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

TABLE OF CONTENTS

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

EFFECTIVE AUGUST 17, 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 *diagnose*, 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.

Hist: Filed 10/20/76 as Admin. Order 4-1976, eff. 11/1/76
Amended 6/5/78 as Admin. Order 7-1978, eff. 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80
Amended 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, off. 6/3/85
Re-numbered from OAR 436-69-005, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 6/26/86 as Admin. Order 4-1986, eff. 7/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff. 3/16/87
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)
Amended 7/20/90 as Admin. Order 14-1990, eff. 7/20/90 (Temporary)
Amended 8/17/90 as Admin. Order 17-1990. eff. 8/17/90 (Temporary)

436-10-041 Palliative Care

(1) For the purposes of this rule, workers are medically stationary when determined to be so by the worker's physician or as established in accordance with OAR 436-30-035. After the worker has become medically, palliative care is compensable:

(a) When provided to a worker who has been determined to have permanent total disability; or

(b) When necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition; or

(c) To monitor the status of a prosthetic device; or

(d) When appropriate to enable the worker to continue current employment.

(2) When the worker's attending physician believes that palliative care is appropriate, the attending physician shall first submit a written request for approval from the insurer for such treatment. The request shall contain objective findings, the reasons that the palliative care is necessary, *the extent and duration of the care to be given, and such other information deemed necessary by the director*.

(3) Within ten (10) working days of the receipt of a written request *from the attending physician to provide* palliative care, *the insurer shall provide written notification to the physician approving or disapproving the request. When the requested palliative care is not approved, the insurer shall provide specific reasons for not approving the care. If all or part of the requested care* is not *approved* by the insurer, the attending physician may requet approval from the director for such treatment. This request must include a copy of the original request to the insurer and a copy of the response from the insurer.

(4) The director will process the request for palliative care *in the manner as provided in* OAR 436-10-046*(5) through (10).*

Hist: Filed 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)
Amended 8/17/90 as Admin. Order 17-1990. eff. 8/17/90 (Temporary)

436-10-046 [Medical] Panels of Physicians

(1) If a worker, insurer or the director believes a worker's treatment is excessive, inappropriate, ineffectual or in violation of the medical rules, [either may request, and the director may establish on the director's own motion, a medical panel.] **and wishes review of the treatment by the director, the worker or insurer shall notify the director.** [A request for a medical panel from a worker or insurer] **The request for review by the director** shall be in writing and include:

(a) The worker's name and claim number;

(b) The insurer's and medical provider's names and addresses;

(c) Reasons treatment is thought to be excessive, inappropriate or ineffectual; and/or specific examples of failure to comply with the medical rules; and

(d) Any harm which has befallen, or might befall the worker.

(2) Any party requesting a review shall notify all other parties, including the medical provider, at the same time the request is made to the director. If the director initiates the panel the director shall notify the parties. **Within five (5) days of a request by the director, the attending physician and the insurer shall forward all pertinent medical records, laboratory results, and other records in a form and format as prescribed by the director.**

(3) [No later than five days after receiving the request the director shall notify the parties whether or not a panel will be authorized and shall inform the parties of their responsibilities in the matter.] **If the director determines that no bona fide medical services dispute exists, the director will issue an order pursuant to ORS 656.327. If the director determines that a bona fide medical services dispute exists, the director will so notify all parties involved.**

(4) Once [*the panel is authorized*] ***a request -for review is made pursuant section (1) of this rule or OAR 436-10-041(3)***, the insurer shall not deny the claim for medical services, nor shall the worker request a hearing on any issues subject to the director's jurisdiction until an order is issued.

[(5) The panel, composed of Oregon physicians whose treatment is not under review and licensed in the same healing art as the physician whose treatment is under review, shall be established as follows:]

[(a) No later than 10 days after the director authorizes the panel the worker and the insurer shall each choose a physician and notify the director.]

[(b) If either the worker or the insurer fails to inform the director of the physician chosen in the allotted time, the director shall choose the physician.]

[(c) The two physicians shall choose a third physician no later than 20 days after the director authorizes the panel.]

[(d) If the third physician is not chosen in the allotted time, the director shall choose the third panel member.]

[(e) The director shall inform the panel the date the panel's report is due, which will be no later than 40 days after the selection of the panel is complete.]

(5) The director will review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to examine the worker and perform any reasonable and necessary medical tests, other than invasive tests. Notwithstanding ORS 656.325 (1), the worker may refuse a test without sanction.

(a) Upon a request by the director, the insurer, or the worker, a panel of physicians may conduct this review. The panel shall be established at the director's discretion pursuant to OAR 436-10-047.

(b) The panel shall be composed of Oregon physicians and at least one member of any such panel shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed.

(6) The review by the director or the panel of physicians will be completed within thirty (30) days of the request.

[(6)] **(7)** The director shall inform the worker of the date, time, and location of the examination with copies to the insurer, attending physician and panel members.

[(7) The insurer and attending physician shall forward all pertinent medical records, laboratory results, and X-rays to the medical panel].

[(8) The medical panel may:]

[(a) Review all medical records and X-rays submitted.]

[(b) Interview and examine the worker.]

[(c) Perform any necessary tests, laboratory studies and X-rays except invasive tests.]

[(d) Submit a report in writing to the director containing the panel's recommendation, with copies to the worker, insurer, and attending physician.]

(8) The examination may include, but not be limited to:

(a) A review of all medical records and X-rays submitted.

(b) An interview and examination of the worker.

(c) Performance of any necessary tests, laboratory studies, or X-rays except invasive tests.

(9) The director or the panel will submit a report in writing with copies to the worker, insurer and attending physician. Their [The] recommendation**s** may include, but not be limited to:

(a) Reason for the panel examination.

(b) Past medical history.

(c) Current medical problem.

(d) Current treatment.

(e) Results of the examination.

(f) Results of tests performed.

(g) Diagnosis.

(h) The medically stationary status.

(i) Whether current treatment is excessive, inappropriate or ineffectual.

(j) Whether or not the current treatment should be continued, modified or terminated.

(10) Within 10 days of receipt of the report the director shall issue a final order.

(11) If the director issues an order declaring medical treatment to be excessive, inappropriate, or ineffectual, the worker is not obligated to pay for such treatment.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temporary)
Amended 8/17/90 as Admin. Order 17-1990, eff. 8/17/90 (Temporary)