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

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EFFECTIVE APRIL 1, 2005

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010

NOTE: Only adopted, amended, and repealed rules are included in this document:

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EXHIBIT "A"

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]**under** 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 an oral surgeon licensed by the Oregon Board of Dentistry;

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

(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;

(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) "Authorized nurse practitioner" means a nurse practitioner [authorized pursuant to ORS 656.245 (§3, ch. 811, OL 2003) to provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim, during that 90 day period. The authorized nurse practitioner may also authorize temporary disability benefits for a period of up to 60 days from the first nurse practitioner visit on the initial claim. Effective October 1, 2004, to be an authorized nurse practitioner, the nurse practitioner must] **licensed under ORS 678.375 to 678.390 who has** certif[y]**ied** to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director **and has been assigned an authorized nurse practitioner number by the director**.

(4) "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.

(5) "Contested Case" means a proceeding as defined in ORS 183.310(2) [pursuant to]**and conducted under** OAR 436-001.

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

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

specified in these rules.

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

(9) "Days" means calendar days.

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

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

(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.

(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.

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

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

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

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

(18) "Home Health Care" 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.

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

(20) "Initial Claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

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

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

(23) "Interim Medical Benefits" means those services provided [pursuant to]**under** ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer's notice of the claim.

(24) "Mailed or Mailing Date," for the purposes of determining timeliness [pursuant to]**under** these rules, means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests [shall]**will** be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, [shall]**will** be considered mailed as of the date of the request.

(25) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(26) "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.

(27) "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.

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

(29) "Medical Provider" means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(30) "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(31) "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]**under** ORS 656.005 and subsections (2)(c) and (2)(d) of this rule.

(32) "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.

(33) "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.

(34) "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]**will** be considered to have the same meaning as Physical Capacity Evaluation.

(35) "Physical Restorative Services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia, 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.

(36) "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.

(37) "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.

(38) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician or authorized nurse practitioner 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.

(39) "Usual Fee" means the fee charged the general public for a given service.

(40) "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]**will** be considered to have the same meaning as Work Capacity Evaluation.

(41) "Work Hardening" means an individualized, medically prescribed and monitored, work oriented treatment process. The process involves the worker participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance,

and productivity to return the worker to a specific job.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.000 et seq.; 656.005
Hist: Filed 10/20/76 as Admin. Order 4-1976, eff 11/1/76
Amended 6/5/78 as Admin. Order 7-1978, eff 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff 2/1/80
Amended 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-005, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 6/26/86 as Admin. Order 4-1986, eff 7/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff 3/16/87
Amended 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
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 7/20/90 as Admin. Order 14-1990, eff 7/20/90 (Temp)
Amended 8/17/90 as Admin. Order 17-1990, eff 8/17/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended 5/3/96 as Admin. Order 96-060, eff 6/1/96
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
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0008 Administrative Review and Contested Cases

(1) Administrative review before the director:

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.247, 656.260, and 656.327.

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

(c) Any party may request that the director provide voluntary mediation **or alternative dispute resolution** 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]**must** be reduced to writing and approved by the director. Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the claimant or claimant's attorney. If the dispute does not resolve through mediation **or alternative dispute resolution**, a director's order [shall]**will** be issued.

(2) Administrative review and contested case processes for change of attending physician or authorized nurse practitioner 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, when 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 disputes subject to dispute resolution within a Managed Care Organization, upon completion of the MCO process, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision. 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. If the MCO does not have a process for resolving the particular type of dispute, the insurer [shall]**must** advise the medical provider or worker that they may request review by the director.

(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. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, which ever occurs last. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438 chapter, division 005.

(c) Disputes regarding elective surgery [shall]**must** 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]**will** not be deemed payable pending the outcome of the review.

(7) Parties [shall]**must** submit requests for administrative review to the director in the form and format provided in Bulletin 293. **When an insurer or the worker's representative submits a request without the required information, at the director's discretion the administrative review may not be initiated until the information is submitted.** Unrepresented workers may seek help from the director in meeting the filing requirements. The requesting party [shall]**must** 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 **or services.**

(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]**under** ORS 656.247, 656.260, or 656.327, the insurer [shall]**must** 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, the packet [shall]**must** include certification that there is no issue of compensability of the underlying claim or condition. If there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet [shall]**must** 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]**must** be preceded by the designation "Ex." and pagination of the multiple page documents [shall]**must** be designated by a hyphen followed by the page number. For example, page two of document ten [shall]**must** be designated "Ex. 10-2." The index [shall]**must** include the document numbers, description of each document, author, number of pages, and date of the document. The packet [shall]**must** include the following notice in bold 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]**must** 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]**must** 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]**must** 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]**will** notify the appropriate parties of the date, time, and location of the examination. The physician or panel [shall]**must** 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]**will** review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

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

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the dispute.

(b) If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order [pursuant to]**under** 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.

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

(A) A request for contested case hearing must be mailed to the director within 30 days from the issuance of an order [pursuant to]**under** ORS 656.245, 656.260, or 656.327, or 60 days from the issuance of an order [pursuant to]**under** ORS 656.247.

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

(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]**must** 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) In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director [shall]**will** award an attorney fee to be paid by the insurer or self-insured employer, as provided in ORS 656.385 [(§2, ch. 756, OL 2003)]. The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration [shall]**will** be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed $2000, nor fall outside the ranges for fees as provided in the following matrix:

Estimated Benefit Achieved	**Professional Hours Devoted**				
	1-2 hours	2.1-4 hours	4.1-6 hours	6.1-8 hours	[8.1-12] **over 8** hours
$1-$2000	$100-400	$200-700	$300-750	$600-1000	$800-1250
$2001-$4000	$200-500	$400-800	$600-900	$800-1300	$1050-1500
$4001-$6000	$300-700	$600-1000	$800-1250	$1000-1450	$1300-1750
Over $600[1]0[-$10000]	$400-900	$800-1300	$1050-1600	$1350-1800	$1550-2000

(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the case if greater than two hours. In the absence of such a statement, the director [shall]**will** assume the time spent on the case was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to, the following:

(A) The fee allowed by the fee schedule provided in OAR 436-009;

(B) The overall cost of the medical treatment or service; or

(C) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above $2000, they may submit a written or faxed statement of the extraordinary circumstances to the director. **Extraordinary circumstances are not established by merely exceeding eight hours or exceeding a benefit of $6000.**

(d) In order to provide parties an opportunity to inform the director of agreements, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any information or statements provided to the director must simultaneously be provided to all other parties to the dispute.

(e) An assessed attorney fee [shall]**must** be paid within 30 days of the date the order authorizing the fee becomes final.

(14) Contested cases before the [director]**Office of Administrative Hearings**: Any party that disagrees with an action or order [pursuant to]**under** 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 mailed within 30 days of the mailing date of the order or notice of action being appealed.

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

(d) In the review of orders issued [pursuant to]**under** ORS 656.327(2), ORS 656.260(14) and (16), and ORS 656.247, no new medical evidence or issues [shall]**will** be admitted at the contested case hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(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.

(15) Contested case hearings of sanction and civil penalties: Under ORS 656.740 [(§9, ch. 170, OL 2003)], any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director [pursuant to]**under** ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

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

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

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

(16) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (15) of this rule, [pursuant to]**under** 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 (14) of this rule.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704
Hist: Filed 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended 12/4/95 as Admin. Order 95-071, eff 12/4/95 (Temp)
Amended 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0200 Advisory Committee on Medical Care

The Advisory Committee on Medical Care [shall]**will** be appointed by the director. The committee [shall]**will** 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]**must** comprise a majority of the committee at all times. The selection of health care providers [shall]**will** 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.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.794
Hist: [Amended]**Filed** 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-095 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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

(1) Attending physicians and authorized nurse practitioners may authorize time loss and manage 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 and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO.

(3) Attending physicians and authorized nurse practitioners may prescribe treatment to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment to be carried out by persons not licensed to provide a medical service or treat independently only when such treatment 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) Physician assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those 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) **Authorized**[N]**n**urse practitioners, **out-of-state 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)(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) Effective October 1, 2004, in order to **provide any compensable medical service under ORS chapter 656,** [qualify as an authorized nurse practitioner, a nurse practitioner] **a nurse practitioner licensed under ORS 678.375 to 678.390** must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request [to any nurse practitioner after April 1, 2004] **and must have been assigned an authorized nurse practitioner number by the director**. **An authorized nurse practitioner may:**

(a) Provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without authorization of an attending physician; and

(b) Authorize temporary disability benefits for a period of up to 60 days from the date of the first nurse practitioner visit on the initial claim.

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

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer [shall]**must** 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.

(9) After giving prior approval, if the out-of-state physician does not comply with these rules, the insurer may object to the worker's choice of physician and [shall]**must** 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]**will** not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

(10) 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)

Stats. Implemented: ORS 656.005(12), 656.245, [(§3, ch. 811, OL 2003)] 656.260

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff 8/20/84;
Renumbered from OAR 436-69-301, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 9/6/88 as Admin. Order 6-1988, eff 9/15/88
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-050 5/3/96 as Admin. Order 96-060, eff 6/1/96

Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0220 Choosing and Changing Medical Providers

(1) A newly selected attending physician, authorized nurse practitioner, or a specialist physician who becomes primarily responsible for the worker's care, [shall]**must** notify the insurer not later than five days after the date of change or first treatment, using Form 827. An attending physician or authorized nurse practitioner:

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

(b) Authorizes time loss,

(c) Monitors ancillary care and specialized care, and

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

(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers [shall]**must** be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable. 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 his or her attending physician or authorized nurse practitioner by choice two times after the initial choice. Referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, initiated by the worker, [shall]**will** count in this calculation. The limitations of the worker's right to choose physicians or authorized nurse practitioners [pursuant to]**under** this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes by choice of the worker:

(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 or authorized nurse practitioner;

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

(e) When workers are required to change medical service providers to receive compensable

medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:

(A) When the physician terminates practice or leaves the area;

(B) When a physician is no longer willing to treat an injured worker;

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

(D) When the 90 day period for treatment by an authorized nurse practitioner has expired;

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

(F) When a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A Worker Requested Medical Examination;

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

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

(4) When a worker has made an initial choice of attending physician or authorized nurse practitioner and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer [shall]**must** 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 or authorized nurse practitioner, the insurer [shall]**must** pay for compensable services rendered prior to notice to the worker. If an attending physician or authorized nurse practitioner begins treatment without being informed that the worker has been given the required notification, the insurer [shall]**must** pay for appropriate services rendered prior to the time the insurer notifies the medical service provider 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 his or her attending physician or authorized nurse practitioner beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of medical service provider or a Form 827 indicating the worker is choosing to change his or her attending physician or authorized nurse practitioner, the insurer [shall]**must** notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer [shall]**must** advise the worker of the reasons,

advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the request, the insurer [shall]**must** notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer [shall]**must** 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 or authorized nurse practitioner issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of Form 2332.

(6) Upon receipt of a worker's request for an additional change of attending physician or authorized nurse practitioner, 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]**will** 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 or authorized nurse practitioner [shall]**will** be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

(a) Whether there is medical justification for a change, including whether the attending physician or authorized nurse practitioner 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 or authorized nurse practitioner closer to the worker's residence.

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

(8) Any party that disagrees with the director's order may request a contested case hearing before the director, [pursuant to]**under** 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 mailed within 30 days of the mailing date of the order.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245[(§3, ch. 811, OL 2003)], 656.252, 656.260
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-401, 5/1/85
Amended 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

Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-060 5/3/96 as Admin. Order 96-060, eff 6/1/96
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
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0230 Medical Services And Treatment Guidelines

(1) Medical services provided to the injured worker [shall]**must** 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]**must** retain a copy of a signed consent form in the claim file.

(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 under an MCO contract, treatment typically does not exceed 15 office visits by any and all attending physicians or authorized nurse practitioners 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) (a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician [shall]**will** not be reimbursed unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven 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]**under** ORS 656.245(2)(b)(A).

(b) The attending physician, authorized nurse practitioner, or specialist physician [shall]**must** sign a copy of the treatment plan within 30 days of the commencement of treatment and send it to the insurer. Failure of the physician or nurse practitioner to sign or mail the treatment plan may subject the attending physician or authorized nurse practitioner to sanctions under OAR 436-010-0340, but shall not affect payment to the ancillary medical service provider.

(c) Medical services prescribed by an attending physician, specialist physician, or authorized

nurse practitioner and provided by a chiropractor, naturopath, acupuncturist, or podiatrist [shall]**will** be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

(d) Unless otherwise provided for within utilization and treatment standards under an 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 or authorized nurse practitioner [shall]**must** 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) The attending physician or authorized nurse practitioner, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, [shall]**must** complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner [shall]**must** notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner [shall]**must** dispense generic drugs to injured workers in accordance with and [pursuant to]**under** ORS 689.515. For the purposes of this rule, the worker [shall]**will** be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the provisions of this rule and OAR 436-009-0090. Compensation for certain drugs are limited as provided in OAR 436-009-0090.

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

(9) Upon request of either the director or the insurer, original diagnostic studies [shall]**must** be forwarded to the director or the insurer. Films [shall]**must** 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) 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 or authorized nurse practitioner [shall]**must** justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

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

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245[(§3, ch. 811, OL 2003)], 656.248, 656.252
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff 8/20/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-110, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff 3/16/87
Amended 6/15/87 as Admin. Order 3-1987, eff 6/15/87
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 9/6/88 as Admin. Order 6-1988, eff 9/15/88
Amended 8/21/89 as Admin. Order 2-1989, eff 9/1/89
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-040, 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Filed 2/11/99 as Admin. Order 99-052, eff. 2/11/99 (Temp)
Amended 4/28/99 as Admin. Order 99-055, eff 4/28/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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 under ORS 656.252. 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 AIDS or when such information is directly relevant to the claimed condition(s).

(2) Any physician, hospital, clinic, or other medical service provider, [shall]**must** provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, or 2476 (Release of Information). "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the director, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule [shall]**will** 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]**must** complete the first medical report (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. The medical service provider [shall]**must** 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]**must** 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 to carry out its duties under ORS chapter 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]**must** notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. The worker [shall]**must** 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 or authorized nurse practitioners [shall]**must**, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return to work form, the insurer [shall]**must** use Form 3245.

(6) Medical providers [shall]**must** 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 or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports [shall]**must** be in accordance with OAR 436-009-0015 (11), 436-009-0070 (2) or (3), whichever applies

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

(9) All records [shall]**must** 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]**must** 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]**must** be reimbursed for copying documents in accordance with OAR 436-009-0070 (1). 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 or authorized nurse practitioner [shall]**must** 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]**must** not consider the anticipated date of becoming medically stationary as a release to return to work.

(12) At the time the attending physician or authorized nurse practitioner declares the worker medically stationary, the attending physician or authorized nurse practitioner [shall]**must** notify the worker, the insurer, and all other medical providers who are providing services to the worker. For disabling claims, if the worker has been under the care of an authorized nurse practitioner, the authorized nurse practitioner must **follow the requirements of OAR 436-010-0280 regarding the determination and reporting of permanent impairment** [refer the worker to a qualified attending physician to complete]**and** [a] closing examination**s**. The attending physician [shall]**must** 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 or authorized nurse practitioner [shall]**must** 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 or nurse [shall]**must** not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

(14) An injured worker's claim for aggravation must be filed on Form 827 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]**must** submit within five days the claim for aggravation and the medical report directly to the insurer

(15) The attending physician, authorized nurse practitioner, or the MCO may request consultation regarding conditions related to an accepted claim. The attending physician, authorized nurse practitioner, or the MCO [shall]**must** 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, authorized nurse practitioner, or MCO [shall]**must** provide the consultant with all relevant clinical information. The consultant [shall]**must** submit a copy of the consultation report to the attending physician, authorized nurse practitioner, 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]**must** be considered insurer medical examinations subject to the provisions of 436-010-0265.

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

(17) Any time an injured worker changes his or her attending physician or authorized nurse practitioner:

(a) The new provider is responsible for:

(A) Submitting Form 827 to the insurer not later than five days after the change or the date of first treatment; and

(B) Requesting all available medical information, including information concerning previous temporary disability periods, from the previous attending physician, authorized nurse practitioner, or from the insurer.

(b) The requirements of paragraphs (A) and (B) also apply anytime a worker is referred to a new physician qualified to be an attending physician or to a new authorized nurse practitioner primarily responsible for the worker's care.

(c) Anyone failing to forward requested information within 14 days to the new physician or nurse will be subject to penalties under OAR 436-010-0340.

(18) Injured workers, or their representatives, are entitled to copies of all protected health information in the medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers under the following conditions:

(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0070(1), but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.

(b) For the purpose of this rule, "protected health information in the medical record" means any oral or written information in any form or medium that is created or received and relates to:

(A) The past, present, or future physical or mental health of the patient;

(B) The provision of health care to the patient; and

(C) The past, present, or future payment for the provision of health care to the patient.

(c) A worker or the worker's representative may request all or part of the record. A summary may substitute for the actual record only if the patient agrees to the substitution. Upon request, the entire health information record in the possession of the medical provider will be provided to the worker or the worker's representative. This includes records from other healthcare providers, except that the following may be withheld:

(A) Information which was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information;

(B) Psychotherapy notes;

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

(D) Other reasons specified by federal regulation.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245[(§3, ch. 811, OL 2003)], 656.252, 656.254, 656.273
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Renumbered from OAR 436-69-101, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 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
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 7/20/90 as Admin. Order 14-1990, eff 7/20/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-030, 5/3/96 as WCD Admin. Order 96-060, eff 6/1/96
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
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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 or authorized nurse practitioner, believes elective surgery is needed to treat a compensable injury or illness, the attending physician, authorized nurse practitioner, or the surgeon [shall]**must** give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification [shall give]**must provide** the medical information that substantiates the need for surgery, 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]**must** 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 **a completed** Form 440-3228 (Elective Surgery Notification) to the recommending physician. **If the form is not completed the physician is not required to respond.** When requested, the consultation [shall]**must** be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer [shall]**must** 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]**should** 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]**may** 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]**must** [provide written notice]**notify** [to] the insurer, the worker and the worker's representative **by signing Form 440-3228 or providing other written notification** [when]**that** further attempts to resolve the matter would be futile [by signing Form 440-3228].

(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]**must** 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 by submitting **a completed** Form 440-3228, or to timely request administrative review [pursuant to]**under** this rule shall bar the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the 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 436-010-0340.

(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 or authorized nurse practitioner should endeavor to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245[(§3, ch. 811, OL 2003)], 656.248, 656.252, 656.260, 656.327
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-501, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered to OAR 436-010-0250 5/3/96 as Admin Order 96-060, eff 6/1/96
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
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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 chapter 656 and these rules.

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

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252
Hist: Filed 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended and renumbered from OAR 436-010-101 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as WCD Admin. Order 01-065, eff. 1/1/02
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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] **under** 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. 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]**must** first notify and

request authorization from the director. Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty. The process for requesting such authorization [shall]**will** be as follows:

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

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. Upon receipt of a written request for additional information from the director, the parties [shall]**will** 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]**under** ORS 656.283 and OAR chapter 438.

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

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

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

(c) 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 or authorized nurse practitioner in accordance with OAR 436-010-0280.

(6) Examinations [shall]**must** be at times and intervals reasonably convenient to the worker and [shall]**must** 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]**must** comply with the notification and reimbursement requirements contained in OAR 436-009-0025 and 436-060-0095.

(8) When scheduling an IME, the insurer [shall]**must** 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]**must** 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) The person conducting the examination [shall]**will** 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) Upon completion of the examination, the examining physician(s) [shall]**must** send a copy of the report to the insurer within seven days. The insurer shall forward a copy of the report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.252, 656.325, 656.245[(§3, ch. 811, OL 2003)], 656.248, 656.260, 656.264
Hist: Filed 12/16/98 as Admin. Order 98-060, eff 1/1/99
Filed 2/11/99 as Admin. Order 99-052, eff. 2/11/99 (Temp)
Amended 4/28/99 as Admin. Order 99-055, eff 4/28/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0270 Insurer's Rights and Duties

(1) Insurers [shall]**must** 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

Form 2476 (Release of Information), with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(3) The insurer [shall]**must** notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim. In claims which have been denied, the insurer shall notify the medical service provider and MCO, if any, within ten days of any change of status of the claim.

(4) Upon request, the insurer [shall]**must** forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner within 14 days.

(5) In disabling and non-disabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers [shall]**must** notify the injured worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

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

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

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

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

(c) Prior to limiting reimbursement under subsection (7)(a) of this rule, the insurer [shall]**must** 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]**must** inform the worker that

treatment may continue with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited as described.

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

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.252, 656.325, 656.245[(§3, ch. 811, OL 2003)], 656.248, 656.260, 656.264
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Renumbered from OAR 436-69-801, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 9/6/88 as Admin. Order 6-1988, eff 9/15/88
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-100 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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

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

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

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

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

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

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

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

(4) When the insurer is enrolling a worker in an MCO, the insurer [shall]**must** simultaneously provide written notice to the worker, **the worker's representative,** all medical service providers, and the MCO of enrollment. The notice [shall]**must**:

(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 or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician or authorized nurse practitioner;

(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 or authorized nurse practitioner.

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

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

(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician or authorized nurse practitioner, the insurer [shall]**must** notify the worker and medical service provider regarding provision of care under the MCO contract, including the provisions for continuity of care.

(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]**must** within 14 days:

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

(b) If the MCO does not have a dispute resolution process for that issue, the insurer [shall]**must** 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]**must** maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

(11) When the insurer is dis-enrolling a worker from an MCO, the insurer must simultaneously provide written notice of the dis-enrollment to the worker, the worker's representative, all medical service providers, and the MCO. The notice must be mailed no later than seven days prior to the date the worker is no longer subject to the contract. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer enrolled.

(12) When a managed care contract expires or terminates without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO, that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days prior to the date of the contract's expiration or termination. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer subject.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245[(§3, ch. 811, OL 2003)], 656.248, 656.260, 656.264
Hist: Filed 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
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0280 Determination of Impairment

(1) The attending physician or authorized nurse practitioner [shall]**must** 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. On disabling claims, when finding or notification that the worker is medically stationary**, a determination of permanent impairment for claim closure must be done under OAR 436-030-0020(2).** [a]**A**n authorized nurse practitioner [shall]**must** refer the

worker to a **licensed physician who** qualifie[d]**s as an** attending physician to complete a closing examination **if there is a reasonable expectation of permanent impairment under ORS 656.214(1)(a) and OAR 436-030-0020(2)(b)**.

(2) [The attending physician shall perform a closing examination pursuant to OAR 436-030-0020 (2) and submit the closing] **A** report **must be submitted to the insurer by the attending physician or authorized nurse practitioner** within 14 days of the examination in which the worker was determined medically stationary[, or] **unless:**

(a) The attending physician does not wish to perform the closing examination, in which case he or she [shall]**must** arrange or request the insurer [to] arrange**, within five days of the examination in which the worker is declared medically stationary,** 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.]**; or**

(b) The authorized nurse practitioner refers the worker for a closing examination, in which case he or she must arrange or request the insurer arrange, within five days of the examination in which the worker is declared medically stationary, for the worker to have a closing examination under section (1) of this rule.

(3) A**n** [closing] examination [shall]**must** be performed when the attending physician **or authorized nurse practitioner** 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.

(a) The attending physician [shall]**must** 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]**must** be scheduled within five days of the denial notification.

(b) [Upon notification that the worker's accepted condition in a disabling claim is no longer the major contributing cause of the worker's condition, an] **The** authorized nurse practitioner [shall]**must either** refer the worker [to qualified attending physician to complete]**for** a closing examination **or provide a written statement, in accordance with sections (1) and (2) of this rule.**

(4) Closing reports for examinations performed by a specialist physician [pursuant to]**under** this rule [shall]**must** 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 physician conducting the examination [shall]**must** 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]**must**

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) The attending physician [shall]**must** specify the worker's residual functional capacity or refer the worker for completion of a second level PCE or WCE (as described in OAR 436-009-0070 (4) 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]**must** estimate the worker's future impairment and residual functional capacity [pursuant]**according** to OAR 436-035-[0007(5)]**0014**.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)(B)
Stats. Implemented: ORS 656.245[(§3, ch. 811, OL 2003)], 656.252
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Renumbered from OAR 436-69-601, 5/1/85
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-080 5/3/96 as Admin. Order 96-060, eff 6/1/96
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
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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. The request [shall]**must**:

(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.

(2) Insurers [shall]**must** date stamp all palliative care requests upon receipt. Within 30 days of receipt, the insurer [shall]**must** 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]**are** [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]**must** 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]**must** 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]**must** 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 director's rules regarding the performance of medical services, the dispute [shall]**will** be resolved in accordance with ORS 656.327 and OAR 436-010-0008.

(6) Subsequent requests for palliative care [shall]**are** [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.

Stat. Auth: ORS 656.726
Stats. Implemented: ORS 656.245

Hist: Filed 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 8/17/90 as Admin. Order 17-1990, eff 8/17/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-041 5/3/96 as Admin. Order 96-060, eff 6/1/96
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
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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

(1) If an injured worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability [pursuant to]**under** ORS 656.245(3). The request [shall]**must** 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.

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

(3) The director [shall]**will** issue an order 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
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended and renumbered from OAR 436-010-045 5/3/96 as Admin. Order 96-060, eff 6/1/96
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
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0330 Medical Arbiters and Panels of Physician

(1) In consultation with the Workers' Compensation Management-Labor Advisory Committee [pursuant to]**under** ORS 656.790, the director [shall]**will** 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]**under** 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]**under** this rule the director [shall]**will** provide notice of the examination to the worker and all affected parties. The notice [shall]**will** inform all parties of the time, date, location and purpose of the examination. Such examinations [shall]**will** be at a place reasonably convenient to the worker, **if possible**.

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

(5) The insurer [shall]**must** pay the worker for all necessary related services [pursuant to]**in accordance with** ORS 656.325(1).

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.268, 656.325, 656.327
Hist: Filed 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-047 5/3/96 as Admin Order 96-060, eff 6/1/96
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
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

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]**under** ORS 656.245, 656.252, and 656.254(1), as found in OAR 436-009 and 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]**will** consider:

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

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations.

(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]**under** ORS 656.254 and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(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]**will** be prima facie justification for the director's order.

(5) If a financial penalty is imposed on the attending physician or authorized nurse practitioner 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 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]**will** 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 may be subject to penalties [pursuant to]**under** 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]**will** be considered a separate violation.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245[(§3, ch. 811, OL 2003)], 656.254, 656.745
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Renumbered from OAR 436-69-901, 5/1/85
Amended 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 (formerly OAR 436-010-0110
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered to OAR 436-010-0340 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05