g) A worker requested medical examination; or

(h) Whether a worker has an attending physician who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines.

(4) When a worker has made an initial choice of attending physician and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer shall inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician, the insurer shall pay for compensable services rendered prior to notice to the worker. If an attending physician begins treatment without being informed that the worker has been given the required notification, the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made and informs the worker of the right to seek approval of the director.

(5)(a) If a worker not enrolled in an MCO wishes to change attending physicians beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of attending physician or a Form 82**7**[9] indicating the worker is choosing to change attending physicians, the insurer shall notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer shall advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (**Worker's** Request to Change Attending Physicians) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change attending physicians beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the change of attending physician request, the insurer shall notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer shall provide the reasons and give notification that the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of [Workers' Request to Change Attending Physicians (] Form 2332 [)].

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

(7) After receipt and review, the director will issue an order advising whether the change is approved. **The change of attending physician shall be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule.** On a case by case basis consideration may be given, but is not limited [,] to**,** the following:

(a) Whether there is medical justification for a change, including whether the attending physician can provide the type of treatment 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 closer to the worker's residence.

(c) Whether such a change will cause unnecessary travel costs and/or lost time from work.

[(d) Whether a worker has an attending physician that works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines.]

(8) Any party that disagrees with the director's order may request a contested case hearing before the director, pursuant to ORS 183.310(2) and OAR 436-001, as follows:

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

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

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436-010-0230 Medical Services And Treatment Guidelines

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

(2) An employer or insurer representative may not attend a worker's medical appointment without written consent of the worker. The consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present. The worker has the right to refuse such attendance. The insurer shall retain a copy of a signed consent form in the claim file.

[(2)] **(3)** Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment. Unless otherwise provided for by statute, or within utilization and treatment standards established by the **director** [department] or MCO contract, treatment typically does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a

month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment.

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

(b) Medical services prescribed by an attending physician and provided by a chiropractor, naturopath, acupuncturist, or podiatrist shall be subject to the treatment plan requirements set forth in **subsection** (**4**[3])(a) of this rule.

(c) Unless otherwise provided for within utilization and treatment standards prescribed by the **director** [department] or MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days, and 4 visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment. The attending physician shall document the need for services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

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

(6) [(5)] Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b)**,** and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist or dispensing physician shall dispense generic drugs to injured workers in accordance with and pursuant to ORS 689.515. For the purposes of this rule, the worker shall be deemed the "purchaser" and may object to the substitution of a generic drug. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

(7) [(6)] Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker or they are provided in accordance with a utilization and treatment standard adopted by the director. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(8) [(7)] X-ray films must be of diagnostic quality and accompanied by a report. 14" x 36" lateral views are not reimbursable.

(9) [(8)] Upon request of either the director or the insurer, original X-ray films shall be forwarded to the director or the insurer. Films shall be returned to the medical provider. A reasonable charge may be made for the costs of delivery of films. If a medical provider refuses to forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

(10) [(9)] Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(11) Physical restorative services may include but are not limited to a regular exercise program or swim therapy. Such services are not compensable unless the nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social and/or functional activity. The attending physician shall justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

(12) [(10)] The cost of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury, is a compensable medical expense, including when the worker received no physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eye glasses.

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436-010-0240 Reporting Requirements for Medical Providers

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, this authorization does not authorize the release of information regarding:

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

(b) The release of HIV related information otherwise protected by ORS 433.045(3). HIV related information should only be released when a claim is made for HIV or AID**S**[s] or when such information is directly relevant to the claimed condition(s).

(2) Any physician, hospital, clinic, or other medical service provider, shall provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, **or 2476 (Release of Information)** [829 or 2837 or any other authorized Release of Information the director may prescribe by bulletin]. "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the [D]**d**irector, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule shall prevent a medical provider from requiring a signed authorized Release of Information.

(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim shall complete the first medical report ([Department of Consumer and Business Services] Form 827) in every detail, to include the worker's name, address, and social security number (SSN), **and** information required by ORS 656.252 and 656.254 [, and other information the director may prescribe by bulletin]. The medical service provider shall mail it to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period).

(a) Diagnoses stated on Form 827 and all subsequent reports shall conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(b) The worker's SSN will be used by the **director** [Department of Consumer and Business Services] to carry out its duties under ORS [C]**c**hapter 656. The worker may voluntarily authorize additional use of the worker's SSN by various government agencies to carry out their statutory duties.

(4) All medical service providers shall notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. The worker shall also be notified that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the worker's chart notes.

(5) Attending physicians shall, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. [Medical services are not compensable until such verification is submitted.] **If the insurer requires the attending physician to complete a release to return to work form, the insurer shall use Form 3245.**

(6) Medical providers shall maintain records necessary to document the extent of services provided to injured workers.

(7) Progress reports are essential. When time loss is authorized by the attending physician, the insurer may require progress reports every 15 days through the use of the physician's [supplemental] report, [form (Department of Consumer and Business Services] Form 82**7** [8)]. **Chart notes may be sufficient to satisfy this requirement.** If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports shall be in accordance with OAR 436-009-**0015 (11), 436-009-0070 (2) or (3), whichever applies** [0020(24). Chart notes may be sufficient.]

(8) Reports may be handwritten and include all relevant or requested information.

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

(10) The medical provider shall respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, and any or all necessary records needed to review the efficacy of treatment, frequency, and necessity of care. The medical provider shall be reimbursed for copying documents in accordance with OAR 436-009-**0070 (1)** [0020(24)(b)]. If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

(11) The attending physician shall inform the insurer **and the worker** of the anticipated date of release to work, the anticipated date the worker will become medically stationary, the next appointment date, and the worker's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(12) At the time the attending physician declares the worker medically stationary, the attending physician shall notify the worker, the insurer, and all other medical providers who are providing services to the worker. The attending physician shall send a closing report to the insurer within 14 days of the examination in which the worker is declared medically stationary, except where a consulting physician examines the worker. The procedures and time frames for a consulting physician to perform the closing exam are provided in OAR 436-010-0280.

(13) The attending physician shall advise the worker, and within five days provide the insurer with written notice, of the date the injured worker is released to return to regular or modified work. The physician shall not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

(14) [The attending physician shall stock the "Notice of Claim Aggravation," Form 2837 and make it available to injured workers wanting to file a claim for aggravation.] An injured worker's claim for aggravation must be filed on Form **827** [2837] and must be accompanied by a medical report from the attending physician supported by objective findings that can be used to determine whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273. The attending physician, on the worker's behalf, shall submit within five days the claim for aggravation and the medical report directly to the insurer.

(15) The attending physician or the MCO may request consultation regarding conditions related to an accepted claim. The attending physician or the MCO shall promptly notify the insurer of the request for consultation. This requirement does not apply to diagnostic studies performed by radiologists and pathologists. The attending physician or MCO shall provide the consultant with all relevant clinical information. The consultant shall submit a copy of the consultation report to the attending physician, the MCO, and the insurer within 10 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report. MCO requested consultations that are initiated by the insurer, which include examination of the worker, shall be considered insurer medical examinations subject to the provisions of 436-010-0265.

(16) A medical service provider shall not unreasonably interfere with the right of the insurer, pursuant to OAR 436-010-0265(1), to obtain a medical examination of the worker by a physician of the insurer's choice.

(17) When an injured worker elects to change attending physicians or is referred to a new physician who is qualified to be an attending physician and who becomes primarily responsible for the worker's care, the new attending physician shall notify the insurer, using Form 82**7** [9], not later than five days after the change or the date of first treatment. The new attending physician shall request all available medical information, including information concerning previous temporary disability periods, from the previous attending physician or from the insurer. A previous attending physician who fails to forward requested information within 14 days to the new attending physician will be subject to penalties as provided by OAR 436-010-0340.

(18) Injured workers, or their representatives, are entitled to copies of all relevant medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers upon the payment of an appropriate charge for copies in accordance with OAR 436-009-**0070 (1)** [0020(24)(b)]. However, records that contain medical and psychological information relevant to the claim, which in the judgment of the writer of the report should not be shown to the worker because it would not be in the worker's best interest, need not be supplied to the worker, but must be supplied to the worker's representative. Upon request by the insurer, the director, or the **worker** [claimant], records containing the relevant information shall be provided, subject to the above exception.

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436-010-0250 Elective Surgery

(1) "Elective Surgery" is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

(2) Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician believes elective surgery is needed to treat a compensable injury or illness, the attending physician or the surgeon [,] shall give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, [an estimate of the surgical date and the post-surgical recovery period, and the hospital where surgery is to be performed] **an estimate of the post-surgical recovery period, and the approximate surgical date and place if known.**

(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the recommending physician, **the** worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired **by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician**. When requested, the consultation shall be completed within 28 days after notice to the attending physician.

(4)(a) Within seven days of the consultation, the insurer shall notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer shall endeavor to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, shall obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

(c) The recommending physician shall provide written notice to the insurer, the worker and the worker's representative when further attempts to resolve the matter would be futile **by signing Form 440-3228**. [The director may, by bulletin, prescribe the form and format for such notification.]

(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in **subsection**(4)**(**c) **of this rule**. Failure of the insurer to timely respond to the physician's elective surgery request or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery was excessive, inappropriate**,** or ineffectual.

(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.

(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-**0**340.

(8) Surgery which must be performed promptly, i.e., 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 should endeavor to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)
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436-010-0260 Monitoring and Auditing Medical Providers

(1) The department will monitor and conduct periodic audits of medical providers to ensure compliance with ORS [c]**c**hapter 656 and these rules.

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

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436-010-0265 Insurer Medical Examinations (IME)

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

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

(a) The insurer shall submit a request for such authorization to the director in a form and format as prescribed by the director **in Bulletin 252** including, but not limited to, **the reasons for an additional IME, the conditions to be evaluated,** [the purpose for the examination,] dates, times, places, **and** purposes of previous examinations, [and reasons why the additional examination is necessary] **copies of previous IME notification letters to the worker, and any other information requested by the director**. A copy of the request shall be provided to the worker and the worker's attorney; and

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. Upon receipt of a written request for additional information from the director, the parties shall have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

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

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

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

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

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

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

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

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

(4) Any party aggrieved by the director's order may request a hearing by the Hearings Division of the Workers' Compensation Board pursuant to ORS 656.283 and OAR [C]**c**hapter 438.

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

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

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

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

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

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

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

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

(8) When scheduling an IME, the insurer shall provide Form 440-3227 (Invasive Medical Procedure Authorization) to the medical service provider.

(9) If a medical service provider intends to perform an invasive procedure as part of an IME, the worker shall sign Form 440-3227 and may refuse the procedure. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

(10) [(8)] The person conducting the examination shall determine the conditions under which the examination will be conducted. Subject to the physician's approval, the worker may use a video camera or tape recorder to record the examination. Also subject to the physician's approval, the worker may be accompanied by a family member or friend during the examination. If the physician does not approve a worker's request to record an examination or allow the worker to be so accompanied, the physician must document the reasons.

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

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436-010-0270 Insurer's Rights and Duties

(1) Insurers shall notify the injured worker in writing, immediately following receipt of notice or knowledge of a claim, of the manner in which they may receive medical services for compensable injuries.

(2) Insurers may obtain relevant medical records, using a computer-generated equivalent of [any authorized] **Form 2476 (**Release of Information) [prescribed by the Director], with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

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

(4) Upon request, the insurer shall forward all relevant medical information to return-to-work specialists or vocational rehabilitation organizations.

[(4)] **(5) In disabling and non-disabling claims,** [I]**i**mmediately following notice or knowledge that the worker is medically stationary, insurers shall notify [all] **the** injured worker[s] and the attending physician in writing which medical services remain compensable under the system**. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).** [and the manner in which they may receive palliative care in accordance with OAR 436-010-0290. The director may, by bulletin, prescribe the form or format for such notification.]

[(5)] **(6)** When a medically stationary date is established by the insurer and is not based on the findings of an attending physician, the insurer shall notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer shall be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician.

[(6)] **(7)** Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(**e**[d])**, 656.325,** and **656.327**[OAR 436-060-0070].

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

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

(c) Prior to limiting reimbursement under **subsection (7)**(a) of this rule, the insurer shall provide the worker a written explanation and a list of providers who can timely provide similar services within a reasonable traveling distance for the worker. The insurer shall inform the worker that treatment may continue with the established attending physician; however, reimbursement of transportation costs may be limited as described.

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

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436-010-0275 Insurer's Duties under MCO Contracts

(1) Insurers who enter into an MCO contract in accordance with OAR 436-015, shall notify the affected insured employers of the following:

(a) The names and addresses of the complete panel of MCO medical providers within the employer's GSA(s);

(b) The manner in which injured workers can receive compensable medical services within the MCO;

(c) The manner in which injured workers can receive compensable medical services by medical providers outside the MCO; and

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

(2) Insurers under contract with an MCO shall notify all newly insured employers in accordance with section (1) of this rule, prior to or on the effective date of coverage.

(3) At least 30 days prior to any significant changes to an MCO contract affecting injured worker benefits, the insurer shall notify in accordance with OAR 436-015-0035 all affected insured employers and injured workers of the manner in which injured workers will receive medical services.

(4) When the insurer is enrolling a worker in an MCO, the insurer shall simultaneously provide written notice to the worker, all medical service providers, and the MCO of enrollment. Any notification to the MCO or medical service provider required by this subsection may be given via electronic mail subject to the requirements for electronic transmissions described in OAR 436-010-0005(**23**[22]). The notice shall:

(a) Notify the worker of the eligible attending physicians within the relevant MCO geographic service area and describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(b) Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;

(c) Describe how the worker can receive compensable medical treatment from a primary care physician who is not a member of the MCO, including how to request qualification of their primary care physician;

(d) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(**5**[6]);

(e) 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;

(f) Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and

(g) Notify the MCO of any request by the worker for qualification of a primary care physician.

(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance shall inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever occurs first.

(6) Insurers enrolling a worker who is not yet medically stationary and is required to change medical providers, shall notify the worker of the right to request review by the MCO if the worker believes the change would be medically detrimental.

(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician, the insurer shall notify the worker and medical service provider **regarding provision of care under the MCO contract, including the provisions for continuity of care** [that services rendered more than seven days after the mailing date of the notice of enrollment shall not be compensable as provided in OAR 436-015-0035(4)(e)].

(8) When an insurer under contract with an MCO receives a dispute regarding a matter that is to be resolved through the MCO dispute resolution process and that dispute has not been simultaneously provided to the MCO, the insurer shall within 14 days:

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

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

(9) The insurer must also notify the MCO of the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, and must keep the MCO informed of any changes.

(10) Insurers under contract with MCOs shall maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

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436-010-0280 Determination of Impairment

(1) The attending physician shall notify the insurer of the date on which the worker became medically stationary from the compensable injury or illness and whether or not the worker is released to any form of work. The medically stationary date should not be a projected date and should relate to an examination.

(2) The attending physician shall perform a closing examination **pursuant to OAR 436-030-0020 (2)** and submit the closing report within 14 days of the examination in which the worker was determined medically stationary, or shall arrange or request the insurer to arrange for the worker to be examined by a consulting physician for all or any part of the closing examination within five days of the examination in which the worker is declared medically stationary.

(3) A closing examination shall be performed when the attending physician is notified by the insurer that the worker's accepted injury is no longer the major contributing cause of the worker's condition and a denial has been issued. The attending physician shall submit a closing report within 14 days of the examination. If the attending physician refers the worker to a consulting physician for all or any part of the closing examination, the examination shall be scheduled within five days of the denial notification.

(4) Closing reports for examinations performed by a consulting physician pursuant to this rule shall be submitted to the attending physician within seven days of the examination. The attending physician must review the report and, within seven days of receipt of the report, concur in writing or provide a report to the insurer describing any finding/conclusion with which the attending physician disagrees.

(5) The insurer or the **director** [Department] may request an examination to determine the extent of impairment. The physician conducting the examination shall provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007.

(6) The closing examination report does not include any rating of impairment or disability, but describes impairment findings to be rated by either the insurer or the director. Physicians shall provide comments regarding the validity of the examination findings as they pertain to the accepted compensable conditions.

(7) The director may prescribe by bulletin what comprises a complete closing report, including, but not limited to, those specific clinical findings related to the specific body part or system affected. The bulletin may also include the impairment reporting format or form to be used as a supplement to the narrative report.

(8) [As prescribed by bulletin, t] **T**he attending physician shall specify the worker's residual functional capacity or refer the worker for completion of a second level PCE [(as described in OAR 436-009-0020(25)(b))] or WCE (as described in OAR 436-009-**0070 (4)** [0020(25)(c)]) pursuant to the following:

(a) A PCE when the worker has not been released to return to regular work, has not returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A WCE when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(9) When the worker's condition is not medically stationary and a denial has been issued because the worker's accepted injury is no longer the major contributing cause of the worker's condition, the physician shall estimate the worker's future impairment and residual functional capacity pursuant to OAR 436-035-0007(5).

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436-010-0290 Palliative Care

(1) When the worker's attending physician believes that palliative care is appropriate to enable the worker to continue current employment or a current vocational training program, the attending physician must first submit a written request for approval to the insurer [in a form and format as prescribed by the director]. The request shall:

(a) Describe any objective findings;

(b) Identify by ICD-9-CM diagnosis, the medical condition for which palliative care is requested;

(c) Detail a treatment plan which includes the name of the provider who will render 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**.** [; and

(f) Any other information the director may prescribe by bulletin.]

(2) Insurers shall date stamp all palliative care requests upon receipt. Within 30 days of receipt, the insurer shall send written notification to the attending physician, worker, and worker's attorney approving or disapproving the request as prescribed.

(a) Palliative treatment may begin following submission of the request to the insurer. If approved, services shall be payable from the date the approved treatment begins. If the requested care is ultimately disapproved, the insurer is not liable for payment of the treatment.

(b) If the insurer disapproves the requested care, the insurer shall explain, in writing:

(A) Any disagreement with the medical condition for which the care is requested;

(B) Why the requested care is not acceptable; and/or

(C) Why the requested care will not enable the worker to continue current employment or a current vocational training program.

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

(4) When the attending physician or the injured worker disagrees with the insurer's disapproval, the attending physician or the injured worker may request administrative review by the director in accordance with OAR 436-010-0008, within 90 days from the date of insurer's notice of disapproval. In addition to information required by OAR 436-010-0008(6), if the request is from a physician, it shall include:

(a) A copy of the original request to the insurer; **and**

(b) A copy of the insurer's response. [;]

(5) When the worker, insurer, or director believes palliative care, compensable under ORS 656.245(1)(c)(J), is excessive, inappropriate, ineffectual, or in violation of the [D]**d**irector's rules regarding the performance of medical services, the dispute shall be resolved in accordance with ORS 656.327 and OAR 436-010-0008.

(6) Subsequent requests for palliative care shall be subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

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436-010-0300 [Evaluating Outmoded and Experimental Treatment] **Process for Requesting Exclusion of Medical Treatment from Compensability**

(1) **If an injured worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability pursuant to ORS 656.245 (3). The request shall include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process.** [If an injured worker, an insurer, or the director feels that any medical treatment recommended for, or provided to, a worker or workers is unscientific, unproven as to its effectiveness, outmoded or experimental, either party may request, or the director may initiate on the director's own authority, an investigation in accordance with OAR 436-010-0008. A copy of the insurer's request for director investigation shall be submitted to the affected medical service provider(s), the worker, and worker's attorney.]

(2) The investigation shall include a request for advice from the licensing boards of practitioners who might be affected and the Medical Advisory Committee.

(3) The director shall issue an order [in accordance with OAR 436-010-0008] and may adopt a rule declaring the treatment to be non-compensable. The decision of the director is appealable to the director for a contested case hearing.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Hist: Filed 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
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Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

436-010-0330 Medical Arbiters and Panels of Physician

(1) In consultation with the Workers' Compensation Management-Labor Advisory Committee pursuant to ORS 656.790, the director shall establish and maintain a list of physicians to be used as follows:

(a) To appoint a medical arbiter or a panel of medical arbiters in accordance with ORS 656.268 **and to select a physician in accordance with ORS 656.325 (1)(b)**.

(b) To appoint an appropriate physician or a panel of physicians to review medical treatment or medical services disputes pursuant to ORS 656.245 and ORS 656.327.

(2) Arbiters, panels of arbiters, physicians, and panels of physicians will be selected by the director.

(3) When a worker is required to attend an examination pursuant to this rule the director shall provide notice of the examination to the worker and all affected parties. The notice shall inform all

parties of the time, date, location and purpose of the examination. Such examinations shall be at a place reasonably convenient to the worker.

(4) The arbiters, the panels of arbiters, the physicians and the panels of physicians selected pursuant to this rule shall be paid by the insurer in accordance with OAR 436-009-**0070 (9) to (11)** [0020(31) to (33)].

(5) The insurer shall pay the worker for all necessary related services pursuant to ORS 656.325(1).

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.268, 656.325, 656.327
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Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

436-010-0340 Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established pursuant to ORS 656.245, 656.252, and 656.254(1), as found in OAR 436-009 and [OAR] 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 services rendered;

(c) Referral to the appropriate licensing board; or

(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations.

(2) The director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence **on** any health care practitioner who, pursuant to ORS 656.254 and 656.327, has been found to:

(a) Fail to comply with the medical rules; [or]

(b) Provide medical treatment that is excessive, inappropriate or ineffectual; or

(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(3) If the conduct as described in section (2) is found to be repeated and willful, the director may declare the practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(4) A health care practitioner whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years. A certified copy of the revocation or suspension order shall be prima facie justification for the director's order.

(5) If a financial penalty is imposed on the attending physician for violation of these rules, no recovery of penalty fees may be sought from the worker.

(6) If an insurer or worker believes sanctions under **sections** (1) or (2) of this **rule** [section] are appropriate, either may submit a complaint in writing to the director.

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

(8) If the director finds any insurer in violation of OAR 436-009 or OAR 436-010, or an order of the director, the insurer shall be subject to penalties pursuant to ORS 656.745 of not more than $2000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.254, 656.745
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
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