DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
MEDICAL SERVICES (TEMPORARY RULES)

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

EFFECTIVE JULY 20, 1990

436-10-005 Definitions

For the purpose of these rules 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 **and who is:**

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

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

(c) As otherwise provided for, in accordance with a managed care organization contract.

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

(3) "Claim" means a written request for compensation from a **subject** worker or [worker's agent], **someone on the worker's behalf,** or any compensable injury [or illness] of which [an] **a subject** employer has notice or knowledge.

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

(5) "Chart note" means a chronological record in which the medical service provider records such things as objective findings in support of medical evidence, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

([5]**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] **give advice**

and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensation injury.

([6]**7**) "Current Procedural Terminology" **or "CPT"** means the Current Procedural Terminology, fourth edition, 1985, published by the American Medical Association.

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

([8]**9**) "Department" means the Oregon Department of Insurance and Finance, consisting of the Board, the Director and all their assistants and employes.

([9]**10**) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend or take over the medical service at any time. A medical service provided at a site removed from the physician, or provided when the physician is not present on the premises, is not under the direct control and supervision of the physician.

([10]**11**) "Director" is the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

([11]**12**) "Disability Prevention Services" means services provided to an injured worker to prevent the injury from causing continuing disability. Such services include physical restoration and psychologic, psychiatric, and vocational evaluation and counseling.

([12]**13**) "Division" means the Workers' Compensation Division of the Department of Insurance and Finance, consisting of the Compliance Section, Evaluation Section, **Medical Review and Abuse Section,** and Rehabilitation Review Section.

([13]**14**) "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.

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

([14]**16**) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(17) "Health Care Provider" means an entity or group of entities, such as a hospital or group of hospitals, organized to provide a facility for medical care and medical services.

([15]**18**) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

([16]**19**) "Hospital" means an institution licensed by the State of Oregon as a hospital.

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

([17]**21**) "Insurer" means the State Accident Insurance Fund Corporation**;** [a guaranty contract carrier, or a self-insured employer] **an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group which has been certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407**.

([18]**22**) "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.

(23) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and is certified in accordance with OAR 436, Division 15.

[(19) "Medical Director" means the physician in the Workers' Compensation Division.]

([20]**24**) "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.

(25) "Medical Service provider" means a person duly licensed to practice one or more of the healing arts in this state.

(26) "Medical Provider" means a medical service provider or a health care provider.

([21]**27**) "Medically Stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(28) "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician pursuant to ORS 656.005 and subsection 1(b) of this rule.

(29) "Objective Findings" means those findings in support of medical evidence that include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence (test results) substantiated by clinical findings.

(30) "Palliative Care" means a medical service rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition as compared to those medical services rendered to heal or permanently alleviate or eliminate an undesirable medical condition.

[(22) "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].

([23]**31**) "Physical Capacity Evaluation" means an objective, directly observed, measurement of worker's ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, **and** Functional Capacity Assessment[, and Work Tolerance Screening] shall be considered to have the same meaning as Physical Capacity Evaluation.

([24]**32**) "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.

([25]**33**) "Promptly" means without delay.

([26]**34**) "Report" means transmittal of medical information in a narrative letter,[on a form or in progress notes] **containing objective findings** [from the worker's medical file]. **Reports may take the form of narrative reports, brief or complete, requested by the insurer, a treatment plan, a closing examination report, or any forms as prescribed by the director.** [Reports may be handwritten but all shall be legible and include all relevant or requested information.]

[(27) "Treating Physician" means attending physician.]

([28]**35**) "Usual Fee" means the fee charged the general public for a given service.

([29]**36**) "Work Capacity Evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening shall be considered to have the same meaning as Work Capacity Evaluation.

([30]**37**) "Worker" means a subject worker as defined in ORS 656.005.

([31]**38**) "Work Hardening" means an individualized, medically ordered and monitored, work oriented treatment process. Involves the worker in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance and productivity to return to work goals.

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436-10-030 Reporting Requirements for Medical Providers

(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 and is not subject to revocation by the worker or the worker's representative.

(2) The initial [attending] physician **on the initial claim** shall complete the first medical report (Department of Insurance and Finance 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) All medical service providers shall notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss.

(4) Attending physicians shall submit verification of the worker's inability to work resulting from an occupational injury or disease upon request from the insurer. Medical services provided by the attending physician are not compensable until the attending physician submits such verification. In addition to attending physicians, the following medical service providers may authorize time loss:

(a) For a period of 30 days from the date of the first visit on the initial claim, nurse practitioners certified by the Oregon State Board of Nursing and physician assistants registered by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type A, Type B, or Type C rural hospitals described in ORS 442.470 and as prescribed in OAR 436-10-050(6).

(b) A medical service provider who by MCO contract has been designated to be able to authorize temporary disability compensation.

([3] **5**) Progress reports are essential. The insurer may require progress reports every 15 days through the use of the physician's supplemental report form (Department of Insurance and Finance 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.

(6) Reports may be handwritten but all shall be legible and include all relevant or requested information.

([4] **7**) **Chart notes shall be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.**

([4] **8**) The [attending physician] **medical provider** shall promptly respond to the request for progress reports **and narrative reports**. If the [physician or other vendor of services] **medical provider** 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] **medical provider** has not complied with this request, penalties under OAR 436-10-130 **or 436-15-120** may be imposed.

([5] **9**) 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] **any medical provider** can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(10) At the time the attending physician examines the worker and declares the worker medically stationary, the attending physician shall promptly send a report to the insurer. The report shall contain all objective findings and all information required in accordance with OAR 436-10-080.

([6] **11**) 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. The physician shall not notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

([7] **12**) The attending physician shall, after a claim has been closed, advise the insurer within five (5) days after treatment is resumed [or] and the reopening of a claim is recommended. **A claim for aggravation, as defined by ORS 656.273 and OAR 436-60-005, requires written medical evidence from the attending physician of a worsened condition supported by objective findings.** The attending physician need not be the same physician who released the worker when the claim was closed.

([8] **13**) 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] **14**) 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 Department of Insurance and

Finance 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. A physician who fails to forward requested information and X-rays to the new attending physician will be subject to penalties as provided by OAR 436-10-130(2).

([10] **15**) 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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