Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Effective March 1, 2015

TABLE OF CONTENTS

NOTE: New text is underlined. Deletions have a ~~strike through~~ style.

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

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436-010-0001 Authority for Rules

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

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

436-010-0002 Purpose

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

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

436-010-0003 Applicability of Rules

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

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794
Hist: Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04

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 under these rules except the hearing process described in OAR 436-001.

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

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

been assigned an authorized nurse practitioner number by the director.

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

(5) "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.

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

(12~~1~~) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(13~~2~~) "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.

(14~~3~~) "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.

(15~~4~~) "Health Care Practitioner or Health Care Provider" has the same meaning as a "medical service provider."

(16~~5~~) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

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

(187) "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.

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

(2019) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(2120) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.

(221) "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.

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

(243) "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.

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

(265) "Mailed or Mailing Date," for the purposes of determining timeliness 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 will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

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

(287) "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.

(2~~98~~) "Medical Service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(30~~29~~) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(31~~0~~) "Medical Provider" means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(32~~1~~) "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.

(33~~2~~) "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also considered outpatient services.

(34~~3~~) "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.

(35~~4~~) "Physical Capacity Evaluation" means an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, and Functional Capacity Assessment will be considered to have the same meaning as Physical Capacity Evaluation.

(36~~5~~) "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.

(37~~6~~) "Report" means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(38~~7~~) "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.

(398) "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, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a workers' compensable injury.

(4039) "Usual Fee" means the medical provider's fee charged the general public for a given service.

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

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.000 et seq.; 656.005
Hist: Amended 11/1/07 as Admin. Order 07-057, eff. 1/2/08
Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
Amended 1/29/15 as Admin. Order 15-051, eff. 3/1/15

436-010-0006 Administration of Rules

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

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

436-010-0008 Administrative Review

(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 disputes arising under ORS 656.245, 656.247, 656.260, 656.325 and 656.327.

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

(c) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement must be in

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

(2) Administrative review and hearing processes for change of attending physician or authorized nurse practitioner issues are in OAR 436-010-0220; additional independent medical examination (IMEs) matters are in OAR 436-010-0265; and fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

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

(4) 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.

(5) 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 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 must be processed in accordance with OAR 436-010-0250.

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

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

(6) Parties must submit requests for administrative review to the director in the form and format provided in Bulletins 293. When an insurer or the worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the information is submitted. Unrepresented workers may seek help from the director to meet the filing requirements. The requesting party must notify at the same time 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.

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

(8) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer 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 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 must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document ten must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

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

(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 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.

(9) 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 must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

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

(c) When such an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. The physician or panel 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.

(10) The director 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 under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the 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) If the director issues an administrative order resolving a bona fide dispute:

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

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

(C) 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.

(D) 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.

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

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

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

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

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

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

(14) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the board as follows:

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

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

(c) The division will forward the request and other pertinent information to the board.

(15) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (14) of this rule, 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 90 days of the disputed action and must specify the grounds upon which the action is contested.

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

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704
Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08
Amended 12-1-2009 as Admin. Order 09-055, eff.1-1-2010

436-010-0200 Advisory Committee on Medical Care

The Advisory Committee on Medical Care will be appointed by the director. The committee 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 must comprise a majority of the committee at all times. The selection of health care providers 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 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0210 Who May Provide Medical Services and Authorize Time Loss

(1) Type A and B attending physicians may authorize time loss and manage medical services subject to the limitations of ORS chapter 656. (See "Matrix for health care provider types" Appendix A)

(2) Emergency room physicians may authorize time loss for not more than 14 days when they refer the worker to a primary care physician. However an emergency room physician also in private practice, apart from the duties of an emergency room physician, may qualify as a type A attending physician. For the purpose of this rule, private practice means a physician who treats individuals on an established patient basis.

(3) Authorized primary care physicians, chiropractic physicians, and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO. An MCO may allow greater latitude for the provider types to treat a worker enrolled under ORS 656.260.

(4) Attending physicians and authorized nurse practitioners may prescribe treatment or services to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment or services to be carried out by persons not licensed to provide a medical service or treat independently only when such services or 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.

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

(6) In order to provide any compensable medical service under ORS chapter 656, a nurse practitioner licensed under ORS 678.375 to 678.390 must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will

provide upon request and must have been assigned an authorized nurse practitioner number by the director. An authorized nurse practitioner may:

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

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

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

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the medical service provider 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 treatment or services to Oregon injured workers; and

(C) The insurer may not pay billings for compensable services in excess of the maximum allowed under the fee schedule.

(8) 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 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 will not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.005(12), 656.245, 656.260
Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14

436-010-0220 Choosing and Changing Medical Providers

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

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

(b) Authorizes time loss,

(c) Monitors ancillary care and specialized care, and

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

(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers 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. When the attending physician or authorized nurse practitioner refers the worker to a specialist physician, the referral must be written. An attending physician must specify any limitations regarding the referral within such document. Unless the documented referral limits the referral to consultation only, the referral is deemed to include attending physician authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate. Nothing in this rule diminishes the attending physician's responsibility to fulfill all their duties under ORS chapter 656, including authorizing temporary disability. Fees for services by more than one physician at the same time are payable only when the service is sufficiently different that separate medical skills are needed for proper care.

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

(a) Emergency services by a physician;

(b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment or services 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 period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired; (See "Matrix for health care provider types" Appendix A);

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

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

(G) When the worker is disenrolled from an MCO because the worker was not subject to the MCO contract and the enrollment into the MCO compelled a change of attending physician or authorized nurse practitioner at the time of enrollment;

(g) A Worker Requested Medical Examination;

(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 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 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 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 must notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer must advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(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 must notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer 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 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 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 or service that is appropriate for the worker's condition.

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

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

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.252, 656.260
Hist: Amended 12/14/07 as Admin. Order 07-070, eff. 1/2/08 (temporary)
Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

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

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Adopted 5/27/10, as Admin. Order 10-053, eff. 7/1/10

436-010-0230 Medical Services and Treatment Guidelines

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

(2) An employer or insurer representative may not attend a worker's medical appointment without written consent of the worker. The worker has the right to refuse such attendance.

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

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

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

(3) At any time, the worker or the medical provider may refuse to allow an employer or insurer representative to attend an appointment, even if the worker previously signed a consent form.

(a) The medical provider may refuse to meet with the employer or insurer representative.

(b) The medical provider may refuse to provide copies of the worker's medical records to the insurer representative without proof that the representative is attending the appointment on behalf of the insurer. The provider may charge for any copies that are provided.

(4) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services.

(5)(a) Except as otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services such as physical or occupational therapy, the ancillary medical service provider must prepare a treatment plan before beginning treatment. The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). If the treatment plan is not sent within seven days, the insurer is not required

to pay for the services provided.

(b) Except as otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes services to be provided by a massage therapist licensed by the State Board of Massage Therapists for the state of Oregon under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. The massage therapist must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician.

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

(d) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a chiropractic physician, naturopathic physician, or acupuncturist, are subject to the treatment plan requirements in subsection (5)(a) and (c) of this rule.

(e) 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 or services. The attending physician or authorized nurse practitioner must document the need for medical 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.

(f) Unless otherwise provided for within utilization and treatment standards under an MCO contract, a physical therapist must simultaneously submit a progress report to the attending physician and the insurer each 30 days or after every visit if the worker is seen less frequently. The progress report may be included in the provider's chart notes. The progress report must include:

(A) Subjective status of the worker;

(B) Objective data from tests and measurements conducted;

(C) Functional status of the worker;

(D) Interpretation of above data; and

(E) Any change in the treatment plan.

(6) 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, must complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner must notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(7) 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 must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker 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 requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090.

(8) 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.

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

(10) Upon request of either the director or the insurer, original diagnostic studies, including but not limited to actual films, must be forwarded to the director, the insurer, or the insurer's designee, within 14 days of receipt of a written request.

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

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

(c) If a medical provider does not forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

(11) A medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film x-rays. Pre-authorization is not a guarantee of payment. The insurer must respond in writing to the provider's request within seven days of receipt of the provider's request.

(12) 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.

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

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

(15) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) is always inappropriate for injured workers with the following conditions (absolute contraindications):

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

(b) Known spondyloarthropathy (seropositive and seronegative);

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

(d) Malignancy of the spine;

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

(f) Pregnancy – currently;

(g) Active infection, local or systemic;

(h) Lumbar spondylolisthesis or lumbar spondylolysis;

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

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

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

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

(b) Arachnoiditis;

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

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

(e) Morbid obesity – BMI greater than 40;

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

(g) Osteopenia – based on bone density test;

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

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

(17) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) is always inappropriate for injured workers with any of the following conditions (absolute contraindications):

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

(b) Significantly abnormal facets;

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

(d) Allergy to metal implant;

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

(f) Uncontrolled diabetes mellitus;

(g) Active infection, local or systemic;

(h) Active malignancy, primary or metastatic;

(i) Bridging osteophytes (severe degenerative disease);

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

(k) Chronic indefinite corticosteroid use;

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

(m) Pseudo-arthrosis at the level of the proposed artificial disc replacement.

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

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

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

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

(d) Prior cervical fusion at one level;

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

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252; [OL 2011, ch. 117]
Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

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 and diagnostic records required under ORS 656.325. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, separate authorization is required for release of information regarding:

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

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

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

(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim must complete the "Worker's and Health Care Provider's Report for Workers' Compensation Claims" (Form 827). Information that must be provided on the form includes, but is not limited to the worker's name, address, and Social Security number if available. For an initial claim, the medical service provider must send Form 827 to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period). Diagnoses stated on Form 827 and all subsequent reports must conform to terminology found in the appropriate International Classification of Disease (ICD) or taught in accredited institutions of the licentiate's profession.

(4) All medical service providers must notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. Providers must also notify workers that they may be personally liable for noncompensable

medical services. Such notification should be made in writing or documented in the worker's medical record.

(5) All medical service providers must give a copy of "A Guide for Workers Recently Hurt on the Job" (Form 3283) to the worker when they give the worker a copy of Form 827.

(6) Attending physicians or authorized nurse practitioners must, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return to work form, the insurer must use Form 3245.

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

(8) Progress reports are essential. When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports must be in accordance with OAR 436-009-0040 (7)(a), 436-009-0060, and Appendix B of division 009, whichever applies.

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

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

(11) The medical provider must respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, original diagnostic studies, including, but not limited to, actual films, and any or all necessary records needed to review the efficacy of medical treatment or medical services, frequency, and necessity of care. The medical provider must be reimbursed for copying documents in accordance with OAR 436-009-0060 and Appendix B of division 009. If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

(12) The attending physician or authorized nurse practitioner 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 must not consider the anticipated date of becoming medically stationary as a release to return to work.

(13) The attending physician or authorized nurse practitioner must notify the worker, insurer, and all other health care providers involved in the worker's treatment when the worker is determined medically stationary. The medically stationary date must be the date of the exam, and not a projected date. The notice must provide:

(a) The medically stationary date; and

(b) Whether the worker is released to any kind of work.

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

(15) When an injured worker files a claim for aggravation, the claim must be filed on Form 827 and must be signed by the worker or the worker's representative and the attending physician. The attending physician, on the worker's behalf, must submit the aggravation form to the insurer within five days of the examination where aggravation is identified. When an insurer or self-insured employer receives a completed aggravation form, it must process the claim. Within 14 days of the examination the attending physician must also send a written report to the insurer that includes objective findings that document:

(a) Whether the worker is unable to work as a result of the compensable worsening; and

(b) Whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273.

(16) A worker may use the Form 827 to request the insurer to formally accept a new or omitted medical condition in writing. If the worker uses the form to request acceptance of a new or omitted medical condition during a medical visit, the health care provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the worker in the space provided on the form. If the injured worker signs the form and gives it to the provider, the provider must send the form to the insurer within five days of the day the worker signs the form.

(17) 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 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 must provide the consultant with all relevant clinical information. The consultant 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, must be considered independent medical examinations subject to the provisions of OAR 436-010-0265.

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

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

(a) The new provider is responsible for:

(A) Submitting Form 827 to the insurer not later than five days after the change or the

date of first treatment; and

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

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

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

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

(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0060, but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.

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

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

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

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

(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 health care providers, except that the following may be withheld:

(A) Information that was obtained from someone other than a health care provider when the health care provider promised confidentiality, and release of the information would likely reveal the source of the information;

(B) Psychotherapy notes;

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

(D) Other reasons specified by federal regulation.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273
Hist: Amended 12-1-2009 as Admin. Order 09-055, eff.1-1-2010
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0250 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 must give the insurer notice at least seven days prior to the date of the proposed surgery. Notification must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.

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

(a) The insurer 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.

(A)The insurer's notice must either communicate approval to the physician or,

(B) If approval is not given, the insurer must submit a completed Form 440-3228 (Elective Surgery Notification) to the recommending physician.

(b) If the form is not completed or insurer approval is not communicated to the physician, the physician is not required to respond.

(c) When requested, the consultation must be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer 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 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, 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) When the recommending physician determines that agreement cannot be reached and that further attempts to resolve the matter would be futile, the recommending physician must notify the insurer, the worker and the worker's representative of such by signing Form 440-3228 or providing other written notification.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or is in violation of these medical rules and cannot resolve the dispute with the recommending physician, the insurer must request an administrative review by the director within 21 days of the notice provided in subsection(4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request either by communicating the insurer's approval of the surgery or by submitting a completed Form 440-3228, or to timely request administrative review 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 and OAR 436-010-0340.

(8) Surgery which must be performed before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases the attending physician or authorized nurse practitioner should endeavor to notify the insurer of the need for emergency surgery.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327
Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

436-010-0260 Monitoring and Auditing Medical Providers

(1) The department will monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and these rules.

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

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252
Hist: Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05

436-010-0265 Independent Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by medical service providers of its choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. Effective July 1, 2006, the insurer must choose a provider to perform the independent medical examination from the director's list described in section (13) of this rule. A claim for aggravation, Board's Own Motion, or reopening of a claim where the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "independent medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician or authorized nurse practitioner. The examination may be conducted by one or more providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the 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 must first notify and request authorization from the director. Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty. The process for requesting such authorization will be as follows:

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

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

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

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

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

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

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

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

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

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

(4) Any party aggrieved by the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the board under ORS 656.283 and OAR chapter 438.

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

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

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

(c) An elective surgery consultation obtained in accordance with OAR 436-010-0250(3);

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

(e) A closing examination by a consulting physician that has been arranged by the insurer, the worker's attending physician or authorized nurse practitioner in accordance with OAR 436-010-0280;

(f) A consultation requested by the Managed Care Organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under its contract.

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

(7) When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(8) A medical provider who unreasonably fails to timely provide diagnostic records required for an IME in accordance with OAR 436-010-0230(10) and 436-010-0240(11) may be assessed a penalty under ORS 656.325.

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

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

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

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

(d) The director will determine if there is substantial evidence to support a finding that the travel is medically contraindicated, or unreasonable based on a showing of good cause.

(A) For the purposes of this rule, "medically contraindicated" means that the travel required to attend the IME exceeds the travel or other limitations imposed by the attending physician, authorized nurse practitioner or other persuasive medical evidence, and alternative methods of travel will not overcome the limitations.

(B) For the purposes of this rule, "good cause" means the travel would impose a hardship for the worker that outweighs the right of the insurer or self-insured employer to select an IME location of its choice.

(10) If a worker fails to attend an IME without notifying the insurer or self-insured employer before the date of the examination or without sufficient reason for not attending, the director may impose a monetary penalty against the worker for such failure under OAR 436-010-0340.

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

(a) An Invasive Medical Procedure Authorization (Form 440-3227), if applicable; and

(b) The Form 440-3923, "Important Information about Independent Medical Exams," available to the injured worker before the exam.

(12) If a medical service provider intends to perform an invasive procedure as part of an IME, the provider must explain the risks involved in the procedure to the worker and the worker's right to refuse the procedure. The worker then must check the applicable box on Form 440-3227 either agreeing to the procedure or declining the procedure, and sign the form. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

(13) Any medical service provider wishing to perform an IME or a Worker Requested Medical Exam (WRME) under ORS 656.325(1)(e) and OAR 436-060-0147 for a workers' compensation claim must meet the director's criteria and be included on the list of authorized providers maintained by the Director of the Department of Consumer and Business Services under ORS 656.328.

(a) To be on the director's list to perform IMEs or WRMEs, a medical service provider must hold a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon Medical Board, and must:

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

(B) Review IME training materials provided by the director at www.oregonwcdoc.info; or

(C) IME training materials approved by the director.

(b) To be included on the list of authorized IME providers, the provider must complete the online certification form. Providers may access the certification form at www.oregonwcdoc.info. The provider must supply his or her license number, the name of the training vendor, and certify to the director that the provider completed at least one of the training requirements under OAR 436-010-0265(13)(a). Any provider that completes the certification agrees to abide by the following:

(A) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board, or the independent medical examination standards published in Appendix C, which apply if the provider's regulatory board does not adopt standards of conduct for IMEs; and

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

(c) Providers on the director's list of authorized IME providers as of March 31, 2011, remain authorized to perform IMEs and do not need to reapply.

(d) A provider may be sanctioned or excluded from the director's list of providers authorized to perform IMEs after a finding by the director that the provider:

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

(B) Failed to comply with the requirements of this rule;

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

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

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

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

(e) Within 60 days of the director's decision to exclude a provider from the director's list, the provider may appeal the decision under ORS 656.704(2) and OAR 436-001-0019.

(14) The medical service provider conducting the examination will determine the conditions under which the examination will be conducted. Subject to the provider's approval, the worker may use a video camera or tape recorder to record the examination.

(15) If there is a finding by the director, an administrative law judge, the Workers' Compensation Board, or the court, that the IME was performed by a provider who was not on the director's list of authorized IME providers at the time of the examination, the insurer shall not use the IME report nor shall the report be used in any subsequent proceeding.

(16) Except as provided in subsection (a) of this section, a worker may elect to have an observer present during the IME.

(a) An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must submit a signed observer form (440-3923A) to the examining provider acknowledging that the worker understands the worker may be asked sensitive questions during the examination in the presence of the observer. If the worker does not sign form 440-3923A, the provider may exclude the observer.

(c) An observer cannot participate in or obstruct the examination.

(d) The worker's attorney or any representative of the worker's attorney shall not be an observer. Only a person who does not receive compensation in any way for attending the examination can be an injured worker's observer.

(e) The IME provider must verify that the worker and any observer have been notified of the requirement in sub-section (b).

(17) The IME provider must make Form 440-3923, "Important Information about Independent Medical Exams," available to the worker upon request by the worker or when needed to complete the observer form (440-3923A).

(18) Upon completion of the examination, the examining medical service provider must:

(a) Send the insurer a copy of the report and, if applicable, the observer form (440-3923A) or the invasive procedure form (440-3227), or both.

(b) Sign a statement at the end of the report verifying who performed the examination and dictated the report, the accuracy of the content of the report, and acknowledging that any false

statements may result in sanction by the director.

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

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

(21) Training must be approved by the director before it is given. Any party may submit medical service provider IME training curriculum to the director for approval. The curriculum must include training outline, goals, objectives, specify the method of training and the number of training hours, and must include all topics addressed in Appendix B.

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

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

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

436-010-0270 Insurer's Rights and Duties

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

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

(5) When an insurer receives a written request for pre-authorization of diagnostic studies from a provider the insurer must respond in writing to the provider's request within seven days of receipt of the provider's request. If the insurer fails to respond within seven days of receiving a written request, penalties under OAR 436-010-0340 may be imposed.

(6) In disabling and non-disabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers must notify the injured worker and the attending

physician or authorized nurse practitioner in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(7) 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 must notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer will be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician or authorized nurse practitioner.

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

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

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

(c) Prior to limiting reimbursement under subsection (8)(a) of this rule, the insurer must provide the worker a written explanation and a list of providers who can timely provide similar medical services within a reasonable traveling distance for the worker. The insurer must inform the worker that medical services may continue with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited as described.

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

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

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

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

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

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

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

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

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

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

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

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

(A) Provide a telephone number the worker may call to ask for a written list; and

(B) Tell the worker that he or she has seven days from the mailing date of the notice to request the list.

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

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

(d) Describe how the worker can receive compensable medical treatment from a primary care physician, chiropractic physician, or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician, chiropractic physician, or authorized nurse practitioner;

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

(f) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

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

(h) Notify the MCO of any request by the worker for qualification of a primary care physician, chiropractic physician, or authorized nurse practitioner.

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

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

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

(8) An enrollment notice is complete:

(a) On the date the notice is mailed when the notice includes all required information and a written list of eligible attending physicians;

(b) On the date the notice is mailed when the notice includes all required information and a Web address to access the list of eligible attending physicians, and the worker does not request a written list within seven days; or

(c) On the date the written list is mailed when the insurer includes all required information and a Web address to access the list of eligible attending physicians, and the worker requests a written list within seven days of the notice.

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

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

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

(10) The insurer must also notify the MCO of:

(a) The name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, any changes in this information; and

(b) Any requests for medical services received from the worker or the worker's medical provider.

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

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

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

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 5/21/09 as Admin. Order 09-051, eff. 7/1/09
Amended 11/12/13 as Admin. Order 13-059, eff. 1/1/14

436-010-0280 Determination of Impairment

(1) On disabling claims, when the worker becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. For workers under the care of an authorized nurse practitioner or a type B attending physician other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam if there is a likelihood the worker has permanent impairment. The closing exam must be completed under OAR 436-030 and OAR 436-035.

(2) The attending physician or authorized nurse practitioner has 14 days from the medically stationary date to send the closing report to the insurer. Within eight days of the medically stationary date, the attending physician may arrange a closing exam with a consulting physician. This exam does not count as an IME or a change of attending physician.

(3) When an attending physician requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report for the concurrence or objections of the attending physician. The attending physician must also state, in writing, whether they agree or disagree with all or part of the findings of the exam. Within seven days of receiving the report, the attending physician must make any comments in writing and send the report to the insurer. (See "Matrix for Health Care Provider types" Appendix A)

(4) The attending physician must specify the worker's residual functional capacity or refer the worker for completion of a second level physical capacities exam or work capacities exam (as described in OAR 436-009-0060) pursuant to the following:

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

(b) A work capacities exam 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.

(5) If the insurer issues a major contributing cause denial on the accepted claim and the worker is not medically stationary, the attending physician must do a closing exam. An authorized nurse practitioner or a type B attending physician other than a chiropractic physician must refer the worker to a type A attending physician for a closing exam. (See "Matrix for Health Care Provider types" Appendix A)

(6) The closing report ~~must address the accepted conditions and~~ must include all of the following:

(a) ~~Objective findings of permanent impairment; and~~ **Findings of permanent impairment.**

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

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

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

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

(b) ~~A statement of the validity of the impairment findings.~~ **Findings documenting permanent work restrictions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth: ORS 656.726(4), 656.245(2)(b)
Stats. Implemented: ORS 656.245, 656.252

Hist: Amended 11/17/11 as WCD Admin. Order 11-056, eff. 1/1/12
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14
Amended 1/29/15 as Admin. Order 15-051, eff. 3/1/15

436-010-0290 Medical Care After Medically Stationary

(1) Palliative care means medical services rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when it is prescribed by the attending physician and is necessary to enable the worker to continue current employment or a vocational training program. 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.

(a)The request must:

(A) Describe any objective findings;

(B) Identify by the appropriate ICD diagnosis, the medical condition for which palliative care is requested;

(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.

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

(A) Palliative care may begin following submission of the request to the insurer. If approved, services are payable from the date the approved medical service begins. If the requested care is ultimately disapproved, the insurer is not liable for payment of the medical service.

(B) If the insurer disapproves the requested care, the insurer must explain, in writing:

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

(ii) Why the requested care is not acceptable; or

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

(c) 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 must include a copy of the

original request and may include any other supporting information.

(d) 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 must include:

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

(B) A copy of the insurer's response.

(e) 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 will be resolved in accordance with ORS 656.327 and OAR 436-010-0008.

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

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

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

(A) Describe any objective findings.

(B) Identify by the appropriate ICD diagnosis, the medical condition for which the care is requested.

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

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

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

(3) In addition to sections (1) and (2) of this rule, medical services after a worker's condition is medically stationary are compensable when they are:

(a) Provided to a worker who has been determined permanently and totally disabled.

(b) Prescription medications.

(c) Services necessary to administer or monitor administration of prescription medications.

(d) Prosthetic devices, braces, and supports.

(e) Services to monitor the status, replacement or repair of prosthetic devices, braces, and supports.

(f) Services provided under an accepted claim for aggravation.

(g) Services provided under Board's Own Motion.

(h) Services necessary to diagnose the worker's condition.

(i) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

Stat. Auth: ORS 656.726
Stats. Implemented: ORS 656.245
Hist: Amended 3/1/11 as Admin. Order 11-051, eff. 4/1/11
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

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

(1) If an injured worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process.

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

(3) The director will issue an order and may adopt a rule declaring the treatment to be non-compensable. The decision of the director is appealable under ORS 656.704.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245
Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

436-010-0330 Medical Arbiters and Panels of Physicians

(1) In consultation with the Workers' Compensation Management-Labor Advisory Committee under ORS 656.790, the director 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 under ORS 656.268 and to select a physician under ORS 656.325 (1)(b).

(b) To appoint an appropriate physician or a panel of physicians to review medical treatment or medical services disputes under ORS 656.245, 656.260, and 656.327.

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

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

all parties of the time, date, location, and purpose of the examination. Examinations will be at a place reasonably convenient to the worker, if possible.

(4) The arbiters, the panels of arbiters, the physicians and the panels of physicians selected under this rule must be paid by the insurer in accordance with OAR 436-009-0060 and Appendix B of division 009.

(5) The insurer must pay the worker for all necessary related services in accordance with ORS 656.325(1).

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.268, 656.325, 656.327
Hist: Amended 3/11/13 as WCD Admin. Order 13-052, eff. 4/1/13
Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

436-010-0340 Sanctions and Civil Penalties

(1) If the director finds any medical service provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), and 656.325, and 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 medical 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 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.

(e) A penalty of $100 for each violation of ORS 656.325(1)(c)(C).

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

(a) Fail to comply with the medical rules;

(b) Provide medical services that are excessive, inappropriate or ineffectual; or

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

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

(4) A medical service provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for

reimbursement for treating workers' compensation claimants for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

(5) 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 not 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 services, 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 will be limited to the amounts listed in section (8) of this rule.

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

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

Stat. Auth: ORS 656.726(4); **Stat. Implemented:** ORS 656.245, 656.254, 656.745
Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

Appendix A - Matrix for health care provider types * See OAR 436-010-0005

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

* This matrix does not apply to Managed Care Organizations

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

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

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

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

      Additional items to discuss:
      - Exclusive remedy.
      - The Legislature found that common law is expensive without proportionate benefit.
      - No fault versus tort.
      - The economy and the costs of injuries.

   b) Causation of work related injuries.
      - Is the injury work related?
      - What are pre-existing conditions?
      - What is major contributing cause?
      - What is material contributing cause?

c) The IME provider role
- Unbiased, neutral third-party
- Independent

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

B. Provider Code of Professional Conduct
IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:

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

C. Report writing

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

D. Communication
What is appropriate communication between claims examiners and medical providers?

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

1. observers
2. recording of exams
3. invasive procedures
4. sanctions and civil penalties
5. worker penalties & suspension
6. exam location disputes
7. forms
8. complaints.

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

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

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

H. Workers' Compensation Division's complaint process:
1. use of injured workers surveys about IMEs
2. complaints received by the Workers' Compensation Division.

I. Impairment findings: the purpose of measuring impairment.
It is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job-at-injury being performed, etc.

J. Other necessary information as determined by the director.

OAR 436-010-0265

Appendix C

INDEPENDENT MEDICAL EXAMINATION STANDARDS

As developed by the Independent Medical Examination Association

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

BEFORE THE DIRECTOR
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

In the Matter of the Amendment of **ORDERS OF**
Oregon Administrative Rules (OAR) chapter 436, **ADOPTION**

Division 009, Oregon Medical Fee and Payment Rules ..... No. 15-050
Division 010, Medical Services ..... No. 15-051
Division 030, Claim Closure and Reconsideration ..... No. 15-052
Division 035, Disability Rating Standards ..... No. 15-053
Division 105, Employer-at-Injury Program ..... No. 15-054
Division 110 Preferred Worker Program ..... No. 15-055
Division 120, Vocational Assistance to Injured Workers ..... No. 15-056

The Director of the Department of Consumer and Business Services, under the general rulemaking authority in ORS 656.726(4), and in accordance with the procedures in ORS 183.335, amends OAR chapter 436.
On Nov. 12, 2014, the Workers' Compensation Division filed with the Secretary of State a *Notice of Proposed Rulemaking Hearing* and *Statement of Need and Fiscal Impact*. The division mailed copies of the *Notice* and *Statement* to interested persons and legislators in accordance with ORS 183.335 and OAR 436-001-0009, and posted copies to its website. The Secretary of State included notice of the public hearing in its December, 2014, *Oregon Bulletin*. On Dec. 19, 2014, a public hearing was held as announced. The record remained open for written testimony through Dec. 29, 2014.

SUMMARY OF RULE AMENDMENTS

- The Workers' Compensation Division has amended OAR 436-030, Claim Closure and Reconsideration, and OAR 436-035, Disability Rating Standards, to reflect the decision of the Oregon Supreme Court in *Schleiss v. SAIF* (364 Or. 637 (2013)). A contributing cause to impairment must be a statutorily recognized preexisting condition to qualify for apportionment. In injury claims, to be recognized as a preexisting condition, a condition must be (1) arthritis or an arthritic condition, or (2) diagnosed or treated prior to the compensable injury. In an occupational disease claim, to be recognized as a preexisting condition, a condition must precede the onset of the claimed occupational disease. Revised rules limit apportionment to those losses that existed before the compensable injury and that qualify as preexisting conditions.
- The division has amended OAR 436-009, Oregon Medical Fee and Payment Rules, 436-010, Medical Services, 436-030, Claim Closure and Reconsideration, 436-035, Disability Rating Standards, 436-105, Employer-at-Injury Program, 436-110 Preferred Worker Program, and 436-120, Vocational Assistance to Injured Workers, to reflect the decision of the Oregon Court of Appeals in *Brown v. SAIF* (262 Or. App. 640 (2014)). The court found that the legislative history established that an insurer's obligation to specify the accepted conditions for a claim was not intended to have a negative impact on the injured

worker's right to benefits resulting from the compensable injury; specifically, the legislature did not mean to equate "compensable injury" with an "accepted condition." Revised rules distinguish definitions and actions that are relevant to compensable injuries from those definitions and actions that are relevant to accepted conditions.

FINDINGS

Having reviewed and considered the record and being fully informed, I make the following findings:

a) The applicable rulemaking procedures have been followed.

b) These rules are within the director's authority.

c) The rules being adopted are a reasonable administrative interpretation of the statutes and are required to carry out statutory responsibilities.

IT IS THEREFORE ORDERED THAT

1) Amendments to OAR chapter 436 are adopted on this 29th day of January, 2015, **to be effective March 1, 2015.**

2) A certified copy of the adopted rules will be filed with the Secretary of State.

3) A copy of the adopted rules with revision marks will be filed with the Legislative Counsel under ORS 183.715 within ten days after filing with the Secretary of State.

DATED this 29th day of January, 2015.

/s/ John L. Shilts
John L. Shilts, Administrator
Workers' Compensation Division

Under the Americans with Disabilities Act guidelines, alternative format copies of the rules will be made available to qualified individuals upon request.

If you have questions about these rules or need them in an alternate format, contact the Workers' Compensation Division, 503-947-7810.

Distribution: Workers' Compensation Division e-mail distribution lists, including advisory committee members and testifiers

Secretary of State
Certificate and Order for Filing

PERMANENT ADMINISTRATIVE RULES

FILED
1-29-15 4:20 PM
ARCHIVES DIVISION
SECRETARY OF STATE

I certify that the attached copies are true, full and correct copies of the PERMANENT Rule(s) adopted on Upon filing. by the

Department of Consumer and Business Services, Workers' Compensation Division	436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	(503) 947-7717
Rules Coordinator	Telephone
PO Box 14480, Salem, OR 97309-0405	
Address	

To become effective 03/01/2015 Rulemaking Notice was published in the December 2014 Oregon Bulletin.

RULE CAPTION

Recognition of preexisting conditions; effects of compensable injury versus accepted conditions

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

RULEMAKING ACTION

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

ADOPT:

436-035-0006

AMEND:

436-009-0005, 436-010-0005, 436-010-0280, 436-030-0005, 436-030-0020, 436-030-0034, 436-030-0035, 436-030-0065, 436-030-0135, 436-030-0165, 436-035-0005, 436-035-0007, 436-035-0008, 436-035-0012, 436-035-0013, 436-035-0014, 436-035-0016, 436-035-0018, 436-035-0250, 436-105-0500, 436-105-0520, 436-110-0350, 436-120-0005

REPEAL:

RENUMBER:

AMEND AND RENUMBER:

Statutory Authority:

ORS chapter 656, primarily 656.726(4)

Other Authority:

Statutes Implemented:

ORS ch. 656, primarily 656.005, 656.214, 656.262, 656.266, 656.268, 656.273, 656.340, 656.622, 656.802

RULE SUMMARY

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