WORKERS' COMPENSATION DEPARTMENT

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10

MEDICAL SERVICE

EFFECTIVE JANUARY 1, 1986

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EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10

436-10-001 Authority For Rules

(1) These rules are promulgated under the Director's general rulemaking authority of ORS 656.726(3) and specific authority under ORS 656.248, 656.252, 656.254, 656.325, and ORS 656.794(3) to provide for: reasonable rates to be paid for medical services; review of medical reports involving unnecessary medical services; prompt submission of medical reports; and penalties.

(2) The Advisory Committee on Medical Care, appointed by the Director under provisions of ORS 656.794, participated in the drafting of these rules.

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Amended 10/20/76 as Admin. Order 4-1976, eff. 11/1/76
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Renumbered from OAR 436-69-003, 5/1/85

436-10-003 Applicability Of Rules

(1) These rules are effective to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.325, and 656.794.

(3) The provisions of OAR 436-10-090 shall be applicable to all services rendered subsequent to the effective date of these rules.

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436-10-004 Scope Of Rules

These rules govern any vendor of medical services licensed or authorized to provide a product or service which is chargeable as a claim cost.

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Renumbered from OAR 436-69-100, 5/1/85

436-10-005 Definitions

Unless the context otherwise requires:

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

(2) "Board" means the Workers' Compensation Board of the Workers' Compensation Department.

(3) "Callahan Center" means the William A. Callahan Center, Wilsonville, Oregon, a physical rehabilitation facility of the Workers' Compensation Department.

(4) "Claim" means a written request for compensation from a worker or worker's agent, or any compensable injury or illness of which an employer has notice or knowledge.

(5) "Claimant" means the worker making a claim.

(6) "Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in diagnosis and/or treatment, and who may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness.

(7) "Current Procedural Terminology" means the Current Procedural Terminology, fourth edition, 1985, published by the American Medical Association.

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

(9) "Department" means the Oregon Workers' Compensation Department, consisting of the Board, the Director and all their assistants and employes.

(10) "Director" is the Director of the Workers' Compensation Department.

(11) "Elective Surgery" means 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. Pain, of itself, does not constitute a surgical emergency.

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

(13) "Insurer" means the State Accident Insurance Fund Corporation, a guaranty contract carrier, or a self-insured employer.

(14) "Major Orthopedic or Neurologic Surgery" means operations on the spine, shoulder, elbow, hip, knee or ankle joints; replacement of any joint; surgery for thoracic outlet syndrome. Surgery for carpal tunnel syndrome is not major neurologic surgery.

(15) "Medical Director" means the physician in the office of the director of the Workers' Compensation Department.

(16) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device.

(17) "Medically Stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(18) "Peer Review" means the evaluation of the care provided to a worker by review of the pertinent records and/or personal interview with the attending physician or consultant. Such review may be conducted by a committee of the provider's peers and/or any other appropriate body selected by the director.

(19) "Physician" or "Doctor" means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate.

(20) "Promptly" means without delay.

(21) "Report" means transmittal of medical information in a narrative letter, on a form or in progress notes from the worker's medical file. Reports may be handwritten but all shall be legible and include all relevant or requested information.

(22) "Treating Physician" means attending physician.

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

(24) "Worker" means a subject worker as defined in ORS 656.005.

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436-10-010 Service Of Orders

Orders issued by the director pursuant to these rules shall be served by:

(1) Delivering a copy to the party in the manner provided for personal service in Rule 7 D. (2), Oregon Rules of Civil Procedure; or

(2) Sending a copy to the party by certified mail with instructions to deliver to the addressee only, return receipt requested. If the party is a corporation, the certified mail may be delivered to any person named in Rule 7 D. (2), Oregon Rules of Civil Procedure. Rule 7 D. (3)(b), Oregon Rules of Civil Procedure.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Renumbered from OAR 436-69-903, 5/l/85

436-10-020 Director's Delegation Of Hearing Authority

In accordance with ORS 656.704(2) hearings shall be conducted in accordance with rules promulgated by the Workers' Compensation Board.

Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Renumbered from OAR 436-69-905, 5/1/85

436-10-030 Reporting

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any physician, hospital, or other medical vendor to supply relevant information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, or the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. No person who reports to these persons in accordance with Department rules shall bear any legal liability for disclosure of such (ORS 656.252). The physician may require evidence from the representative of his or her representative capacity. The authorization is valid for the duration of the work related injury or illness.

(2) The initial attending physician shall complete the first medical report (Workers' Compensation Department Form 827) in every detail and mail it to the proper insurer no later

than 72 hours after the claimant's first visit (Saturdays, Sundays and holidays will not be counted in the 72-hour period). Diagnoses stated on the 827 and all subsequent reports shall conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(3) Progress reports are essential. The insurer may require progress reports every 15 days through the use of the physician's supplemental report form (Workers' Compensation Department Form 828). If more information is required, the insurer may request a limited or comprehensive narrative report. Progress notes from the clinical chart, if legible, may suffice to give the insurer all the information the insurer needs.

(4) ORS 656.252 requires the attending physician to inform the insurer of the anticipated date of release to work, the anticipated date the worker will become medically stationary and the next appointment date. To the extent the physician can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(5) The attending physician shall advise the insurer and the worker within five (5) days of the date the injured worker is released to return to work.

(6) The attending physician shall, after a claim has been closed, advise the insurer within five (5) days after treatment is resumed or the reopening of a claim is recommended. The attending physician need not be the same physician who released the worker when the claim was closed.

(7) The attending physician shall promptly respond to the request for progress reports. If the physician or other vendor of services fails to comply with this requirement within 10 days, the insurer may send another request by certified mail, return receipt requested. If within 10 days the physician or other vendor has not complied with this request, penalties under OAR 436-10-110 may be imposed.

(8) Consultations. The attending physician may request consultation regarding conditions related to an accepted claim. The attending physician shall promptly notify the insurer of the referral (referrals to radiologists and pathologists for diagnostic studies are exempt from this requirement). The attending physician shall provide the consultant with all the available clinical information. The consultant shall submit a copy of his consultation report to the attending physician and the insurer within 10 working days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report.

(9) Independent Medical Examination (IME) is a special consultation which may be requested only by the insurer or with the insurer' s prior authorization. The fee for an IME is to be agreed upon prior to the examination. When a worker known to be represented by a lawyer is scheduled for an IME, the worker's lawyer shall be sent simultaneously a copy of the notification sent to the worker.

(10) When an injured worker elects to change attending physicians, the newly selected attending physician shall so notify the insurer not later than five (5) days after the change or the date of first treatment using Workers' Compensation Department Form 829. The newly selected physician shall make a diligent effort to secure from the previous physician, or from the insurer, all of the available medical information including information concerning previous temporary

total disability periods. The previous attending physician shall immediately forward, upon proper request, all requested information and X-rays to the new attending physician.

(11) Injured workers, or their representatives, are entitled to copies of all relevant medical information. This information should ordinarily be available from the insurers, but may be obtained from physicians upon the payment of an appropriate charge for copies. However, reports that contain medical and psychological information relevant to the claim, which in the judgment of the writer of the report should not be shown to the worker because it would not be in the worker's best interest, must be supplied to the worker's representative but need not be supplied to the worker directly. Upon request by the insurer, the director, or the claimant, chart notes containing the relevant information shall be provided subject to the above exception.

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436-10-040 Medical Services

(1)(a) The insurer shall pay for all medical services which the nature of the compensable injury and the process of recovery requires. The insurer will not pay for care unrelated to the compensable injury. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable. Billings for services which appear to the insurer to be in excess of the standards set forth in these rules, or of generally accepted medical standards, may be referred to the medical director. Such referral shall be made within 60 days of receipt of the bill.

(b) Peer review committees shall be composed of health care providers licensed under the same authority as the health care provider who rendered the services being reviewed. The committees shall provide advice and assistance to the medical director on other health matters when requested. The director may solicit recommendations from professional associations, licensing authorities and professional schools.

(c) The report of such committee shall be submitted to the department which may:

(A) Issue an order compelling compliance with the judgment of the committee, or

(B) Forward the report to the insurer and provider for appropriate action.

(2)(a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed.

(b) A reasonable fee is payable for this report. A judgment by the insurer that the report does not set forth sufficient grounds for the frequency of treatment in excess of the standard may

be referred by the physician to the medical director. The medical director may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(3) X-ray films must be of diagnostic quality. 14" x 36" lateral views are not reimbursable. Billings for X-ray s are not reimbursable without a report of the findings. Upon the request of either the director or the insurer, X-ray films shall be forwarded to the director or the insurer. Films shall be returned to the vendor. A reasonable charge may be made for the costs of delivery of films. Refusal of the physician to forward the films to the director or the insurer upon proper request shall result in nonpayment of the fee for the radiological study.

(4)(a) Physical therapy, biofeedback or acupuncture shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment and which must be completed and signed by the attending physician within one week of the beginning of treatment. The treatment plan shall include objectives, modalities, and frequency of treatment. A copy of the progress notes shall be provided insurer upon request.

The initial treatment plan shall be for no more than 20 therapy visits in the first 60 days. If more than 20 therapy visits are required in the first 60 days or more than four therapy visits a month after the first 60 days, the physician shall submit a report documenting the need for services in excess of the guidelines upon request of the insurer.

(b) A judgment by the insurer that the report does not justify treatment in excess of the guidelines shall promptly be communicated to the physician and the therapist. The physician may appeal to the medical director who may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(c) The preparation of a written therapy or biofeedback prescription and supplying progress notes are integral parts of the fee for the therapy service. No additional fee shall be paid except a reasonable amount for copies or summaries of the records of treatment.

(5) Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

(6) Dietary supplements - such as minerals and vitamins are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from compensable gastrointestinal injury.

(7) Furniture is not a medical service. Articles such as 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 and the process of recovery requires" that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to rest areas or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(8) Physician mark-up shall not exceed 20 percent for braces, supports and other medical devices with a unit price greater than $25. Invoices for these devices shall be provided on request of insurer.

(9) Insurers and claimants are not responsible for payment for treatment procedures rendered in connection with the compensable injury that are not approved and taught by accredited institutions of the licentiate's profession. If the insurer believes procedures to be inappropriate, of unproven value or experimental in nature, the issue may be referred to the medical director who may refer the matter to a committee of consultants of the provider's peers.

(10) Dimethylsulfoxide (DMSO) is not reimbursable unless prescribed for treatment of compensable interstitial cystitis.

(11) Prolotherapy is not reimbursable without prior authorization by insurer.

(12) Liquid crystal thermography, photographic or electronic, is not reimbursable without prior authorization. Insurer may require documentation to show why its use is preferable to usual diagnostic tests. Insurer may limit the number of times it may be used in each case.

(13) A written request for authorization for prolotherapy or thermography shall be answered within 14 working days of receipt by insurer or approval will be assumed.

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Renumbered from OAR 436-69-110, 5/1/85
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436-10-050 Who May Provide Services

(1) Physicians licensed by the Board of Medical Examiners, the Board of Dental Examiners, the Board of Chiropractic Examiners, and the Board of Naturopathic Examiners may be designated as attending physicians.

(2) Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service, or by persons not licensed to provide a medical service who work under the direct control and supervision of the attending physician.

(3) The insurer may pay for treatment by prayer or spiritual means.

(4) A nurse practitioner who is a family nurse practitioner or an adult nurse practitioner as defined in OAR 851-30-002, and licensed under ORS 678.375, may provide such services as the license permits, and be reimbursed as provided by OAR 436-10-090(7), when the following conditions are met:

(a) The insurer is not required to reimburse a nurse practitioner for treating a disabling injury or illness unless the worker has been referred for treatment by the worker's attending physician, who shall remain the attending physician.

(b) The insurer is not required to pay for treatment prescribed by a nurse practitioner when that treatment is performed by a person not licensed to provide such treatment.

(c) The nurse practitioner is not an attending physician and, therefore, cannot authorize time loss or do closing evaluation examinations and reports, or other similiar functions which may be done only by an attending physician.

(5) A physician assistant, registered under ORS 677.515, may provide services and be reimbursed as provided by OAR 436-10-090(7) only under the following conditions:

(a) The physician assistant is approved for independent practice by the Board of Medical Examiners.

(b) The physician assistant may prescribe treatment to be performed by others only when the person who is to provide the treatment is licensed to do so.

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436-10-060 Choosing And Changing Doctors

(1) A newly selected attending physician shall notify the insurer not later than five (5) days after the date of change or first treatment, using Form 829 (Change of Attending Physician).

(2) The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician who shall promptly notify the insurer of the request. Fees for treatment by more than one physician at the same time are payable only when the medical conditions present are related to the treatment of the compensable injury or illness and are sufficiently different that separate medical skills are needed for proper treatment.

(3) The worker is allowed to change physicians by choice four times after the initial choice. Referral by the attending physician to another attending physician shall not count in this calculation. Examinations at the request of the insurer, and consultations requested by the attending physician, do not constitute a change in attending physician.

(4) When a worker has made an initial choice of attending physician and subsequently changed four times, the insurer shall inform the worker by certified mail that any subsequent changes must have the approval of the insurer or the director.

In the event that the worker again changes physician without the approval of the insurer, the insurer may deny payment for services rendered by the additional physician and inform the claimant of the right to seek approval of the director.

If a physician begins treatment without being informed that the worker has been given the required notification the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made.

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436-10-070 Elective Surgery

(1) When the attending surgeon believes elective surgery is needed for occupational injury or illness, the surgeon shall give the insurer actual notice at least five (5) working days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, an estimate of the surgical date, and the hospital where surgery is to be performed. The notice of intent to perform surgery must come from the surgeon who intends to perform the operation.

(2) When elective major orthopedic or neurological surgery is recommended, the insurer may recommend an independent consultation with a physician of insurer's choice. The insurer

shall notify the attending physician within five (5) days if a consultation is desired. The consultation shall take place within 14 days of the attending surgeon being notified of the intent to obtain the consultation.

(3)(a) Upon receipt of the consultant's report, the insurer shall notify the surgeon within 72 hours whether payment will be made for the proposed surgery.

(b) If the surgeon and consultant disagree about the need for surgery, the insurer may inform the claimant of the consultant's opinion. The decision as to whether or not to proceed with surgery remains with the surgeon and the claimant.

(4) A physician who proceeds to perform elective major orthopedic or neurological surgery without providing the insurer with the required prior notification and opportunity to obtain consultation shall be subject to the penalties of these rules as outlined in 10-110. If a financial penalty is imposed on the surgeon for violation of these rules in the form of a fine or reduction or recovery of fees, no part of such fine or reduction or recovery of fees may be sought from the claimant.

(5) Surgery which must be performed promptly, i.e., before five (5) 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 surgeon should endeavor to notify the insurer of the need for emergency surgery.

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436-10-080 Determination Of Impairment

When the patient has become medically stationary from the compensable injury or illness, the attending physician shall notify the insurer. If there is no permanent impairment he shall so state. If there is permanent impairment, the attending physician may elect to perform a closing examination prior to writing a complete report. A reasonable fee may be charged and includes the examination and report.

The report must contain all pertinent objective findings such as loss of member, measured ranges of motion, strength, measurable atrophy, muscle spasm, reflex changes, sensory changes, etc. The physician does not rate disability, but describes impairments.

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Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-601, 5/1/85

436-10-090 Charges And Fees

(1) All billings shall be fully itemized and services identified by code numbers and descriptions found in the Current Procedural Terminology. Hospitals may bill for inpatient services and surgery using the International Classification of Diseases, 9th edition-with Clinical Manifestations (ICD9-CM).

(2) When services are provided in hospital emergency or outpatient departments which are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes and reimbursed at no more than the 75th percentile as

shown in the departments' relative value scale. Such services include outpatient physical therapy, outpatient X-rays and emergency department treatment and physician's services.

When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment.

(3) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the vendor for correction or paid at the value of the service provided. Any service not identifiable with a code number shall be adequately described.

(4) The vendor of medical services shall bill the vendor's usual fee charged to the general public. The submission of the bill by the vendor shall serve as a warrant that the fee submitted is the usual fee of the vendor for the services rendered. The department shall have the right to require documentation from the vendor establishing that the fee under question is the vendor's usual fee charged to the general public.

(5) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The vendor of medical services may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness.

(6) The insurer may not pay any more than the vendor's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 75th percentile of the usual and customary fees as determined by the director. The vendor may not attempt to collect from the injured worker any sums deleted by the insurer.

(a) In the event of a dispute about fees between the vendor and the insurer, either may appeal to the medical director. The medical director will investigate and advise the director who may issue an order advising either party to comply. If orders are issued, either party may request a hearing pursuant to OAR 436-10-110(5).

(7) For those medical services for which no CPT code or relative value has been established the medical director shall determine which services are most commonly provided to injured workers and promulgate a reasonable rate for the services, which shall be the same for all primary health care providers. Such services include, but are not limited to, First Medical Report (Form 827), Subsequent Medical Report (Form 828), Change of Attending Physician Report (Form 829), brief narrative report and complete narrative report.

(8) The director shall review and update medical fees annually using data from a statistically valid survey, the physician service component of the National Consumer Price Index, or from any state agency having access to usual and customary medical fee information.

(9) Physician's assistants or nurse practitioner fees will be paid at the rate of 80 percent of a physician's fee for a comparable service except that assisting in surgery shall be paid at the rate of 50 percent of the comparable fee for a physician assisting in surgery.

(10) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings will be subject to discounts, not to exceed 10 percent, for each 30 day period or fraction thereof, beyond 60 days.

(11) Billings shall include the claimant's full name, date of injury, the employer's name and, if available, the insurer's claim number. Billings not correctly filled out may be returned to the vendor for correction and resubmission.

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

(13) The definitions of commonalty in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services.

(14) Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

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436-10-100 Insurer's Rights and Duties

(1)(a) The director or insurer may obtain medical examinations of the worker by physicians of their choice. The number of such examinations is limited by ORS 656.325. In the event the insurer believes that a need exists for more than three examinations, the insurer shall request approval of the director. In arriving at a decision the director will consider such matters as the date of injury, date of last examination, nature of examinations that have been performed, the complexities of the medical issues. The worker shall be notified of the purpose of the examination. Such examinations shall be at places, times, and intervals reasonably convenient to the worker, and shall not delay or interrupt proper treatment of the worker.

(b) The examiner shall promptly send a copy of the report to the attending physician and the insurer or person requesting the exam.

(c) Any physician who unreasonably and without good cause interferes with the right of the insurer to obtain examination by physicians of their choice may be subject to penalties.

(2) An examination obtained at the request of the Evaluation Division is not considered one of the three examinations allowed to the insurer.

(3) Insurer shall pay bills for medical services within 60 days of receipt of the bill, if the billing is submitted in proper form and clearly shows that the treatment is related to the accepted compensable injury or disease. Failure to do so shall render insurer liable to pay a reasonable monthly service charge after the 60th day, if the provider customarily levies such a service charge to the general public.

(4) In claims which have been denied and are on appeal, the insurer shall notify the vendor promptly of any change of status of the claim.

(5) In the event of a dispute over portions of a billing, the insurer shall pay within 60 days the undisputed portion of the bill.

(6) In the event a vendor of medical services feels aggrieved by the conduct of an insurer, the vendor may request the assistance of the department. If the matter involves treatment or fees,

the matter shall be resolved pursuant to OAR 436-10-040(4)(b). If the matter involves actions of the insurer and cannot be resolved informally, the director may issue an order compelling compliance and setting forth the appeal rights of the parties.

(7) The limitations of the worker's right to choose attending physicians (ORS 656.245) and the insurer's right to independent examinations (656.325) begin with the date of injury and extend through the life of the claim. Exceptions to both limitations will be handled on a case by case basis.

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Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-801, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86

436-10-110 Complaint Procedures And Penalties

(1) Complaints shall be directed to the medical director. Complaints shall be in writing and fully documented. If the medical director believes the complaint may have merit, the medical director may investigate the matter and afford the party complained of an opportunity to respond to the allegations. The medical director may consult with an appropriate committee of the physician's peers before presenting a recommendation to the director.

(2) The medical director shall upon completion of his investigation recommend an appropriate disposition to the director. The medical director may recommend, and the director may elect, not to investigate the matter or issue an order but rather refer the matter to a referee. Notwithstanding ORS 183.315(1) the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

(a) The order of the referee shall be a final order of the director;

(b) The director shall have the same right to a judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(3) If the medical director finds any violation of OAR 436-10-040, 436-10-050, 436-10-060, 436-10-090 or 436-10-100(1)(c) the medical director may recommend to the director, and the director may impose, one or more of the following sanctions:

(a) Reprimand by the director;

(b) Nonpayment or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board.

(4) If the medical director finds any violation of the rules enforcing the provisions of ORS 656.252 and 656.254 as found in OAR 436-10-030, 436-10-070 and 436-10-080 of these rules, the medical director may recommend to the director, and the director may impose, one or more of the following sanctions:

(a) Reprimand by the director;

(b) Nonpayment or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board; or

(d) Civil penalty not to exceed $1,000 for each occurrence. The maximum penalty shall be levied only upon repeated or willful violation. In determining the amount of penalty to be assessed, the director shall consider:

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

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations.

(5) A hearing relating to a proposed order issued under these rules shall be held by a referee of the Hearings Division of the Workers' Compensation Board. A hearing shall not he granted unless a request for hearing is filed within 30 days of receipt of the proposed order. If a request for hearing is not so filed, the order, as proposed, shall be a final order of the department. Notwithstanding ORS 183.315(1) the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

(a) The order of the referee shall be a final order of the director; and

(b) The director shall have the same right to judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(6) Insurers who violate these rules shall be subject to the penalties in ORS 656.745.

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APPENDIX A

OREGON RELATIVE VALUE SCHEDULE FOR MEDICAL SERVICE

(1) The coding structure is that of the Current Procedural Terminology (CPT). Fourth Edition, 1985.

(2) There are four sections, each of which has its own schedule of relative values which is completely independent of and unrelated to any of the other four sections.

(3) In each section the code unit is followed by a relative value number, when such has been established. When no value has been established, the provider must submit with the billing a description of the service in detail sufficient for the payor to judge whether the fee is reasonable.

(4) In the surgery section, a third column shows the number of days of post-operative care included in the fee.

(5) In the radiology section, the second column shows the total value of an examination, i.e., costs of X-ray film, interpretation and making a report of the study.

(6) Physicians who inject air, contrast material or isotopes as part of a radiologic study shall bill for this service using CPT codes from the surgery section, e.g. 62284 - injection for myelography.

(7) The Definitions and Items of Commonality, Current Procedural Terminology, pp. xiv - xviii, 1985, shall be the basis for determining levels of service. A disagreement about the level of service may be referred, by the physician, to the Medical Director, who may resolve the issue in favor of either party.

(8) Fees for reports:

a. 827 - $10

828 - $10

829 - $10

b. Copies of office chart notes when requested by insurer - $3.50 for 1st page, $.50 a page thereafter

c. Brief Narrative - Summary of Rx to date and current status; answer to 3-5 specific questions - $25

d. Complete narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary? - $50