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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

FILED: 06/25/2026 2:20 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Implementing HB 4040 (2026) and updating OAR 436-015-0030(5)(j)

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 07/30/2026 11:55 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
Marie Rogers
Rules Coordinator

HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 07/23/2026
TIME: 11:00 AM
OFFICER: Barbara Belcher

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-503-446-4951
SPECIAL INSTRUCTIONS:
Virtual only

NEED FOR THE RULE(S):

Rule changes are needed to implement HB 4040 (2026), which is effective upon passage. Additionally, Workers' Compensation Division (WCD) is making a single change to OAR 436-015-0030(5)(j), which is unrelated to HB 4040 (2026). Specifically, WCD is changing 14 days to 30 days (for a worker to remain eligible to receive authorized temporary

disability benefits) in OAR 436-015-0030(5)(j) to align with recent changes, effective April 1, 2026, to OAR 436-015-0037(3)(e)(A).

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Documents regarding HB 4040 (2026) and amendments to 436-015-0037(3)(e)(A) effective April 1, 2026. These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Marie Rogers, rules coordinator, 971-286-0316, WCD.Policy@dcbs.oregon.gov.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The Workers' Compensation Division does not collect data about race or ethnicity related to workplace injuries and illness in Oregon, but the United States Bureau of Labor Statistics publishes lists of occupations and numbers of Americans employed broken down by race. Black/African Americans and Hispanic/Latino workers are represented in some of the more dangerous occupations in higher numbers than their respective shares of the U.S. workforce. To the extent Oregon workers in these racial groups suffer more on-the-job injuries and illnesses, increased or decreased workers' compensation benefits may impact these racial groups more than others. The agency does not have sufficient data needed to estimate specific effects on racial equity in Oregon, but invites public input.

FISCAL AND ECONOMIC IMPACT:

The agency projects the proposed rule amendments, if adopted, will not affect the agency's cost to carry out its responsibilities under ORS chapter 656 and OAR chapter 436. Possible impacts on stakeholders are included under "Statement of Cost of Compliance" below.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The businesses affected by the proposed rule amendments are workers' compensation insurers, self-insured employers, service companies, and health care providers. Insurers and self-insured employers are generally large businesses. The agency estimates that fewer than 10 Oregon service companies are small businesses. The agency does not have exact data on the number of health care providers in Oregon, but estimates that less than 5,000 Oregon medical providers are small businesses.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: The agency estimates that adoption of the proposed amendments will not affect costs to small businesses for reporting, recordkeeping, other administrative activities, or professional services required for compliance.

c. Equipment, supplies, labor and increased administration required for compliance: The agency estimates that adoption of the proposed amendments will not increase costs to small businesses for equipment, supplies, labor, or increased administration required for compliance.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The agency sent rule advisory committee invitations to more than 4,500 stakeholders, including representatives of small

businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
436-009-0005, 436-009-0010, 436-009-0025, 436-009-0040, 436-009-0060, 436-009-0080, 436-009-0090, 436-010-0005, 436-010-0210, 436-010-0220, 436-010-0230, 436-010-0240, 436-010-0241, 436-010-0250, 436-010-0265, 436-010-0270, 436-010-0280, 436-010-0290, 436-015-0005, 436-015-0030, 436-015-0040, 436-015-0070, 436-030-0005, 436-030-0020, 436-030-0034, 436-030-0035, 436-030-0115, 436-030-0155, 436-030-0165, 436-035-0005, 436-035-0007, 436-035-0009, 436-035-0011, 436-035-0260, 436-035-0360, 436-035-0380, 436-035-0385, 436-035-0400, 436-060-0005, 436-060-0010, 436-060-0020, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0137, 436-060-0147, 436-060-0150

AMEND: 436-009-0005

RULE SUMMARY: Revised rule 0005:
-Removes the definition of “authorized nurse practitioner”
-Removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-009-0005
Definitions ¶

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.¶
(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:¶
(a) CMS means Centers for Medicare & Medicaid Services.¶
(b) CPT® means Current Procedural Terminology published by the American Medical Association.¶
(c) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies.¶
(d) EDI means electronic data interchange.¶
(e) HCPCS means Healthcare Common Procedure Coding System published by CMS.¶
(f) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.¶
(g) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.¶
(h) MCO means managed care organization certified by the director.¶
(i) NPI means national provider identifier.¶
(j) OSC means Oregon specific code.¶
(k) PCE means physical capacity evaluation.¶
(l) WCE means work capacity evaluation.¶
(3) "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.¶
(4) "Ambulatory surgery center" or "ASC" means:¶
(a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or¶
(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.¶
(5) "Attending physician" has the same meaning as described in ORS 656.005(12)(b). See Appendix A, "Matrix for Health Care Provider Types." [Attached.]¶
(6)~~"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 who has been assigned an authorized nurse practitioner number by the director.¶~~
~~(7)~~ "Board" means the Workers' Compensation Board and includes its Hearings Division.¶
(~~8~~7) "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.¶
(~~9~~8) "Clinic" means a group practice in which several medical service providers work cooperatively.¶
(~~10~~9) "CMS form 2552" (Hospital and Hospital Health Care Complex Cost Report) means the annual report a hospital makes to Medicare.¶
(1~~1~~0) "Current procedural terminology" or "CPT®" means the Current Procedural Terminology codes and terminology published by the American Medical Association unless otherwise specified in these rules.¶
(1~~2~~1) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.¶
(1~~3~~2) "Days" means calendar days.¶
(1~~4~~3) "Director" means the director of the Department of Consumer and Business Services or the director's designee.¶
(1~~5~~4) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(1~~6~~5) "Enrolled" means an eligible worker has received notification from the insurer that the worker is being required to receive treatment under the provisions of a managed care organization (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 MCO's certified geographical service area.¶
(1~~7~~6) "Fee discount agreement" means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.¶
(1~~8~~7) "Good Cause" means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.¶
(1~~9~~8) "Hospital" means an institution licensed by the State of Oregon as a hospital.¶
(a) "Inpatient" means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.¶
(b) "Outpatient" means a patient 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 that do not result in admission are also considered outpatient services.¶
(~~20~~19) "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.¶
(2~~1~~0) "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 and meets the qualifications of a self-insured employer under ORS 656.407.¶
(2~~2~~1) "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.¶
(2~~3~~2) "Interpreter" means a person who:¶
(a) Provides oral or sign language translation; and¶
(b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider's employee, or a family member or friend of the worker.¶
(2~~4~~3) "Interpreter services" means the act of orally translating between a medical provider and a worker who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the worker as well as reasonable time spent on necessary paperwork for the provider's office.¶
(2~~5~~4) "Legal holidays" means holidays listed in ORS 187.010 and 187.020.¶
(2~~6~~5) "Mailed or mailing date" 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 by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.¶
(2~~7~~6) "Managed care organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.¶
(2~~8~~7) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.¶
(2~~9~~8) "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.¶

(3~~1~~0) "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.¶
(3~~2~~1) "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.¶
(3~~3~~2) "Patient" means the same as worker as defined in ORS 656.005(28).¶
(3~~4~~3) "Physical capacity evaluation" means an objective, directly observed, measurement of a patient's ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.¶
(3~~5~~4) "Provider network" means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.¶
(3~~6~~5) "Regular Oregon business hours" means from 8:00 am to 5:00 pm Pacific Time.¶
(3~~7~~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.¶
(3~~8~~7) "Residual functional capacity" means a patient's remaining ability to perform work-related activities. 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 patient can perform each activity.¶
(3~~9~~8) "Specialist physician" means a licensed physician who qualifies as an attending physician and who examines a patient 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 patient's compensable injury.¶
(~~40~~39) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A). See Appendix A, "Matrix for Health Care Provider Types." [Attached.]¶
(4~~1~~0) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B). See Appendix A, "Matrix for Health Care Provider Types." [Attached.]¶
(4~~2~~1) "Usual fee" means the medical provider's fee charged to the general public for a given service.¶
(4~~3~~2) "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 has the same meaning as Work Capacity Evaluation.¶
(4~~4~~3) "Work hardening" means an individualized, medically prescribed and monitored, work-oriented treatment process. The process involves the patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.726(4), ORS 656.000 et seq., ORS 656.005

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0005.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336603

AMEND: 436-009-0010

RULE SUMMARY: Revised rule 0010:

-Removes the term “authorized nurse practitioner”

-Removes reference to the 180 days treatment limitation for nurse practitioners

CHANGES TO RULE:

436-009-0010
Medical Billing and Payment ¶

(1) General.¶
(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim. Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician ~~or authorized nurse practitioner~~. Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.¶
(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.¶
(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.¶
(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.¶
(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.¶
(f) When rebilling, medical providers must indicate that the charges have been previously billed.¶
(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.¶
(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)¶
(a) Medical providers must bill within:¶
(A) 60 days of the date of service;¶
(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or¶
(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.¶
(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.¶
(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause.¶
(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.¶
(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.¶
(3) Billing Forms.¶
(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).¶
(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:¶
(A) Dental billings, which must be submitted on American Dental Association dental claim forms;¶

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or¶
(C) Electronic billing transmissions of medical bills (see OAR 436-008).¶
(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.¶
(d) Medical providers may use computer-generated reproductions of the appropriate forms.¶
(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual. [See attached table.]¶
(4) Billing Codes.¶
(a) When billing for medical services, a medical provider must use codes listed in CPT® 2026, or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service. If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service. If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2026, or the appropriate unlisted HCPCS code, and provide a description of the service provided. A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.¶
(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.¶
(5) Modifiers.¶
(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2026, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.¶
(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:¶
(A) Unusually lengthy procedure;¶
(B) Excessive blood loss during the procedure;¶
(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);¶
(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;¶
(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or¶
(F) The services rendered are significantly more complex than described for the submitted CPT®.¶
(6) Physician Associates and Nurse Practitioners. Physician associates and nurse practitioners must document in the chart notes that they provided the medical service. If physician associates or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."¶
(7) Chart Notes.¶
(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.¶
(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.¶
(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.¶
(8) Challenging the Provider's Bill. For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.¶
(9) Billing the Patient and Patient Liability.¶
(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:¶
(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;¶
(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician ~~or authorized nurse practitioner~~, or a specialist physician upon referral of the attending physician ~~or authorized nurse~~

~~practitioner~~. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit ~~period or by nurse practitioners in excess of the 180-day~~ period, as set forth in ORS 656.245 ~~and OAR 436-010-0210~~;¶
(C) If the insurer notifies the patient that they are medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;¶
(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or¶
(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.¶
(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.¶
(c) A provider may bill a patient for a missed appointment under section (13) of this rule.¶
(10) Disputed Claim Settlement (DCS). The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.¶
(11) Payment Limitations.¶
(a) Insurers do not have to pay providers for the following:¶
(A) Completing form 827;¶
(B) Providing chart notes with the original bill;¶
(C) Preparing a written treatment plan;¶
(D) Supplying progress notes that document the services billed;¶
(E) Completing a work release form or completion of a PCE form, when no tests are performed;¶
(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or¶
(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician ~~or authorized nurse practitioner~~.¶
(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.¶
(c) 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 patient.¶
(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.¶
(12) Excluded Treatment. The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:¶
(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;¶
(b) Intradiscal electrothermal therapy (IDET);¶
(c) Surface electromyography (EMG) tests;¶
(d) Rolfing;¶
(e) Prolotherapy;¶
(f) Thermography;¶
(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:¶
(A) The single level artificial disc replacement is between L3 and S1;¶
(B) The patient is 16 to 60 years old;¶
(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and¶
(D) The procedure is not found inappropriate under OAR 436-010-0230;¶
(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and¶
(i) Platelet rich plasma (PRP) injections, unless they are for non-operative:¶
(A) Knee: Osteoarthritis pain, chondral surface injury and partial thickness meniscal tears after failure of three months of conservative care, which may include a standard course of physical therapy;¶
(B) Elbow: Lateral and medial epicondylitis after failure of three months of conservative care, which may include a standard course of physical therapy; or ¶

(C) Shoulder: Tendon, bursa, and muscle injuries, including partial tears and small tears, and adhesive capsulitis after failure of three months of conservative care, which may include a standard course of physical therapy.¶
(13) Missed Appointment (No Show).¶
(a) In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.¶
(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:¶
(A) The provider has a written missed-appointment policy that applies not only to workers' compensation patients, but to all patients;¶
(B) The provider routinely notifies all patients of the missed-appointment policy;¶
(C) The provider's written missed-appointment policy shows the cost to the patient; and¶
(D) The patient has signed the missed-appointment policy.¶
(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.
Statutory/Other Authority: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0010.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336605

AMEND: 436-009-0025

RULE SUMMARY: Revised rule 0025 removes the term and reference to “authorized nurse practitioner”

CHANGES TO RULE:

436-009-0025
Worker Reimbursement ¶

(1) General.¶
(a) When the insurer accepts the claim the insurer must notify the worker in writing that:¶
(A) The insurer will reimburse claim-related services paid by the worker; and¶
(B) The worker has two years to request reimbursement.¶
(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use Form 3921 - Request for Reimbursement of Expenses.¶
(c) Insurers must date stamp requests for reimbursement on the date received.¶
(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.¶
(e) The explanation to the worker must be in 10 point size font or larger and must include:¶
(A) The amount of reimbursement for each type of out-of-pocket expense requested.¶
(B) The specific reason for nonpayment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;¶
(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within two days, excluding Saturdays, Sundays, and legal holidays;¶
(D) The following notice, Web link, and phone number:¶
"To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit wcd.oregon.gov or call 503-947-7606.";¶
(E) Space for the worker's signature and date; and¶
(F) A notice of the right to administrative review in bold text and formatted as follows:¶
~~If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:¶~~
~~- Submit your request within 90 days of the mailing date of this explanation¶~~
~~- Sign and date this explanation in the space provided¶~~
~~- Explain why you think the payment is incorrect¶~~
~~- Attach required supporting documentation of your expense¶~~
~~- Send the documents to:¶~~
~~DCBS Workers' Compensation Division¶~~
~~Medical Resolution Team¶~~
~~350 Winter Street NE¶~~
~~PO Box 14480¶~~
~~Salem OR 97309-0405¶~~
~~Or¶~~
~~Fax your request to the Medical Resolution Team at 503-947-7629¶~~
~~- Send a copy of your request to the insurer¶~~
~~Keep a copy of this document for your records.~~ [See attachment.] ¶
(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(4), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.¶
(2) Timeframes.¶
(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:¶
(A) Two years from the date the costs were incurred or¶
(B) Two years from the date the claim or medical condition is finally determined compensable.¶
(b) The insurer may disapprove the reimbursement request if the worker requests reimbursement after two years as listed in subsection (a).¶
(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable

or if the costs are not related to the accepted claim.¶
(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request.¶
(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement or disapprove the request.¶
(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, the insurer must, within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.¶
(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later.¶
(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day or 14-day time frame for the insurer to issue reimbursement or disapprove the request.¶
(e) When any action, other than those listed in subsections (c) and (d) of this section, causes the reimbursement request to be payable, the insurer must reimburse the worker within 14 days of the action.¶
(f) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.¶
(g) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.¶
(3) Meal and Lodging Reimbursement.¶
(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.¶
(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.¶
(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location. The reimbursement rates for meals and lodging expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).¶
(4) Travel Reimbursement.¶
(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.¶
(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.~~ The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.~~ The insurer must inform the worker that the worker may continue treating with the established attending physician~~ or authorized nurse practitioner~~; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.¶
(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician ~~or authorized nurse practitioner~~ even if there are medical providers closer to the worker.¶
(d) Travel reimbursement dispute decisions 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.¶
(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112. The reimbursement rates for mileage expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).¶
(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.¶
(5) Other Reimbursements.¶
(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.¶
(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the

worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.¶
(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.¶
(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.¶
(6) Advancement Request. If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.
Statutory/Other Authority: ORS 656.245, ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.704, ORS 656.726(4)

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0025.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336606

AMEND: 436-009-0040

RULE SUMMARY: Revised rule 0040:

-Removes the term “authorized” in reference to nurse practitioners

-Removes the reference to out-of-state nurse practitioners

CHANGES TO RULE:

436-009-0040
Fee Schedule
(1) Fee Schedule Table.¶
(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table: [See attached table.]¶
(b) The global period is listed in the column Global Days' of Appendix B.¶
(2) Anesthesia.¶
(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.¶
(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.¶
(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier NT' (no time) must be on the bill.¶
(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.¶
(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.¶
(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $60.93. Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:¶
(A) The maximum allowable payment amount for anesthesia codes; or¶
(B) The provider's usual fee.¶
(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.¶
(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.¶
(3) Surgery. Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:¶
(a) One surgeon [See attached table.]¶
(b) Two or more surgeons [See attached table.]¶
(c) Assistant surgeons [See attached table.]¶
(d) Nurse practitioners or physician associates [See attached table.]¶
(e) Self-employed surgical assistants who work under the direct control and supervision of a physician [See attached table.]¶
(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.¶
(g) If the surgery is nonelective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.¶
(4) Radiology Services.¶
(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views. ¶
(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component. The reductions apply to multiple

studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.¶
(5) Pathology and Laboratory Services.¶
(a) The payment amounts in Appendix B apply only when there is direct physician involvement.¶
(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.¶
(6) Physical Medicine and Rehabilitation Services.¶
(a) Time-based CPT® codes must be billed and paid per code according to this table: [See attached table.]¶
(b) Except for CPT® codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code. When a provider bills for more than three separate CPT®-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.¶
(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.¶
(d) CPT® codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.¶
(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.¶
(7) Reports.¶
(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT® codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.¶
(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.¶
(8) Nurse Practitioners and Physician Associates. Services provided by ~~authorized~~ nurse practitioners~~;~~ or physician associates~~, or out-of-state nurse practitioners~~ must be paid at 85 percent of the amount calculated in section (1) of this rule.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0040.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336607

AMEND: 436-009-0060

RULE SUMMARY: Revised rule 0060:
-Adds “physician associate” and “nurse practitioner” to the descriptor of Oregon specific code D0019 (IME – review and response)
-Removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-009-0060
Oregon Specific Codes ¶

(1) Multidisciplinary Services.¶
(a) Services provided by multidisciplinary programs not otherwise described by CPT® codes must be billed under Oregon specific codes.¶
(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:¶
(A) The type of service rendered,¶
(B) The medical provider who provided the service,¶
(C) Whether treatment was individualized or provided in a group session, and¶
(D) The amount of time treatment was rendered for each service billed.¶
(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.) [See attached table.]¶
(3) CARF / JCAHO Accredited Programs.¶
(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).¶
(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.¶
(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.¶
(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0060.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336608

AMEND: 436-009-0080

RULE SUMMARY: Revised rule 0080 removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-009-0080
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) ¶

(1) Durable medical equipment (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:¶
(a) Is primarily and customarily used to serve a medical purpose,¶
(b) Can withstand repeated use,¶
(c) Could normally be rented and used by successive patients,¶
(d) Is appropriate for use in the home, and¶
(e) Is not generally useful to a person in the absence of an illness or injury.¶
(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.¶
(3) An orthotic is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.¶
(4) Supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.¶
(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:¶
(a) NU for purchased, new equipment;¶
(b) UE for purchased, used equipment; and¶
(c) RR for rented equipment¶
(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table: [See attached table.]¶
(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes): [See attached table.]¶
(8) For items rented, unless otherwise provided by contract:¶
(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.¶
(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.¶
(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.¶
(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:¶
(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or¶
(b) The provider may offer a service agreement at an additional cost.¶
(10) Hearing aids: Notwithstanding OAR 436-009-0010(1)(a), a licensed audiologist may prescribe programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel hearing aids without the approval of an attending physician~~, authorized nurse practitioner,~~ or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. Any hearing aids other than BTEs, ITEs, or CICs needed for medical conditions will be considered based on justification from the attending physician~~ or authorized nurse practitioner~~. Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $7000 for a pair of hearing aids, or $3500 for a single hearing aid. If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.¶
(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for vision services billed with HCPCS codes V0000 through V2999.¶

(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.¶
(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.¶
(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0080.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336609

AMEND: 436-009-0090

RULE SUMMARY: Revised rule 0090 removes the term “authorized” in reference to nurse practitioners

CHANGES TO RULE:

436-009-0090
Pharmaceutical ¶

(1) General.¶
(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.¶
(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.¶
(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.¶
(2) Pharmaceutical Billing and Payment.¶
(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed. This includes compounded drugs, which must be billed by ingredient, listing each ingredient's NDC. Ingredients without an NDC are not reimbursable.¶
(b) All bills from pharmacies must include the prescribing provider's NPI or license number.¶
(c) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.¶
(d) Unless directly purchased by the worker (see OAR 436-009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table: [See attached table.]¶
(e) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., RED BOOK or Medi-Span.¶
(3) Dispensing by Medical Service Providers.¶
(a) Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or ~~authorized~~ nurse practitioner's office are compensable only for the initial supply to treat the patient, up to a maximum of 10 days.¶
(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248, ORS 656.252, ORS 656.254

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NOTE: Attachments referenced are attached to this document. You may view the attachment 436-009-0090.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336610

AMEND: 436-010-0005

RULE SUMMARY: Revised rule 0005:

-Removes the definition of “authorized nurse practitioner”

-Removes the term “authorized nurse practitioner”

-Adds a reference to “physician associate” and “nurse practitioner” in the definition of “Direct control and supervision”

CHANGES TO RULE:

436-010-0005
Definitions ¶

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.¶
(2) "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.¶
(3) "Attending physician" has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider Types."¶
(4) ~~"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 who has been assigned an authorized nurse practitioner number by the director.¶~~
~~(5)~~ "Board" means the Workers' Compensation Board and includes its Hearings Division.¶
(~~6~~5) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records information such as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return-to-work goals and status.¶
(~~7~~6) "Come-along provider" means a primary care physician, chiropractic physician, physician associate or a~~n authorized~~ nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)¶
(~~8~~7) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.¶
(~~9~~8) "Days" means calendar days.¶
(~~10~~9) "Direct control and supervision" means the physician, physician associate, or nurse practitioner 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.¶
(1~~1~~0) "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."¶
(1~~2~~1) "Director" means the director of the Department of Consumer and Business Services or the director's designee.¶
(1~~3~~2) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(1~~4~~3) "Eligible worker" means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO's authorized geographical service area, covered by an insurer that has a contract with that MCO.¶
(1~~5~~4) "Enrolled" means an eligible worker has received notification from the insurer that the worker is being required to treat under the provisions of a managed care organization (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.¶
(1~~6~~5) "Health care practitioner or health care provider" has the same meaning as a "medical service provider."¶
(1~~7~~6) "Home health care" means necessary medical and medically related services provided in the patient's home environment. These services may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.¶
(1~~8~~7) "Hospital" means an institution licensed by the State of Oregon as a hospital.¶
(1~~9~~8) "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.¶
(~~20~~19) "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 that meets the qualifications of a self-insured employer under ORS 656.407.¶
(2~~1~~0) "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.¶
(2~~2~~1) "Mailed or mailing date" 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 by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.¶
(2~~3~~2) "Managed care organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.¶
(2~~4~~3) "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 used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.¶
(2~~5~~4) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.¶
(2~~6~~5) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, or other related services; drugs, medicine, crutches, prosthetic appliances, braces, and supports; and where necessary, physical restorative services.¶
(2~~7~~6) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.¶
(2~~8~~7) "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.¶
(2~~9~~8) "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.¶
(~~30~~29) "Patient" means the same as worker as defined in ORS 656.005(28).¶
(3~~1~~0) "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 Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.¶
(3~~2~~1) "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 or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the patient's highest functional ability consistent with the patient's condition.¶
(3~~3~~2) "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.¶
(3~~4~~3) "Residual functional capacity" means a patient's remaining ability to perform work-related activities. 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 patient can perform each activity.¶
(3~~5~~4) "Specialist physician" means a licensed physician who qualifies as an attending physician and who examines a patient 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 patient's compensable injury.¶
(3~~6~~5) "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 has the same meaning as Work Capacity Evaluation.¶
[Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.000 et seq., ORS 656.005

AMEND: 436-010-0210

RULE SUMMARY: Revised rule 0210:
-Removes the term “authorized nurse practitioner”
-When referring to “attending physicians” no longer references types A through C
-Removes the limit of 180 days that physician associates may assume the role of attending physician and authorize time loss
-Removes the provision that physician associates may not make findings of impairment
-Removes the limit of 180 days that nurse practitioners may provide compensable medical services and authorize time loss
-Clarifies that the reference to “physician” means “attending physician”

CHANGES TO RULE:

436-010-0210
Attending Physician, ~~Authorized~~ Nurse Practitioner, and Temporary Disability Authorization ¶

(1) An attending physician ~~or authorized nurse practitioner~~ is primarily responsible for the patient's care, authorizes temporary disability, and prescribes and monitors ancillary care and specialized care.¶
(a) No later than five days after becoming a patient's attending physician ~~or authorized nurse practitioner~~, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician ~~or authorized nurse practitioner~~.¶
(b) Type A~~, type B,~~ and type ~~C~~B attending physicians ~~and authorized nurse practitioners~~ may authorize temporary disability and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types" [Attached])¶
(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician ~~or authorized nurse practitioner~~.¶
(2) Chiropractic Physicians and Naturopathic Physicians (Type B providers).¶
(a) Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director.¶
(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days or 18 visits, whichever occurs first, from the first visit on the initial claim with any type B provider.¶
(c) Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim to any type B provider.¶
(d) Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.¶
(3) Physician Associates ~~(Type C providers).¶~~
~~(a).~~ Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a physician associate must certify to the director that the provider has reviewed a packet of materials provided by the director.¶
(~~b~~4) ~~Physician associates may assume the role of attending physician for a cumulative total of 180 days from the date of the first visit on the initial claim with any physician associate.¶~~
~~(c) Physician associates may authorize payment of temporary disability compensation for a period not to exceed 180 days from the date of the first visit on the initial claim to any physician associate.¶~~
~~(d) Physician associates may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.¶~~
~~(4) Authorized Nurse Practitioners.¶~~
~~(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.¶~~
~~(b) 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 visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner 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~~Nurse Practitioners. Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a nurse practitioner must review a packet of materials provided by the division and complete the statement of authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.¶
(5) Emergency Room Physicians. Emergency room physicians may authorize temporary disability for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in the physician's private practice apart from their duties as an emergency room physician, the physician may be the attending physician.¶
(6) Unlicensed to Provide Medical Services. Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient'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.¶
(7) Out-of-State Attending Physicians. The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days. If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician.¶
(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:¶
(A) The Oregon medical fee and payment rules, OAR 436-009;¶
(B) The manner in which the out-of-state attending physician may provide compensable medical treatment or services to Oregon workers; and¶
(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.¶
(b) If the insurer disapproves the worker's out-of-state attending physician or withdraws a prior approval, the insurer must send the worker written notice that:¶
(A) Clearly states the reasons for the disapproval or withdrawal of the prior approval, for example, the out-of-state attending physician's refusal to comply with OAR 436-009 and 436-010;¶
(B) Identifies at least two other attending physicians of the same healing art and specialty in the same area that the insurer would approve;¶
(C) Informs the worker that if the worker disagrees with the disapproval or withdrawal, the worker may request approval from the director under OAR 436-010-0220; and¶
(D) Informs the worker that the worker may be liable for payment of services provided after the date of notification if the worker receives further medical services from the disapproved or no longer approved out-of-state physician.¶
(c) If the insurer withdraws approval of the out-of-state attending physician, the insurer must notify the physician of the following in writing:¶
(A) The reasons for withdrawing the approval;¶
(B) That any future services provided by that physician will not be paid by the insurer; and¶
(C) That the worker may be liable for payment of services provided after the date of notification.¶
(d) The worker or worker's representative may request approval from the director under OAR 436-010-0220 if the worker disagrees with the insurer's decision to:¶
(A) Disapprove an out-of-state attending physician; or¶
(B) Withdraw the approval of the out-of-state attending physician.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.005(12), ORS 656.245, ORS 656.260, ORS 656.799

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-010-0210.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336612

AMEND: 436-010-0220

RULE SUMMARY: Revised rule 0220:

-Removes the term “authorized nurse practitioner” and “type C attending physician”

-Removes the reference to the requirement that physician associates and nurse practitioners must refer workers to attending physicians for closing exams.

CHANGES TO RULE:

436-010-0220
Choosing and Changing Medical Providers ¶

(1) The worker may have only one attending physician ~~or authorized nurse practitioner~~ at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician ~~or authorized nurse practitioner~~. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment the physician considers appropriate, unless the referral is for a consultation only. The attending physician ~~or authorized nurse practitioner~~ continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:¶
(a) Emergency services;¶
(b) Insurer or director requested examinations;¶
(c) A Worker Requested Medical Examination;¶
(d) Consultations or referrals for specialized treatment or services initiated by the attending physician ~~or authorized nurse practitioner~~; and¶
(e) Diagnostic studies provided by radiologists and pathologists upon referral.¶
(2) Changing Attending Physician ~~or Authorized Nurse Practitioner~~. The worker may choose to change attending physician ~~or authorized nurse practitioner~~ only twice after the initial choice. When the worker requests a referral by the attending physician ~~or authorized nurse practitioner to another attending physician or authorized nurse practitioner~~to another attending physician, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians ~~or authorized nurse practitioners~~ begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician ~~or authorized nurse practitioner~~ initiated by the worker and do not count toward the worker's two changes:¶
(a) When the 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;¶
(b) When the 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; or¶
(c) When the worker is required to change attending physician ~~or authorized nurse practitioner~~ due to conditions beyond the worker's control. This could include, but is not limited to:¶
(A) When the attending physician ~~or authorized nurse practitioner~~ terminates practice or leaves the area;¶
(B) When the attending physician ~~or authorized nurse practitioner~~ is no longer willing to treat the worker;¶
(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician ~~or authorized nurse practitioner~~;¶
(D) When the period for treatment or services by a type B ~~or type C~~ attending physician ~~or an authorized nurse practitioner~~ has expired (See Appendix A "Matrix for Health Care Provider Types");¶
(E) ~~When the physician associate or authorized 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 the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician ~~or authorized nurse practitioner~~ on the MCO's panel;¶
(~~G~~F) When the worker who, at the time of MCO enrollment was required to change attending physician ~~or authorized nurse practitioner~~, is disenrolled from an MCO; or¶
(~~H~~G) When the worker has to change because their attending physician ~~or authorized nurse practitioner~~ is no longer qualified as an attending physician ~~or authorized~~ to continue providing compensable medical services.¶
(3) Insurer Notice to the Worker. When the worker has changed attending physicians ~~or authorized nurse practitioners~~ twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or

the director. If the insurer fails to provide such notice and the worker later chooses another attending physician ~~or authorized nurse practitioner~~, the insurer must pay for compensable medical services rendered prior to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change attending physician ~~or authorized nurse practitioner~~ without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.¶
(4) Worker Requesting Additional Changes of Attending Physician ~~or Authorized Nurse Practitioner~~.¶
(a) If a worker not enrolled in an MCO has changed attending physicians ~~or authorized nurse practitioners~~ by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:¶
(A) Send the worker a written explanation of the reasons;¶
(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician ~~or Authorized Nurse Practitioner~~); and¶
(C) Inform the worker that the worker may request director approval by sending Form 2332 to the director.¶
(b) When the worker submits a request to the director for an additional change of attending physician ~~or authorized nurse practitioner~~, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.¶
(c) The director will issue an order advising whether the request for change of attending physician ~~or authorized nurse practitioner~~ is approved. On a case-by-case basis the director will consider circumstances, such as:¶
(A) Whether there is medical justification for a change, e.g., 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.¶
(d) 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.¶
(5) Managed Care Organization (MCO) Enrolled Workers.¶
(a) An MCO enrolled worker must choose:¶
(A) A panel provider unless the MCO approves a non-panel provider, or¶
(B) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.¶
(b) Notwithstanding subsection (a) of this section, if a worker is unable to find three providers that are willing to treat the worker in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's geographic service area (GSA), the worker may contact the MCO for a list of three providers who are willing to treat the worker. If the MCO, within 14 days, is unable to provide a list of three providers who are willing to treat the worker within a reasonable period of time, the worker may choose a non-panel provider in that category.¶
(c) Notwithstanding subsection (a) of this section, if the MCO has fewer than three providers in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's GSA, the worker may choose a non-panel provider in that category.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.252, ORS 656.260

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-010-0220.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336613

AMEND: 436-010-0230

RULE SUMMARY: Revised rules 0230 removes the term “authorized nurse practitioner”

CHANGES TO RULE:

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) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.¶
(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize temporary disability. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.¶
(4) Consent to Attend a Medical Appointment.¶
(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.¶
(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.¶
(B) The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.¶
(C) The insurer must keep a copy of the signed consent form in the claim file.¶
(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.¶
(5) Request for Records at a Medical Appointment. The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.¶
(6) Requesting a Medical Provider Consultation. The attending physician~~, authorized nurse practitioner,~~ or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.¶
(7) Ancillary Services - Treatment Plan.¶
(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician ~~or an authorized nurse practitioner~~ prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.¶
(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.¶
(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes. If the ancillary treatment needs to continue beyond the duration stated in the treatment plan, the ancillary care provider must obtain a new prescription from the attending or specialist physician ~~or authorized nurse practitioner~~ to continue treatment. The ancillary care provider also must send a new treatment plan to the insurer the prescribing provider within seven days.¶
(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")¶
(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.~~¶~~
~~(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician associates directed by the attending physician do not have to provide a written treatment plan as prescribed in this section.~~¶
(8) Massage Therapy. Unless otherwise provided by an MCO, when an attending physician~~, authorized nurse practitioner,~~ or specialist physician prescribes ancillary services provided by a massage therapist licensed by the

Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by massage therapists must follow the same requirements as those for ancillary providers in section (7) of this rule.¶
(9) Therapy Guidelines and Requirements.¶
(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.¶
(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician ~~(or authorized nurse practitioner)~~ and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:¶
(A) Subjective status of the patient;¶
(B) Objective data from tests and measurements conducted;¶
(C) Functional status of the patient;¶
(D) Interpretation of above data; and¶
(E) Any change in the treatment plan.¶
(10) Physical Capacity Evaluation. The attending physician ~~or authorized nurse practitioner~~ must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician ~~or authorized nurse practitioner~~ does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician ~~or authorized nurse practitioner~~ must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.¶
(11) Prescription Medication.¶
(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or ~~authorized~~ nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.¶
(b) Providers should review and are encouraged to adhere to the division's opioid guidelines. See https://wcd.oregon.gov/medical/provider-training/Pages/opioid-guidelines.aspx.¶
(12) Diagnostics. Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.¶
(13) Articles. Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices are not compensable unless a report by the attending physician ~~or authorized nurse practitioner~~ clearly justifies the need. The report must:¶
(a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and¶
(b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.¶
(14) Physical Restorative Services.¶
(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:¶
(A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and¶
(B) A report by the attending physician ~~or authorized nurse practitioner~~ clearly justifies why the worker requires services not usually considered necessary for the majority of workers.¶
(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not

reimbursable unless special medical circumstances are shown to exist.¶
(15) Lumbar Artificial Disc Replacement Guidelines.¶
(a) Lumbar artificial disc replacement is always inappropriate for patients 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.¶
(b) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients 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.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, 656.248, 656.252

AMEND: 436-010-0240

RULE SUMMARY: Revised rules 0240 removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-010-0240
Medical Records and Reporting Requirements for Medical Providers ¶

(1) Medical Records and Reports.¶
(a) Medical providers must maintain records necessary to document the extent of medical services provided.¶
(b) 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.¶
(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.¶
(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).¶
(2) Diagnostic Studies. When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they 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 a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.¶
(3) Multidisciplinary Programs. When an attending physician ~~or authorized nurse practitioner~~ approves a multidisciplinary treatment program for the worker, the attending physician ~~or authorized nurse practitioner~~ must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.¶
(4) Release of Medical Records.¶
(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]¶
(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A 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, and¶
(B) HIV-related information protected by ORS 433.045.¶
(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.¶
(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. 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.¶
(e) Workers or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Workers or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. Insurers must respond to the workers' or their representatives' request within the timeframes provided in OAR 436-060-0017(5). Medical providers must respond within 14 days of receipt of a request from workers or their representatives for medical or payment records. A summary may substitute for the actual record only if the worker agrees to the substitution. The following records may be withheld:¶
(A) Psychotherapy notes;¶
(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;¶
(C) Other reasons specified by federal regulation; and¶
(D) Information that was obtained from someone other than a medical provider when the medical provider

promised confidentiality and release of the information would likely reveal the source of the information.¶
(f) A medical provider may charge the patient or the patient's representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of the patient's medical records because of inability to pay.¶
(g) A medical provider is encouraged to discuss potential modified work duties with employers. However, a medical provider may not discuss medical treatments or diagnoses with employers, or release medical records other than work release documentation, to employer representatives who are not directly responsible for claims processing responsibilities. This subsection does not relieve a medical provider from the requirements outlined in subsections (a) through (d) of this section.¶
(5) Release to Return to Work.¶
(a) When requested by the insurer, the attending physician ~~or authorized nurse practitioner~~ must submit verification that the patient's medical limitations related to their ability to work result 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.¶
(b) The attending physician ~~or authorized nurse practitioner~~ must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.¶
(6) Temporary Disability and Medically Stationary.¶
(a) When temporary disability is authorized by the attending physician ~~or authorized nurse practitioner~~, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request. If the medical provider fails to provide information under this rule within 14 days of receiving a request sent by fax or certified mail, penalties under OAR 436-010-0340 may be imposed.¶
(b) The attending physician ~~or authorized nurse practitioner~~ must, if known, inform the patient and the insurer of the following and include it in each progress report:¶
(A) The anticipated date of release to work;¶
(B) The anticipated date the patient will become medically stationary;¶
(C) The next appointment date; and¶
(D) The patient's medical limitations.¶
(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.¶
(d) The attending physician ~~or authorized nurse practitioner~~ must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.¶
(7) Consultations. When the attending physician~~, authorized nurse practitioner,~~ or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:¶
(a) The attending physician~~, authorized nurse practitioner,~~ or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.¶
(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician~~, authorized nurse practitioner,~~ or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.252, ORS 656.254

AMEND: 436-010-0241

RULE SUMMARY: Revised rule 0241

-Removes the term “authorized nurse practitioner”

-Clarifies that the reference to “physician” means “attending physician”

CHANGES TO RULE:

436-010-0241
Form 827, Workers and Health Care Providers Report for Workers Compensation Claims ¶

(1) First Visit.¶
(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit. Saturdays, Sundays, and legal holidays are not counted in the 72-hour period. Legal holidays are those listed in ORS 187.010 and 187.020.¶
(b) Form 3283 ("A Guide for Workers Recently Hurt on the Job") is included with Form 827. All medical service providers must give a copy of Form 3283 and Form 827 to the patient.¶
(2) New or Omitted Medical Condition. A patient may use Form 827 to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.¶
(3) Change of Attending Physician. When the patient changes attending physician ~~or authorized nurse practitioner~~, the patient and the new medical service provider must complete and sign Form 827. The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician ~~or authorized nurse practitioner. The new attending physician or authorized nurse practitioner~~. The new attending physician is responsible for requesting all available medical records from the previous attending physician ~~, authorized nurse practitioner,~~ or insurer. Anyone failing to forward the requested information to the new attending physician ~~or authorized nurse practitioner~~ within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.¶
(4) Aggravation. After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign Form 827. The attending physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:¶
(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and¶
(b) Whether the patient is unable to work as a result of the compensable worsening. [Forms referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.252, ORS 656.254, ORS 656.273

AMEND: 436-010-0250

RULE SUMMARY: Revised rule 0250 removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-010-0250
Elective Surgery ¶

(1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health.¶
(2) Except as otherwise provided by the MCO:¶
(a) The attending physician~~, authorized nurse practitioner,~~ or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. To notify the insurer of the proposed surgery, the provider has the option of using Form 5425 (Elective Surgery Notification) or using their own form that includes the data gathered on Form 5425.¶
(b) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.¶
(c) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery:¶
(A) Is approved;¶
(B) Is not approved and a consultation is requested by using Form 3228 (Elective Surgery Response); or¶
(C) Is disapproved by using Form 3228.¶
(d) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.¶
(e) If the insurer requests a consultation, it must be completed within 28 days after sending Form 3228 to the physician.¶
(f) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.¶
(g) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.¶
(h) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must send either the signed and dated Form 3228 or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.¶
(i) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.¶
(j) Surgery that 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 try to notify the insurer of the need for emergency surgery.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, 656.248, 656.252, 656.260, 656.327

AMEND: 436-010-0265

RULE SUMMARY: Revised rule 0265 removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-010-0265
Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs) ¶

(1) General.¶
(a) An independent medical exam (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325, except as provided in section (13) of this rule. A worker requested medical exam (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker's attending physician ~~or authorized nurse practitioner~~.¶
(b) The insurer may obtain three IMEs for each opening of the claim without authorization by the director. These IMEs may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as one of the three IMEs. A claim for aggravation, Board's Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training under OAR 436-120 (Vocational Assistance to Injured Workers) allows a new series of three IMEs. Refer to section (12) of this rule to request additional IMEs.¶
(c) The IME may be conducted by one or more providers of different specialties, generally performed at one location. If the providers are not at one location, the IME must be at locations reasonably convenient to the worker. IMEs completed within a 72-hour period count as one IME.¶
(d) The insurer must choose the medical service provider from the director's list of authorized IME providers online at www.oregonwcdoc.info. If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.¶
(e) The provider will determine the conditions under which the IME will be conducted. The IME should be performed in a professional setting that is primarily used for conducting exams. If an IME is not performed in a professional setting that is primarily used for conducting exams, the IME location should be a safe and secure environment, including a place for the worker to disrobe in private, and allow for confidentiality.¶
(f) IMEs must be scheduled at times and intervals reasonably convenient to the worker and must not delay or interrupt medical treatment that the worker has scheduled.¶
(g) The insurer must comply with the notification and reimbursement requirements under OAR 436-009-0025 and 436-060-0095.¶
(h) A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a medical service provider of the insurer's choice.¶
(i) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.¶
(j) The worker may complete an online survey at www.wcdimesurvey.info or make a complaint about the IME on the division's website. If the worker does not have access to the Internet, the worker may call the division at 800-452-0288.¶
(2) IME and WRME Provider Authorization and Removal.¶
(a) Medical service providers can perform IMEs, WRMEs, or both once they are on the director's list of authorized IME providers.¶
(b) To be on the director's list of authorized IME providers, a medical service provider must:¶
(A) Complete the online application available at www.oregonwcdoc.info;¶
(B) Hold a current license with the provider's professional regulatory licensing board;¶
(C) Be in good standing as determined by the division. For the purpose of this paragraph, the division determines good standing to mean the provider is not currently, or within the past two years has not been subject to, a disciplinary action or stipulated agreement with the provider's regulatory licensing board that the division determines to be detrimental to performing IMEs; and¶
(D) Complete the director's Training Guide to Performing Independent Medical Exams including the corresponding quiz both of which are available at www.oregonwcdoc.info; or¶
(E) Complete a director-approved training course regarding IMEs provided by an outside vendor.¶
(c) By submitting the application to the division, the medical service provider agrees to abide by:¶
(A) The standards of professional conduct for performing IMEs adopted by the provider's regulatory licensing board or the IME standards of professional conduct published in Appendix B [See attached] if the provider's regulatory licensing board does not have standards of professional conduct for performing IMEs; and¶

(B) All relevant workers' compensation laws and rules.¶
(d) A provider may be removed from the director's list of authorized IME providers after the director finds that the provider:¶
(A) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory licensing board or the IME standards published in Appendix B if the provider's regulatory licensing board does not have IME standards;¶
(B) Has a current restriction on their license or is under a current disciplinary action from their professional regulatory licensing board; or¶
(C) Has entered into a voluntary agreement with their regulatory licensing board that the director determines is detrimental to performing IMEs.¶
(e) A provider may appeal the director's decision to remove the provider from the director's list within 60 days of the mailing date of the order under ORS 656.704(2) and OAR 436-001-0019.¶
(3) IME Complaint Process.¶
(a) A complaint about an IME may be submitted to the division for investigation.¶
(b) The division reviews IME complaints to determine the appropriate action under the director's jurisdiction.¶
(c) The division investigates IME complaints to determine if there is a violation of one or more of the standards of professional conduct or workers' compensation laws or rules.¶
(d) If the division determines additional information is needed the division will contact the IME provider regarding the allegations in the complaint and request:¶
(A) A written response regarding the allegations;¶
(B) A copy of the IME report;¶
(C) Contact information for scribes, chaperones, or other people attending the IME at the IME provider's request; or¶
(D) A copy of a video or audio recording of the IME, if the IME was recorded.¶
(e) If the division does not receive a response to information requested under subsection (d) within 14 days from the date of the request, the division may make a decision based on available information.¶
(f) The division may contact any person who may have information or view any documentation or items regarding the IME or complaint.¶
(g) The division will notify the IME provider and complainant in writing of the outcome of the IME investigation.¶
(h) When investigating a new complaint regarding an IME provider, the division will review all complaints about that provider received in the past two years, excluding complaints where the director found no violation, to determine if there is a pattern of behavior involving the IME provider. If there is a pattern of behavior, the director may take additional action, up to and including removal of the provider from the director's list of authorized IME providers.¶
(i) An order issued by the director to remove an IME provider from the director's list of authorized IME providers will include a notice of appeal rights under ORS 656.704(2) and OAR 436-001-0019.¶
(4) IME Training. An outside vendor may provide initial IME training to providers wanting to become an IME provider, as long as the training is approved by the director before it is provided.¶
(5) IME Related Forms.¶
(a) When scheduling an IME, the insurer must ensure the medical service provider has:¶
(A) Form 3923, "Important Information about Independent Medical Exams," available to the worker before the exam; and¶
(B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.¶
(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.¶
(6) IME Observer.¶
(a) A worker may choose to have an observer present during the IME. An observer is not allowed to be present during a psychological examination unless the IME provider approves.¶
(b) The worker's observer must not be paid to attend the IME. The worker's attorney or any representative of the worker's attorney may not be an observer.¶
(c) If the observer interferes with or obstructs the IME, the IME provider may ask the observer to leave and continue the IME with the worker's consent or end the IME.¶
(d) If the worker chooses to have an observer present, the provider must verify that the worker has signed Form 3923A, "IME Observer Form," acknowledging that the worker understands:¶
(A) The IME provider may ask sensitive questions during the exam in the presence of the observer;¶
(B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and¶
(C) The observer must not be paid to attend the exam.¶
(7) Invasive Procedure.¶
(a) For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters

the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form. The IME provider must make a copy of the signed Form 3227 for the worker and send the original to the insurer.¶
(b) An IME provider may be sanctioned under OAR 436-010-0340(1) for failing to follow this section.¶
(8) Recording the IME. With the IME provider's approval, the worker may use a video camera or other device to record the IME.¶
(9) Objection to the IME Location. When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.¶
(a) The request may be made in-person, by telephone, fax, email, 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 travel is medically contraindicated or unreasonable because:¶
(A) The travel exceeds limitations imposed by the attending physician~~, authorized nurse practitioner,~~ or any medical conditions;¶
(B) Alternative methods of travel will not overcome the limitations; or¶
(C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.¶
(10) Failure to Attend an IME. If the worker fails to attend an IME and does not notify the insurer before the date of the IME or does not have sufficient reason for not attending the IME, the director may impose a monetary penalty against the worker for failure to attend.¶
(11) IME Report.¶
(a) After the IME is complete, the IME provider must send the insurer a report that includes, but is not limited to the following:¶
(A) Clear and accurate documentation of all tests performed;¶
(B) Who performed the IME;¶
(C) Who dictated the report;¶
(D) A signed quality assurance statement acknowledging that to the best of the IME provider's ability all statements contained in the report are true and accurate; and¶
(E) A copy of the observer Form 3923A, the invasive procedure Form 3227, or both, if applicable.¶
(b) The IME provider must communicate with the insurer if the IME provider is unable to provide the report within the insurer's requested time period and provide a date when the report will be sent.¶
(c) The insurer must forward a copy of the signed report to the attending physician ~~or authorized nurse practitioner~~ within three business days of the insurer's receipt of the report.¶
(12) Request for Additional IME.¶
(a) When the insurer has obtained the three IMEs allowed under section (1) of this rule, the insurer must request authorization from the director before scheduling the worker for an additional IME. An insurer that fails to request authorization from the director may be assessed a civil penalty.¶
(b) The insurer must submit a request for authorization to the director for an additional IME by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if represented.¶
(c) The director will review the request and determine if additional information from the insurer or the worker is needed.¶
(A) Upon receiving a written request for additional information from the director, the parties have 14 days to respond.¶
(B) If the parties do not provide the requested information within the timeframes in paragraph (A), the director will issue an order approving or disapproving the request based on available information.¶
(d) The director, when making a determination to approve or deny the request for an additional IME, will consider, but is not limited to, whether:¶
(A) An IME involving the same disciplines or review of the same condition has been completed within the past six months;¶
(B) There has been a significant change in the worker's condition;¶
(C) There is a new condition or compensable aspect in the claim;¶
(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits;¶
(E) The IME is requested to establish a preponderance for medically stationary status;¶

(F) The IME is medically harmful to the worker, and¶
(G) The IME is requested for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.¶
(e) Any party that disagrees with the director's order to approve or disapprove a request for an additional IME may request a hearing by the board under ORS 656.283 and OAR chapter 438.¶
(13) Other Exams - Not Considered IMEs. The following exams are not considered IMEs and do not require approval as outlined in section (12) of this rule:¶
(a) An exam, including a closing exam, requested by the worker's attending physician ~~or authorized nurse practitioner~~;¶
(b) An exam requested by the director;¶
(c) An elective surgery consultation requested under OAR 436-010-0250(2)(b);¶
(d) An exam of a permanently totally disabled worker required under ORS 656.206(5);¶
(e) A closing exam that has been arranged by the insurer at the attending physician's ~~or authorized nurse practitioner's~~ request; and¶
(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.252, ORS 656.325, ORS 656.245, ORS 656.248, ORS 656.260, ORS 656.264

AMEND: 436-010-0270

RULE SUMMARY: Revised rule 0270 removes the term “authorized nurse practitioner”

CHANGES TO RULE:

436-010-0270
Insurers Rights and Duties ¶

(1) Notifications.¶
(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.¶
(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician ~~or authorized nurse practitioner~~, if known, and the MCO, if any.¶
(c) In disabling and nondisabling claims, within seven days notice or knowledge that the worker is medically stationary, the insurer must notify the worker, the attending physician, and all actively treating ancillary care providers in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c). For the purpose of this rule, actively treating ancillary care providers means ancillary care providers who have submitted a current treatment plan to the insurer as required by OAR 436-010-0230.¶
(d) When the insurer establishes a medically stationary date that 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. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician ~~or authorized nurse practitioner~~.¶
(2) Medical Records Requests.¶
(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.¶
(b) Within 14 days of receiving a 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~~.¶
(3) Pre-authorization. Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.¶
(4) Communication with Providers.¶
(a) The insurer or its representative must respond to a medical provider's inquiry about claim status, accepted conditions, or MCO enrollment within two days during regular Oregon business hours, excluding Saturdays, Sundays, and legal holidays listed in ORS 187.010 and 187.020. For the purpose of this rule, "regular Oregon business hours" means from 8:00 am to 5:00 pm Pacific Time. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.¶
(b) An insurer or its representative and a medical provider may agree to communicate about claim status, accepted conditions, or MCO enrollment by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Information Protection Act under ORS 646A.600 to 646A.628 and federal law.¶
(5) Insurer's Duties under MCO Contracts.¶
(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:¶
(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);¶
(B) How workers can receive compensable medical services within the MCO;¶
(C) How workers can receive compensable medical services by non-panel providers; and¶
(D) The geographical service area governed by the MCO.¶
(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.¶
(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the worker's attorney's name, mailing address, phone number, and, if known, fax number and email address to the MCO.¶
(d) 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 providers, and the MCO of enrollment. To be considered complete, 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:¶
(i) Provide a telephone number the worker may call to ask for a written list; and¶
(ii) Tell the worker that they have seven days from the mailing date of the notice to request the list;¶
(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;¶
(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:¶
(i) Must change attending physician ~~or authorized nurse practitioner~~ to an MCO panel provider, or¶
(ii) May continue to treat with the worker's current attending physician~~ or authorized nurse practitioner~~;¶
(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;¶
(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. For the purpose of this rule, "coordinated health care program" means an employer program providing 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 workers with health care benefits even if a workers' compensation claim is denied; and¶
(F) Notify the worker of the worker's right to appeal MCO decisions and 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.¶
(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.¶
(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.¶
(g) The insurer may delegate to the MCO responsibility for issuing the enrollment notice required by ORS 656.245(4)(a) and these rules by express provision in the contract between those parties; however, the insurer remains liable for any deficiencies in the notice issued by the MCO.¶
(h) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0037(3).¶
(i) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:¶
(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, notify the parties in writing to seek administrative review before the director.¶
(j) The insurer must notify the MCO within seven days of receiving notification of the following:¶
(A) When the worker obtains representation by an attorney, the attorney's name, mailing address, phone number, and, if known, fax number and email address;¶
(B) Any changes to the worker's or worker's attorney's name, address, or telephone number;¶
(C) Any requests for medical services from the worker or the worker's medical provider; or¶
(D) Any request by the worker to continue treating with a "come-along" provider.¶
(k) When an MCO pre-certifies a surgical service as medically appropriate, the insurer must, within 45 days from the mailing date of the MCO decision, notify the worker, the worker's representative, the provider, and the MCO whether the insurer approves the surgery.¶
(A) If the insurer disapproves the surgery for reasons other than appropriateness or whether the surgery is excessive or ineffectual, the disapproval must include the following notice in bold text and be formatted as follows:¶
~~Notice to worker, worker's attorney, and medical provider:¶~~
~~If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:¶~~
~~- Notify the Department of Consumer and Business Services (DCBS) in writing.¶~~
~~- Send your written request for review of the insurer's disapproval to:¶~~
~~DCBS Workers' Compensation Division¶~~

~~Medical Resolution Team¶~~
~~350 Winter Street NE¶~~
~~PO Box 14480¶~~
~~Salem OR 97309-0405¶~~
~~If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the insurer's decision.¶~~
~~For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consulta~~ [See attachment.]¶
(B) If the insurer disagrees with the appropriateness decision of the MCO, the insurer must appeal the decision to the MCO under OAR 436-015-0110(4).¶
(l) Insurers under contract with MCOs must maintain records including, but not limited to:¶
(A) A listing of all employers covered by MCO contracts;¶
(B) The employers' WCD employer numbers;¶
(C) The estimated number of employees governed by each MCO contract;¶
(D) A list of all workers enrolled in the MCO; and¶
(E) The effective dates of such enrollments.¶
(m) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.¶
(n) When an MCO contract expires or is terminated 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 before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.252, ORS 656.325, ORS 656.245, ORS 656.248, ORS 656.260, ORS 656.264

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-010-0270.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336619

AMEND: 436-010-0280

RULE SUMMARY: Revised rule 0280:

-No longer requires physician associates and nurse practitioners to refer the worker to a type A attending physician to do a closing exam when a worker has become medically stationary

-Removes the term “authorized nurse practitioner”

-Clarifies that the reference to “physician” means “attending physician”

-Clarifies that physician associates and nurse practitioners must make a statement regarding the validity of an impairment finding for a closing report

CHANGES TO RULE:

436-010-0280
Determination of Impairment/Closing Exams ¶

(1) When a worker becomes medically stationary and there is a reasonable expectation of permanent disability, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of ~~an authorized nurse practitioner, physician associate, or~~ a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam.~~-~~¶
(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".)~~-~~¶
(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.¶
(4) When an attending physician ~~or authorized nurse practitioner~~ 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 to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the attending physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.~~-~~¶
(5) The attending physician must specify the worker's residual functional capacity if:¶
(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and~~-~~¶
(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.¶
(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:~~-~~¶
(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or~~-~~¶
(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.¶
(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:~~-~~¶
(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or~~-~~¶
(b) A~~n authorized nurse practitioner, physician associate, or~~ naturopathic physician, must refer the worker to a type A attending physician for a closing exam.¶
(8) The closing report must include all of the following:¶
(a) Findings of permanent impairment.¶
(A) 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 or a direct medical sequela of an accepted condition.¶
(B) 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 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 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) Findings documenting permanent work restrictions.¶
(A) 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 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 or a direct medical sequela of an accepted condition.¶
(C) 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 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 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 sequel of an accepted occupational disease.¶
(c) A statement regarding the validity of an impairment finding is required in the following circumstances:¶
(A) If the examining physician, physician associate, or nurse practitioner 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, physician associate, or nurse practitioner 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, physician associate, or nurse practitioner 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.
Statutory/Other Authority: ORS 656.726(4), 656.245(2)(b)
Statutes/Other Implemented: ORS 656.245, 656.252

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-010-0280.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336620

AMEND: 436-010-0290

RULE SUMMARY: Revised rule 0290 clarifies that the reference to “physician” means “attending physician”

CHANGES TO RULE:

436-010-0290
Medical Care After Medically Stationary ¶

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:¶
(a) Palliative care under section (2) of this rule;¶
(b) Curative care under sections (3) and (4) of this rule;¶
(c) Provided to a worker who has been determined permanently and totally disabled;¶
(d) Prescription medications;¶
(e) Necessary to administer or monitor administration of prescription medications;¶
(f) Prosthetic devices, braces, or supports;¶
(g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;¶
(h) Provided under an accepted claim for aggravation;¶
(i) Provided under Board's Own Motion;¶
(j) Necessary to diagnose the worker's condition; or¶
(k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.¶
(2) Palliative Care.¶
(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:¶
(A) Describe any objective findings;¶
(B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;¶
(C) Detail a treatment plan which includes the name of the provider who will provide 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) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.¶
(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice approving or disapproving the request to the attending physician, the provider who will provide the care, the worker, and the worker's attorney. If the request is disapproved, the notice must include the following in bold text and be formatted as follows:¶
~~Notice to worker, worker's attorney, and attending physician:¶~~
~~If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:¶~~
~~- Notify the Department of Consumer and Business Services (DCBS) in writing.¶~~
~~- Send your written request for review to:¶~~
~~DCBS Workers' Compensation Division¶~~
~~Medical Resolution Team¶~~
~~350 Winter Street NE¶~~
~~PO Box 14480¶~~
~~Salem OR 97309-0405¶~~
~~If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the decision.¶~~
~~For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consulta~~ [See attachment.]¶
(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:¶

(A) The palliative care services are not related to the compensable conditions;¶
(B) The palliative care services are excessive, inappropriate, or ineffectual; or¶
(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.¶
(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:¶
(A) A copy of the original request to the insurer; and¶
(B) A copy of the insurer's response.¶
(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the attending physician must include a copy of the original request and may include any other supporting information.¶
(g) 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.¶
(3) Curative Care. Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.¶
(4) Advances in Medical Science. The director must approve curative care arising from a generally recognized, nonexperimental 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 attending physician must submit a written request for approval to the director. The request must:¶
(a) Describe any objective findings;¶
(b) Identify 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; and¶
(e) Describe why the care is otherwise justified by the circumstances of the claim.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.245

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-010-0290.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336621

AMEND: 436-015-0005

RULE SUMMARY: Revised rule 0005 removes the descriptor “authorized” from the tern nurse practitioner if the definition of “Come-along provider”

CHANGES TO RULE:

436-015-0005
Definitions ¶

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.¶
(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) "Come-along provider" means a primary care physician, a chiropractic physician, physician associate, or a~~n authorized~~ nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO.¶
(3) "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 workers with health care benefits even if a workers' compensation claim is denied.¶
(4) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(5) "Geographic service area (GSA)" means an area of the state in which a managed care organization may be authorized by the director of the Department of Consumer and Business Services to provide managed care services. There are 15 geographic service areas in Oregon.¶
(6) "Good cause" means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.¶
(7) "Group of medical service providers" means individuals duly licensed to practice one or more of the healing arts who join together to provide medical services through a managed care organization, whether or not such providers have an ownership interest in the managed care organization.¶
(8) "Health care provider" means an entity or group of entities, organized to provide health care services or to provide administrative support services to entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.¶
(9) "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 and meets the qualifications of a self-insured employer under ORS 656.407.¶
(10) "Managed care organization" ("MCO") means an organization formed to provide medical services and certified under these rules.¶
(11) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.¶
(12) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services.¶
(13) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.¶
(14) "Non-qualifying employer" means either:¶
(a) An insurer as defined in this rule, with respect to managed care services to be provided to any subject worker; or¶
(b) An employer as defined under ORS 656.005(13), other than a health care provider, with respect to managed care services to such employer's employees.¶
(15) "Primary care physician" means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.¶
(16) "Show-cause hearing" means an informal meeting with the director or the director's designee where the MCO is provided an opportunity to explain and present evidence regarding any proposed orders by the director to suspend or revoke the MCO's certification.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0030

RULE SUMMARY: Revised rule 0030:

-Removes the term “authorized nurse practitioner”

-Removes the descriptor “authorized” from the term nurse practitioner when describing the process that allows enrolled workers to select a nurse practitioner

-Clarifies that the reference to “physician” means “attending physician”

-Changes OAR 436-015-0030(5)(j) 14 days to 30 days to align with recent changes to 436-015-0037(3)(e)(A) (not related to HB 4040 (2026))

-Updates a reference from OAR 436-010-0270(4)(d) to OAR 436-010-0270(5)(d) in OAR 436-015-0030(5)(j)

CHANGES TO RULE:

436-015-0030
Applying for Certification ¶

(1) General. The MCO must establish one place of business in Oregon where it administers the plan and keeps membership and other records as required by OAR 436-015-0050.¶
(2) An applicant for MCO certification must submit the following to the director:¶
(a) One copy of the application;¶
(b) A nonrefundable fee of $1,500, payable to the Department of Consumer and Business Services, which will be deposited in the Consumer and Business Services Fund;¶
(c) Affidavits of each person identified in section (3) of this rule, certifying that the individuals have no interest in a non-qualifying employer under OAR 436-015-0009;¶
(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services under the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and¶
(e) A complete organizational chart.¶
(3) MCO Application. The application must include:¶
(a) The name of the MCO;¶
(b) The name of each person who will be a director of the MCO;¶
(c) The name of the person who will be the president of the MCO;¶
(d) The title and name of the person who will be the day-to-day administrator of the MCO;¶
(e) The title and name of the person who will be the administrator of the financial affairs of the MCO; and¶
(f) A proposed plan for the MCO, in which the applicant identifies how the MCO will meet the requirements of ORS 656.260 and these rules.¶
(4) MCO Plan - General. The plan must:¶
(a) Identify the initial GSAs in which the MCO intends to operate (For details regarding GSAs, see http://wcd.oregon.gov/Bulletins/bul_248.pdf);¶
(b) Describe the reimbursement procedures for all services provided;¶
(c) Include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service;¶
(d) Describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers and how workers can access those providers;¶
(e) Provide a procedure to identify those providers in the panel provider listings that only accept existing patients as workers' compensation patients. This procedure is not subject to the timeframe established in subsection (f) of this section;¶
(f) Provide a procedure for regular, periodic updating of all MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days; and¶
(g) Include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization under OAR 436-015-0040 and OAR 436-009.¶
(5) MCO Plan - Worker Rights. The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:¶
(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;¶
(b) Receive initial treatment by an MCO attending physician ~~or authorized nurse practitioner~~ of the worker's choice within 24 hours of the MCO's knowledge of the need or a request for treatment;¶

(c) Receive treatment by an MCO attending physician ~~or authorized nurse practitioner~~ of the worker's choice within five working days after the worker received treatment outside the MCO;¶
(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include:¶
(A) The worker's right to receive emergency or urgent care, and¶
(B) The MCO's regular hours of operation if the worker needs assistance selecting an attending physician or has other questions.¶
(e) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;¶
(f) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographic service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if the provider agrees to the MCO's terms and conditions;¶
(g) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker;¶
(h) Receive specialized medical services the MCO is not able to provide;¶
(i) Receive treatment that is consistent with MCO treatment standards and protocols; and¶
(j) Remain eligible to receive authorized temporary disability benefits up to ~~14~~30 days after the mailing date of a notice enrolling the worker's claim in an MCO under OAR 436-010-0270(4~~5~~)(d).¶
(6) MCO Plan - Choice of Provider. The plan must provide all of the following:¶
(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers within a GSA or the MCO, within 14 days, is unable to provide a list of three providers willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(b) A process that allows workers to select a~~n authorized~~ nurse practitioner. If the MCO has fewer than three ~~authorized~~ nurse practitioners within a GSA or the MCO, within 14 days, is unable to provide a list of three ~~authorized~~ nurse practitioners willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a~~n authorized~~ nurse practitioner, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such ~~authorized~~ nurse practitioners cannot be required to comply with the terms and conditions regarding services performed by the MCO. These ~~authorized~~ nurse practitioners are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(c) A process that allows workers to select a physician associate. If the MCO has fewer than three physician associates within a GSA or the MCO, within 14 days, is unable to provide a list of three physician associates willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a physician associate, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such physician associates cannot be required to comply with the terms and conditions regarding services performed by the MCO. These physician associates are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(d) A procedure that allows workers to receive compensable medical treatment from a come-along provider authorized under OAR 436-015-0070.¶
(7) MCO Plan - Provider Agreement. The plan must include:¶
(a) A copy of the standard provider agreement used by the MCO when a provider is credentialed as a panel provider. Variations from the standard provider agreement must be identified when the plan is submitted for director approval; and¶
(b) An initial list of the names, addresses, and specialties of the individuals who will provide services within the MCO. This list must indicate which medical service providers will act as attending physicians in each GSA.¶
(8) MCO Plan - Monitoring and Reviewing. The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including:¶

(a) A program of peer review and utilization review including the following:¶
(A) Pre-admission review of elective admissions to the hospital and elective surgeries;¶
(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;¶
(C) ~~P~~Attending physician profile analysis which may include such information as each attending physician's total charges, number and costs of related services provided, workers' temporary disability, and total number of visits in relation to care provided by other attending physicians to patients with the same diagnosis. An attending physician's profile must not be released to anyone outside the MCO without the attending physician's specific written consent, except that the attending physician's profile must be released to the director without the necessity of obtaining such consent;¶
(D) Concurrent review programs that periodically review the care after treatment has begun, to determine if continued care is medically necessary;¶
(E) Retrospective review programs that examine care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and¶
(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.¶
(b) A quality assurance program that includes:¶
(A) A system for monitoring and resolving problems or complaints, including those identified by workers or medical service providers;¶
(B) Physician peer review, which must be conducted by a group designated by the MCO or the director. The group must include members of the same healing art as the peer-reviewed physician; and¶
(C) A standardized medical record system.¶
(c) A program that specifies the criteria for selection and termination of panel providers and the process for peer review. The processes for terminating a panel provider and peer review must provide adequate notice and hearing rights.¶
(d) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, or quality assurance.¶
(9) MCO Plan - Dispute Resolution. The plan must include:¶
(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers under OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing waiver of the 30-day period to appeal a decision to the MCO upon a showing of good cause; and¶
(b) A description of how the MCO will ensure workers continue to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process.¶
(10) MCO Plan - Treatment Standards, Protocols, and Guidelines. The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must describe:¶
(a) The medical expertise or specialties of the clinicians involved;¶
(b) The basis for protocols and guidelines;¶
(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines;¶
(d) The criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines;¶
(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and¶
(f) A process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.¶
(11) MCO Plan - Return to Work and Workplace Safety. The plan must provide other programs that meet the requirements of ORS 656.260(4), including:¶
(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers; and¶
(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must:¶
(A) Identify how the MCO will promote such services;¶
(B) Describe the method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer;¶
(C) Describe the method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001;¶

(D) Include a provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and¶
(E) Include a provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO.¶
(12) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA(s) of the MCO. If the certification is denied, the director will provide the applicant with the reason for the denial.¶
(13) The director will not certify an MCO if the plan does not meet the requirements of these rules.¶
(14) Communication Liaison. The MCO must designate an in-state communication liaison(s) to the director and the insurers at the MCO's established in-state location.
Statutory/Other Authority: ORS 656.260, 656.726(4)
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0040

RULE SUMMARY: Revised rule 0040 removes the descriptor “authorized” from the term nurse practitioner

CHANGES TO RULE:

436-015-0040
Reporting Requirements for an MCO ¶

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO must provide the director with a copy of the entire text of any MCO-insurer contract, signed by the insurer and the MCO, within 30 days of execution of such contracts. The MCO must submit any amendments, addenda, or cancellations to the director within 30 days of execution.¶
(2) When an MCO-insurer contract contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination. If the MCO does not provide the director with a copy of the signed contract extension, workers will no longer be subject to the contract after it expires or terminates.¶
(3) The MCO must submit any amendments to the certified plan to the director for approval. The MCO must not take any action based on a proposed amendment until the director approves the amendment.¶
(4) Within 45 days of the end of each calendar quarter, each MCO must provide the following information to the director, current on the last day of the quarter, as described in Bulletin 247:¶
(a) The quarter being reported;¶
(b) MCO certification number; and¶
(c) Membership listings by category of medical service provider (in coded form), including:¶
(A) Provider names;¶
(B) Specialty (in coded form);¶
(C) Tax ID number;¶
(D) National Provider Identifier (NPI) number; and¶
(E) Business address and phone number. When a medical service provider has multiple offices, only one office location in each geographic service area needs to be reported.¶
(5) By April 30 of each year, each MCO must provide the director with the following information for the previous calendar year:¶
(a) A summary of any sanctions or punitive actions taken by the MCO against its members; and¶
(b) A summary of actions taken by the MCO's peer review committee.¶
(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of come-along providers. The MCO's report must include the following:¶
(a) Provider type (primary care physician, chiropractic physician, physician associate or ~~authorized~~ nurse practitioner) reported by geographic service area (GSA).¶
(b) The number of workers affected, reported by provider type.¶
(c) Date of denial or termination.¶
(d) One or more of the following reasons for each denial or termination:¶
(A) Provider failed to meet the MCO's credentialing standards within the last two years;¶
(B) Provider has been previously terminated from serving as an attending physician within the last two years;¶
(C) Treatment is not according to the MCO's service utilization process;¶
(D) Provider failed to comply with the MCO's terms and conditions after being granted come-along privileges; or¶
(E) Other reasons authorized by statute or rule.¶
(7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.¶
(8) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0070

RULE SUMMARY: Revised rule 0070 clarifies the requirement for nurse practitioner to be a come-along provider

CHANGES TO RULE:

436-015-0070
Come-along Providers ¶

(1) The MCO must authorize a physician, physician associate, or nurse practitioner who is not an MCO panel provider to provide medical services to an enrolled worker if:¶
(a) The nurse practitioner ~~is~~has been assigned an authorized nurse practitioner ~~under ORS 656.245~~number by the division, the chiropractic physician or physician associate has certified to the director that the chiropractic physician or physician associate has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);¶
(b) The physician, physician associate, or ~~authorized~~ nurse practitioner agrees to comply with MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services under OAR 436-015-0090; and¶
(c) The physician, physician associate, or ~~authorized~~ nurse practitioner agrees to refer the worker to the MCO for specialized care that the worker may require, including physical therapy.¶
(2) The physician, physician associate, or ~~authorized~~ nurse practitioner who is not an MCO panel provider will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's, physician associate's, or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if a worker has selected a physician, physician associate, or ~~authorized~~ nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.¶
(3) The MCO may not limit the length of treatment authority of a come-along provider unless such limits are stated in ORS chapter 656.¶
(4) Notwithstanding section (1), for those workers receiving their medical services from a facility that maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians, physician associates, or ~~authorized~~ nurse practitioners who are not MCO panel providers, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician, physician associate, or ~~authorized~~ nurse practitioner to treat the compensable injury.¶
(5) Any questions or disputes relating to the worker's selection of a physician, physician associate, or ~~authorized~~ nurse practitioner who is not an MCO panel provider must be resolved under OAR 436-015-0110.¶
(6) Any disputes relating to a come-along provider's or other non-MCO provider's compliance with MCO standards and protocols must be resolved under OAR 436-015-0110.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260

AMEND: 436-030-0005

RULE SUMMARY: Revised rule 0005 to remove the definition of “authorized nurse practitioner.”

CHANGES TO RULE:

436-030-0005
Definitions ¶

Unless a term is defined in these rules or the context otherwise requires, the definitions of ORS chapter 656 are incorporated by reference and made part of these rules. ¶
(1) ~~"Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.¶~~
~~(2)~~ "Board" means the Workers' Compensation Board and includes its Hearings Division.¶
(~~3~~2) "Day" means calendar day unless otherwise specified (e.g., "working day").¶
(~~4~~3) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. ¶
(~~5~~4) "Director" means the director of the Department of Consumer and Business Services, or the director's designee.¶
(~~6~~5) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(~~7~~6) "Instant fatality" means a compensable claim for death benefits when the worker dies within 24 hours of the injury.¶
(~~8~~7) "Insurer" means the State Accident Insurance Fund; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer, or a self-insured employer group.¶
(~~9~~8) "Irreversible findings" has the same meaning as described in OAR 436-035-0005(7).¶
(~~10~~9) "Mailed" or "mailing date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by fax will be 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 received by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.¶
(1~~1~~0) "Notice of Closure" means a notice to the worker, estate, or beneficiary issued by the insurer to:¶
(a) Close an accepted disabling claim, including fatal claims;¶
(b) Correct, rescind, or rescind and reissue a Notice of Closure previously issued; or¶
(c) Reduce permanent total disability to permanent partial disability.¶
(1~~2~~1) "Reconsideration" means review by the director of an insurer's Notice of Closure.¶
(1~~3~~2) "Statutory closure date" means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).¶
(1~~4~~3) "Statutory appeal period" means the time frame for appealing a Notice of Closure or Order on Reconsideration.¶
(1~~5~~4) "Work disability," for purposes of determining permanent disability, means the separate factoring of impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.
Statutory/Other Authority: ORS 656.268, 656.726
Statutes/Other Implemented: ORS 656.268, 656.726, 656.005

AMEND: 436-030-0020

RULE SUMMARY: Revised rule 0020 to remove the term “authorized nurse practitioner.”

CHANGES TO RULE:

436-030-0020
Requirements for Claim Closure ¶

(1) Issuance of a Notice of Closure. Unless the worker is enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:¶
(a) Medical information establishes that there is sufficient information to determine the extent of permanent disability and indicates that the worker is medically stationary;¶
(b) The compensable injury is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;¶
(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met;¶
(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the requirements for claim closure under OAR 436-030-0034 have been met; or¶
(e) A worker receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.¶
(2) Sufficient Information. For purposes of determining the extent of permanent disability, except as provided in section (14) of this rule for closure after training, "sufficient information" requires: a qualifying statement of no permanent disability under subsection (a) of this section or a qualifying closing report under subsection (b) of this section. Additional documentation is required under subsection (c) of this section unless there is clear and convincing evidence that an attending physician ~~or authorized nurse practitioner~~ has released the worker to the job held at the time of injury or that the worker has returned to the job held at the time of injury.¶
(a) Qualifying statements of no permanent disability. A statement indicating that there is no permanent disability is sufficient if it meets all of the following requirements:¶
(A) Qualified providers. An ~~authorized nurse practitioner or~~ attending physician must provide or concur with the statement.¶
(B) Support by the medical record. The statement must be supported by the medical record. If the medical record reveals otherwise, a closing examination and report specified under subsection (b) of this section are required.¶
(C) In initial injury claims. In an initial injury claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and¶
(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.¶
(D) In new or omitted condition claims. In a new or omitted condition claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and¶
(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.¶
(E) In aggravation claims. In an aggravation claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and¶
(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.¶
(F) In occupational disease claims. In an occupational disease claim, the statement must clearly indicate the following:¶
(i) There is no reasonable expectation of any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and¶

(ii) There is no reasonable expectation of any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.¶
(b) Qualifying closing reports. A closing medical examination and report are required if there is a reasonable expectation of permanent disability. A closing report is sufficient if it meets all of the following requirements:¶
(A) Qualified providers. A type A attending physician or a chiropractic physician serving as the attending physician must provide or concur with the closing report.¶
(B) Release to regular work. If the worker has no permanent work restriction and the provider identified in paragraph (A) of this rule has not already clearly established the following information, 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.¶
(C) In initial injury claims. In an initial injury claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted condition or a direct medical sequela of an accepted condition; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted condition or a direct medical sequela of an accepted condition.¶
(D) In new or omitted condition claims. In a new or omitted condition claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.¶
(E) In aggravation claims. In an aggravation claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted worsened condition or a direct medical sequela of an accepted worsened condition.¶
(F) In occupational disease claims. In an occupational disease claim, the closing report must include detailed documentation of all measurements, findings, and limitations regarding:¶
(i) Any permanent impairment due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease; and¶
(ii) Any permanent work restriction that:¶
(I) Prevents the worker from returning to the job held at the time of injury; and¶
(II) Is due to an accepted occupational disease or a direct medical sequela of an accepted occupational disease.¶
(c) Additional documentation. Unless there is clear and convincing evidence that an attending physician ~~or authorized nurse practitioner~~ has released the worker to the job held at the time of injury (for dates of injury on or after January 1, 2006) or that the worker has returned to the job held at the time of injury, all of the following is required:¶
(A) An accurate description of the physical requirements of the worker's job held at the time of injury, which has been provided by certified mail to the worker and the worker's attorney, if any, either before closing the claim or at the time the claim is closed, unless the record clearly establishes the physical requirements of the worker's job held at the time of injury;¶
(B) The worker's wage established consistent with OAR 436-060;¶
(C) The worker's date of birth;¶
(D) Except as provided in OAR 436-030-0015(4)(d), the worker's work history for the period beginning five years before the date of injury to the mailing date of the Notice of Closure, including tasks performed or level of SVP, and physical demands; and¶
(E) The worker's level of formal education.¶
(3) When determining disability and issuing the Notice of Closure, the insurer must apply all statutes and rules consistent with their provisions, particularly as they relate to major contributing cause denials, worker's failure to seek treatment, worker's failure to attend a mandatory examination, medically stationary status, temporary disability, permanent partial and total disability, and review of permanent partial and total disability.¶

(4) When issuing a Notice of Closure (Form 1644), the insurer must prepare and attach a Notice of Closure Worksheet (Form 2807), as described by bulletin of the director, and an Insurer Notice of Closure Summary (Form 1503).¶
(5) The Notice of Closure (Form 1644) is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, or to the worker's estate if the worker is deceased, regardless of the date on the Notice itself.¶
(6) The Notice of Closure (Form 1644) must be in the form and format prescribed by the director in these rules and include only the following:¶
(a) The worker's name, address, and claim identification information;¶
(b) The appropriate dollar value of any individual scheduled or unscheduled permanent disability based on the value per degree for injuries occurring before January 1, 2005 or, for injuries occurring on or after January 1, 2005, the appropriate dollar value of any "whole person" permanent disability, including impairment and work disability as determined appropriate under OAR 436-035;¶
(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director;¶
(d) The percentage of loss of the specific body part(s), including either the number of degrees that loss represents as appropriate for injuries occurring before January 1, 2005, or the percentage of the whole person the worker's loss represents as appropriate for injuries occurring on or after January 1, 2005;¶
(e) If there is no permanent disability award for this Notice of Closure, a statement to that effect;¶
(f) The duration of temporary total and temporary partial disability compensation;¶
(g) The date the Notice of Closure was mailed;¶
(h) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034;¶
(i) The date the worker's aggravation rights end;¶
(j) The appeal rights of the worker and any beneficiaries;¶
(k) A statement that the worker has the right to consult with the Ombuds Office for Oregon Workers;¶
(l) For claims with dates of injury before January 1, 2005, the rate in dollars per degree at which permanent disability, if any, will be paid based on date of injury as identified in Bulletin 111;¶
(m) For claims with dates of injury on or after January 1, 2005, the state's average weekly wage applicable to the worker's date of injury;¶
(n) The worker's return to work status;¶
(o) A general statement that the insurer has the authority to recover an overpayment;¶
(p) A statement that the worker has the right to be represented by an attorney; and¶
(q) A statement that the worker has the right to request a vocational eligibility evaluation under ORS 656.340.¶
(7) The Notice of Closure (Form 1644) must be accompanied by the following:¶
(a) The brochure "Understanding Claim Closure and Your Rights";¶
(b) A copy of summary worksheet Form 2807 containing information and findings that result in the data appearing on the Notice of Closure;¶
(c) An accurate description of the physical requirements of the worker's job held at the time of injury unless it is not required under (2)(a) or (2)(c) of this rule or it was previously provided under (2)(c)(A) of this rule;¶
(d) The Updated Notice of Acceptance at Closure which clearly identifies all accepted conditions in the claim and specifies those which have been denied and are on appeal or which were the basis for this opening of the claim; and¶
(e) A cover letter that:¶
(A) Specifically explains why the claim has been closed (e.g., expiration of a period of suspension without the worker resolving the problems identified, an attending physician stating the worker is medically stationary, worker failure to treat without attending physician authorization or establishing good cause for not treating);¶
(B) Lists and describes enclosed documents; and¶
(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.¶
(8) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:¶
(a) The worker;¶
(b) The employer;¶
(c) The director; and¶
(d) The worker's attorney, if the worker is represented.¶
(9) If the worker is deceased at the time the Notice of Closure is issued:¶
(a) The worker's copy of the notice must be addressed to the estate of the worker and mailed to the worker's last known address.¶
(b) Copies of the notice may be mailed to any known or potential beneficiaries to the worker's estate. If a copy of

the notice is mailed to a beneficiary, it must be mailed by both regular mail and certified mail return receipt requested.¶
(10) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.¶
(11) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.¶
(12) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:¶
(a) To recover payments for permanent disability which were made prematurely;¶
(b) To recover overpayments for temporary disability; and¶
(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements, or other benefits payable under ORS 656.001 to 656.794.¶
(13) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.¶
(14) Under ORS 656.268(10), if, after claim closure, the worker becomes enrolled and actively engaged in an authorized training plan under OAR 436-120, the insurer must again close the claim consistent with the following:¶
(a) The claim must be closed when the worker ceases to be enrolled and actively engaged in the training and:¶
(A) The worker is medically stationary;¶
(B) The worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions; or¶
(C) The claim otherwise qualifies for closure under OAR 436-030-0034.¶
(b) If the worker is medically stationary, there must be a current (within 60 days before closure) determination of medically stationary status.¶
(c) For claims with dates of injury on or after January 1, 2005, permanent disability must be redetermined for work disability only. For claims with dates of injury before January 1, 2005, permanent disability must be redetermined for unscheduled disability only.¶
(d) Except for claims closed under ORS 656.268(1)(c), the insurer must have sufficient information to redetermine work disability or unscheduled disability. The requirements in section (2) of this rule regarding sufficient information apply only as necessary for the redetermination, as follows:¶
(A) For claims with dates of injury on or after January 1, 2005, the insurer must have sufficient information to determine work disability under OAR 436-035-0012. An evaluation of the adaptability factor of work disability under OAR 436-035-0012(7) through (13) must be based on a current (within 60 days before closure) medical determination of the worker's residual functional capacity.¶
(B) For claims with dates of injury before January 1, 2005, the insurer must have sufficient information to determine unscheduled disability under OAR 436-035-0008(2). An evaluation of unscheduled disability must be based on a current (within 60 days before closure) medical determination.¶
(15) When, after a claim is closed, the insurer changes or is ordered to change the worker's weekly wage upon which calculation of the work disability portion of a permanent disability award may be based, the insurer must notify the parties and the division of the change and the effect of the change on any permanent disability award. For purposes of this rule, the insurer must complete Form 1502 consistent with the instructions of the director and distribute it within 14 days of the change.
Statutory/Other Authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), ORS 656.726
Statutes/Other Implemented: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), ORS 656.726, ORS 656.210, ORS 656.212, ORS 656.214, ORS 656.745

AMEND: 436-030-0034

RULE SUMMARY: Revised rule 0034 to:

-Remove the term “authorized nurse practitioner.”

-Replace the term “physician” ("health care provider" in the temporary rules) with “provider” in section (2).

CHANGES TO RULE:

436-030-0034
Administrative Claim Closure ¶

(1) The insurer must close a claim when the worker is not medically stationary and the worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician ~~or authorized nurse practitioner~~ and for reasons within the worker's control. In order to close a claim under this section, the insurer must:¶
(a) Wait for the 30-day lack of treatment period to expire or any additional time period recommended by the attending physician ~~or authorized nurse practitioner~~ before sending the worker written notification by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented, informing the worker of the following:¶
(A) The worker's responsibility to seek medical treatment in a timely manner;¶
(B) The consequences for failing to seek treatment in a timely manner which include, but are not limited to, claim closure and possible loss or reduction of a disability award; and¶
(C) The claim will be closed unless the worker establishes within 14 days from the date the letter was sent certified mail that:¶
(i) Treatment has resumed by attending an existing appointment or scheduling a new appointment; or¶
(ii) The reasons for not treating were outside the worker's control.¶
(b) Wait the 14-day period given in the notification letter to allow the worker to provide evidence that the lack of treatment was either authorized by the attending physician or ~~authorized nurse practitioner or~~ beyond the worker's control.¶
(c) Determine whether claim closure is appropriate based on the information received.¶
(d) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited to, any irreversible findings.¶
(e) Use 30 days from the last treatment provided or any additional time period authorized by the attending physician ~~or authorized nurse practitioner~~ as the date the claim qualifies for closure on the Notice of Closure.¶
(2) Regardless of whether the worker is medically stationary, the insurer must close a claim when a worker has not sought treatment for more than 30 days with a health care provider authorized under ORS 656.005 and ORS 656.245 (e.g., a worker enrolled in a managed care organization (MCO) who treats with a p~~hysician~~rovider outside the MCO is not treating with an authorized health care provider). To close a claim under this section, the insurer must follow the requirements in section (1) of this rule and inform the worker that the reason for the impending closure is because the worker failed to treat with an authorized health care provider.¶
(3) A claim must be closed, regardless of whether the worker is medically stationary, when the worker fails to attend a mandatory closing examination for reasons within the worker's control. To close a claim under this section, the insurer must:¶
(a) Inform the worker in writing sent by certified and regular mail, with a copy sent to the worker's attorney if the worker is represented, at least 10 days prior to the mandatory closing examination of:¶
(A) The date, time, and place of the examination;¶
(B) The worker's responsibility to attend the examination;¶
(C) The consequences for failing to attend, which include, but are not limited to, claim closure and the possible loss or reduction of a disability award; and¶
(D) The worker's responsibility to provide, within seven days from the date of the scheduled examination, information to the insurer regarding why the examination was not attended, if the reason was beyond the worker's control.¶
(b) Wait seven days from the date of the missed examination to allow the worker to demonstrate good cause for failing to attend before closing the claim.¶
(c) Rate all permanent disability apparent in the record at the time of claim closure. This includes, but is not limited, to any irreversible findings.¶
(d) Use the date of the failed mandatory closing examination as the date the claim qualifies for closure on the Notice of Closure.¶
(4) The insurer may close the claim under section (1) of this rule, regardless of whether the worker is medically

stationary, when a closing examination has been scheduled between a worker and attending physician directly and the worker fails to attend the examination.¶
(5) A claim may be closed when the worker's otherwise compensable injury is not medically stationary and a major contributing cause denial has been issued on an accepted combined condition.¶
(a) The major contributing cause denial must inform the worker that claim closure may result from the issuance of the denial and provide all other information required by these rules.¶
(b) When a major contributing cause denial has been issued following the acceptance of a combined condition, the date the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability under OAR 436-030-0020(2) or the date of the denial, whichever is later.¶
(6) When two or more of the above events occur concurrently, the earliest date the claim qualifies for closure is used to close the claim.¶
(7) The attending physician ~~or authorized nurse practitioner~~, if the worker has one, must be copied on all notification and denial letters applicable to this rule.¶
(8) When the director has issued a suspension order under OAR 436-060-0095 or OAR 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.
Statutory/Other Authority: ORS 656.262, ORS 656.268, 656.726
Statutes/Other Implemented: ORS 656.268, 656.726

AMEND: 436-030-0035

RULE SUMMARY: Revised rule 0035 to:

-Remove the term “authorized nurse practitioner.”

-Replace the term “physician” (“health care provider” in the temporary rules) with “provider” in sections (3), (6), and (9).

-Replace the term “physician” (“health care provider” in the temporary rules) with “provider” in two instances and with “attending physician” in one instance in section (5).

CHANGES TO RULE:

436-030-0035
Determining Medically Stationary Status ¶

(1) A worker is medically stationary in the following circumstances:¶
(a) In initial injury claims. In an initial injury claim, a worker is medically stationary when the attending physician~~, authorized nurse practitioner,~~ or a preponderance of medical opinion declares that all accepted conditions and direct medical sequelae of accepted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(b) In new or omitted condition claims. In a new or omitted condition claim, a worker is medically stationary when the attending physician~~, authorized nurse practitioner,~~ or a preponderance of medical opinion declares that all accepted new or omitted conditions and direct medical sequelae of accepted new or omitted conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(c) In aggravation claims. In an aggravation claim, a worker is medically stationary when the attending physician~~, authorized nurse practitioner,~~ or a preponderance of medical opinion declares that all accepted worsened conditions and direct medical sequelae of accepted worsened conditions are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(d) In occupational disease claims. In an occupational disease claim, a worker is medically stationary when the attending physician~~, authorized nurse practitioner,~~ or a preponderance of medical opinion declares that all accepted occupational diseases and direct medical sequela of accepted occupational diseases are either "medically stationary" or "medically stable" or when the provider uses other language meaning the same thing.¶
(2) When there is a conflict in the medical opinions as to whether a worker is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.¶
(3) Where there is not a preponderance of medical opinion stating a worker is or is not medically stationary, deference will generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference is given to the opinion of the p~~hysician~~rovider with the greatest expertise in, and understanding of, the worker's medical condition.¶
(4) When there is a conflict as to the date upon which a worker became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.¶
(5) The insurer may request that the attending physician ~~or authorized nurse practitioner~~ concur with or comment on the closing examination when the attending physician ~~or authorized nurse practitioner~~ arranges or refers the worker for a closing examination with another p~~hysician~~rovider. When the insurer closes a claim relying on an independent medical examination to support a preponderance of opinion establishing medically stationary status, before issuing the closure the insurer must request the attending physician ~~or authorized nurse practitioner~~ to concur with or comment on the independent medical examination. A concurrence with another p~~hysician~~rovider's report is an agreement in every particular, including the medically stationary impression and date, unless the attending physician expressly states to the contrary and explains the reasons for disagreement. Concurrence cannot be presumed in the absence of the attending physician's response.¶
(6) A worker is medically stationary on the date so specified by a p~~hysician~~rovider. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. P~~hysician~~rovider projected medically stationary dates cannot be used to establish a medically stationary date.¶
(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for closing medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.¶
(8) If a worker dies and the attending physician has not established a medically stationary date, for purposes of

claim closure, the medically stationary date is the date of death.¶
(9) Notwithstanding any other provision of this rule, a p~~hysician or nurse practition~~rovider may not retroactively determine a worker to be medically stationary more than 60 days prior to the date of the determination, except in the case of claims that are subject to ORS 656.268 (13). If the medically stationary date under sections (1), (4), (5), or (6) of this rule is more than 60 days prior to the date of the determination, the medically stationary date is the 60th day prior to the date of the determination.
Statutory/Other Authority: ORS 656.268 (OL2022, ch. 73, sections 4 & 5), ORS 656.726
Statutes/Other Implemented: ORS 656.268 (OL2022, ch. 73, sections 4 & 5)

AMEND: 436-030-0115

RULE SUMMARY: Revised rule 0115 removes the term “authorized nurse practitioner.”

CHANGES TO RULE:

436-030-0115
Reconsideration of Notices of Closure ¶

(1) A worker, insurer, or beneficiary may request reconsideration of a Notice of Closure as provided in ORS 656.268.¶
(2) Under ORS 656.218(4), a worker's estate may request reconsideration of a Notice of Closure if the worker dies before filing a request and there are no persons entitled to receive death benefits under ORS 656.204.¶
(3) A request for reconsideration may be made by mailing, phoning, or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005 and 436-030-0145(1). The reconsideration proceeding begins as described in OAR 436-030-0145(2).¶
(4) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician ~~or authorized nurse practitioner~~ at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed under OAR 436-030-0165(9) because the worker's condition is not medically stationary, medical evidence submitted may address the worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).¶
(5) All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record under ORS 656.268(6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments, written statements, and sworn affidavits from the parties.¶
(6) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:¶
(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.¶
(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but may not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.¶
(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter, the costs for the original transcript and one copy for each party, and the cost of necessary interpreter services. An original transcript of the deposition must be sent to the department and each party must be sent a copy of the transcript.¶
(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.¶
(7) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will review those issues raised by the parties and the requirements under ORS 656.268(1). Once the reconsideration proceeding is initiated, issues must be raised and further evidence submitted within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed under ORS 656.268(6).
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.218, 656.268

AMEND: 436-030-0155

RULE SUMMARY: Revised rule 0155 to:

-Remove the term “authorized nurse practitioner.”

-Replace the term “physician” (“health care provider” in the temporary rules) with “provider” in section (4), subsection (4)(a), and subsection (4)(b)

CHANGES TO RULE:

436-030-0155
Reconsideration Record ¶

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding.¶
(a) The record is maintained by the division and consists of all documents and material documented as received by the director prior to the issuance of the Order on Reconsideration, unless the document is an exact duplicate of what is in the file then the director is not required to retain the duplicate document.¶
(b) The insurer or self-insured employer may not send billing information and duplicate documents to the department, unless specifically requested by the director.¶
(c) Evidence stored by the parties on audio media and submitted as part of the reconsideration record may only be submitted in transcribed form.¶
(2) Except as noted in this section, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.¶
(3) The director will send non-medical information, nursing notes, or physical therapy treatment notes to the arbiter if:¶
(a) A party requests the director to submit those specific materials;¶
(b) The party identifies and provides the director with specific dates of those materials requested to be submitted; and¶
(c) The materials otherwise meet the requirements of this rule.¶
(4) When any surveillance video obtained prior to closure has been submitted to a p~~hysician~~rovider involved in the evaluation or treatment of the worker, it must be provided for arbiter review.¶
(a) Surveillance video provided for arbiter review must have been reviewed prior to claim closure by a p~~hysician~~rovider involved in the evaluation or treatment of the worker.¶
(b) All written materials previously forwarded to a p~~hysician~~rovider along with the surveillance video, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted.¶
(c) Surveillance video must be labeled according to the date and total time of the recording.¶
(5) When reconsideration is requested, the insurer is required to provide the director and the other parties with a copy of all documents contained in the record at claim closure. For cases involving a health care provider who must meet criteria other than those of an attending physician or who practices under contract with a managed care organization, the insurer must provide documentation of the health care provider's authority to act as an attending physician. Responses of the parties to the medical arbiter report will be included in the record if received prior to completion of the reconsideration proceeding.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.268

AMEND: 436-030-0165

RULE SUMMARY: Revised rule 0165 to:

-Replace the term “physician” with “medical arbiter” in sections (1), (2), and (3).

-Replace the term “doctors” with “medical arbiters” in paragraph (1)(b)(B).

-Replace the term “physician” with “provider qualified to be an attending physician under ORS 656.005(12)(b)(A).”

CHANGES TO RULE:

436-030-0165
Medical Arbiter Examination Process ¶

(1) The director will select a medical arbiter ~~physician~~ or a panel of ~~physician~~medical arbiters in accordance with ORS 656.268(8).¶
(a) For the purpose of this rule, a "panel" ~~of physicians~~ is defined as two or three medical arbiters.¶
(b) When a panel medical arbiter examination is requested, the director will generally appoint three medical arbiters. The director may consider the following criteria when determining whether to appoint two medical arbiters instead:¶
(A) The location of the worker;¶
(B) The specialties of the ~~docto~~medical arbiters needed for the medical arbiter examination; and¶
(C) The time frame for completing the reconsideration process.¶
(c) Any party that objects to a ~~physician~~medical arbiter on the basis that the ~~physician~~medical arbiter is not qualified under ORS 656.005(12)(b)(A) must notify the director of the specific objection before the examination. If the director determines that the ~~physician~~medical arbiter is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different ~~physician~~medical arbiter.¶
(d) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a p~~hysician~~rovider qualified to be an attending physician under ORS 656.005(12)(b)(A) who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(8).¶
(e) Arbiters or panel members will not include any health care provider whose examination or treatment is the subject of the review.¶
(f) The insurer must pay all costs related to the completion of the medical arbiter process in this rule. These costs may include, but are not limited to, costs for child care, travel, meals, lodging, and an amount equivalent to the worker's net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if the worker does not receive benefits under ORS 656.210(4) during the period of absence.¶
(2) If the director determines there are enough appropriate ~~physician~~medical arbiters available to create a list of possible arbiters and it is practicable, each party will be given the opportunity to agree on a ~~physician~~medical arbiter and to remove one ~~physician~~medical arbiter from the list through the process described below:¶
(a) The director will send the list to the parties electronically or by overnight mail.¶
(b) If the parties agree on a physician, every party must send a signed, written notice of that choice to the director.¶
(c) A party can remove a ~~physician~~medical arbiter from the list, even when the parties have agreed on a ~~physician~~medical arbiter to conduct the exam, by submitting a signed, written notice of that choice to the director.¶
(d) To be effective, the written notice of agreement on or rejection of a ~~physician~~medical arbiter must be received by the director within three working days of the date the director sent the list.¶
(3) The worker's disability benefits will be suspended when the director determines the worker failed to attend or cooperate with the medical arbiter examination, unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The worker must call the director within 24 hours of the missed examination to provide any "good cause" reason.¶
(a) Notice of the examination will be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney, if the worker is represented.¶
(b) For the purposes of this rule, non-cooperation includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the ~~physician~~medical arbiter reports the findings as medically invalid.¶
(c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause."¶
(4) If a worker misses the medical arbiter examination, the director will determine whether or not there was a "good cause" reason for missing the examination.¶

(5) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with the arbiter, the worker's disability benefits will be suspended and the reconsideration proceeding postponed for up to an additional 60 days.¶
(6) The suspension will be lifted if any of the following occur during the additional 60-day postponement period:¶
(a) The worker establishes a "good cause" reason for missing or failing to cooperate with the examination;¶
(b) The worker withdraws the request for reconsideration; or¶
(c) The worker attends and cooperates with a rescheduled arbiter examination.¶
(7) If none of the events that end the suspension under section (6) of this rule occur before the expiration of the 60-day additional postponement, the suspension of benefits will remain in effect.¶
(8) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment.¶
(a) The parties must submit to the director any issues they wish the medical arbiter or panel of medical arbiters to address within 14 days of the date of the director's notice of the start of the reconsideration proceeding. The parties may not submit issues directly to the medical arbiter or panel of medical arbiters. The medical arbiter or panel of medical arbiters will only consider issues appropriate to the reconsideration proceeding.¶
(b) The report of the medical arbiter or panel of medical arbiters must address all questions raised by the director.¶
(c) The medical arbiter will provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer within five working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0060 and must be paid by the insurer.¶
(9) When a worker's medical condition prevents the worker from fully participating in a medical arbiter examination that must be conducted to determine findings of impairment, the director may send a letter to the parties requesting consent to defer the reconsideration proceeding. The medical condition that prevents the worker from participating in the medical arbiter examination does not need to be related to the work injury.¶
(a) If the parties agree to the deferral, the reconsideration proceeding will be deferred until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the worker's impairment may be submitted at the time the parties notify the director that the medical arbiter examination can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (8).¶
(b) If deferral is not appropriate, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).¶
(10) All costs related to record review, examinations, tests, and reports of the medical arbiter must be billed and paid under OAR 436-009-0010, 436-009-0030, 436-009-0040, and 436-009-0060.¶
(11) When requested by the board, the director may schedule a medical arbiter examination for a worker who has appealed a Notice of Closure rescinding permanent total disability benefits under ORS 656.206.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.268, 656.325

AMEND: 436-035-0005

RULE SUMMARY: Revised rule 0005 to replace the term “physician” with “provider qualified to be an attending physician” in section (8).

CHANGES TO RULE:

436-035-0005
Definitions ¶

As used in OAR 436-035-0001 through 436-035-0500, unless the context requires otherwise:¶
(1) "Activities of daily living (ADL)" include, but are not limited to, the following personal activities required by an individual for continued well-being: eating/nutrition; self-care and personal hygiene; communication and cognitive functions; and physical activity, e.g., standing, walking, kneeling, hand functions, etc.¶
(2) "Ankylosis" means a bony fusion, fibrous union, or arthrodesis of a joint. Ankylosis does not include pseudarthrosis or articular arthropathies.¶
(3) "Date of issuance" means the mailing date of a notice of closure or Order on Reconsideration under ORS 656.268 and ORS 656.283(6).¶
(4) "Dictionary of Occupational Titles" or (DOT) means the publication of the same name by the U.S. Department of Labor, Fourth Edition Revised 1991.¶
(5) "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".¶
(6) "Earning capacity" means impairment as modified by age, education, and adaptability.¶
(7) "Irreversible findings" for the purposes of these rules are:¶
(a) Arm:¶
(A) Arm angulation;¶
(B) Radial head resection;¶
(C) Shortening;¶
(b) Eye:¶
(A) Enucleation;¶
(B) Lens implant;¶
(C) Lensectomy.¶
(c) Gonadal: Loss of gonads resulting in absence of, or an abnormally high, hormone level.¶
(d) Hand:¶
(A) Carpal bone fusion;¶
(B) Carpal bone removal.¶
(e) Kidney: Nephrectomy;¶
(f) Leg:¶
(A) Knee angulation;¶
(B) Length discrepancy;¶
(C) Meniscectomy;¶
(D) Patellectomy.¶
(g) Lung: Lobectomy;¶
(h) Shoulder:¶
(A) Acromionectomy;¶
(B) Clavicle resection.¶
(i) Spine;¶
(A) Compression, spinous process, pedicle, laminae, articular process, odontoid process, and transverse process fractures;¶
(B) Diskectomy;¶
(C) Laminectomy.¶
(j) Spleen: Splenectomy;¶
(k) Urinary tract diversion:¶
(A) Cutaneous ureterostomy without intubation;¶
(B) Nephrostomy or intubated uresterostomy;¶
(C) Uretero-Intestinal.¶
(l) Other:¶

(A) Amputations/resections;¶
(B) Ankylosed/fused joints;¶
(C) Displaced pelvic fracture ("healed" with displacement);¶
(D) Loss of opposition;¶
(E) Organ transplants (heart, lung, liver, kidney);¶
(F) Prosthetic joint replacements.¶
(8) "Medical arbiter" means a provider qualified to be an attending physician under ORS 656.005(12)(b)(A) appointed by the director under OAR 436-010-0330.¶
(9) "Offset" means to reduce a current permanent partial disability award, or portions of the award, by a prior Oregon workers' compensation permanent partial disability award from a different claim.¶
(10) "Physician's release" means written notification, provided by the attending physician to the worker and the worker's employer or insurer, releasing the worker to work and describing any limitations the worker has.¶
(11) "Pre-existing condition"¶
(a) Injury claims. For all industrial injury claims with a date of injury on or after Jan. 1, 2002, "pre-existing condition" means a condition that:¶
(A) Is arthritis or an arthritic condition; or¶
(B) Was treated or diagnosed before:¶
(i) The initial injury in a claim for an initial injury or omitted condition;¶
(ii) The onset of the new medical condition in a claim for a new medical condition; or¶
(iii) The onset of the worsened condition in a claim for an aggravation under ORS 656.273 or 656.278.¶
(b) Occupational disease claims. For all occupational disease claims with a date of injury on or after Jan. 1, 2002, "pre-existing condition" means a condition that precedes the onset of the claimed occupational disease, or precedes a claim for worsening under ORS 656.273 or 656.278.¶
(12) "Preponderance of medical evidence" or "opinion" does not necessarily mean the opinion supported by the greater number of documents or greater number of concurrences; rather it means the more probative and more reliable medical opinion based upon factors including, but not limited to, one or more of the following:¶
(a) The most accurate history,¶
(b) The most objective findings,¶
(c) Sound medical principles, or¶
(d) Clear and concise reasoning.¶
(13) "Redetermination" means a re-evaluation of disability under ORS 656.267, 656.268(10), 656.273, and 656.325.¶
(14) "Regular work" means the job the worker held at the time of injury.¶
(15) "Scheduled disability" means a compensable permanent loss of use or function that results from injuries to those body parts listed in ORS 656.214(3)(a) through (5).¶
(16) "Social-vocational factors" means age, education, and adaptability factors under ORS 656.726(4)(f).¶
(17) "Superimposed condition" means a condition that arises after the compensable injury or disease that contributes to the worker's overall disability or need for treatment but is not the result of the original injury or disease. Disability from a superimposed condition is not rated. For example: The compensable injury results in a low back strain. Two months after the injury, the worker becomes pregnant (non-work related). The pregnancy is considered a "superimposed condition."¶
(18) "Unscheduled disability" means permanent loss of earning capacity as a result of a compensable injury, as described in these rules and arising from those losses under OAR 436-035-0330 through 436-035-0450.¶
(19) "Work disability," for the purposes of determining permanent disability, means impairment as modified by age, education, and adaptability to perform the job at which the worker was injured.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.005, 656.214, 656.267, 656.268, 656.273, 656.325, 656.726

AMEND: 436-035-0007

RULE SUMMARY: Revised rule 0007 to:

-Remove the term “authorized nurse practitioner.”

-In sections (9) and (11), to replace the term “physician” with “provider.”

CHANGES TO RULE:

436-035-0007
General Principles ¶

(1) Eligibility for impairment.¶
(a) Eligibility, generally. A worker is eligible for an award for impairment if:¶
(A) The worker suffers permanent loss of use or function of a body part or system;¶
(B) The loss is established by a preponderance of medical evidence based upon objective findings of impairment; and¶
(C) The loss is due to the compensable injury.¶
(b) Apportionment. A worker's award for impairment is limited to the amount of impairment caused by the compensable injury subject to the following:¶
(A) If the loss of use or function of a body part or system is entirely caused by the compensable injury, the worker is eligible for the full award provided for the loss under the rating standards in this division of rules.¶
(B) If the loss of use or function of a body part or system is partly caused by the compensable injury, the following provisions apply:¶
(i) The worker is eligible for an award for impairment for:¶
(I) The portion of the loss due to the compensable injury;¶
(II) The portion of the loss caused by a condition that does not qualify as a pre-existing condition but that existed before the initial injury in an initial injury or omitted condition claim, before the onset of the accepted new medical condition in a new condition claim, or before the onset of the accepted worsened condition in an aggravation claim; and¶
(III) The portion of the loss caused by a condition that qualifies as a pre-existing condition, but is not part of a denial of a combined condition.¶
(ii) The worker is not eligible for an award for impairment for the portion of the loss caused by:¶
(I) A superimposed condition;¶
(II) A pre-existing condition, as defined by OAR 436-035-0005(11) and ORS 656.005(24), if the pre-existing condition was accepted as part of a combined condition and there is a subsequent denial of the combined condition, unless the pre-existing condition is otherwise compensable under ORS 656.225; or¶
(III) A combined condition denied in its entirety.¶
(C) If the loss of use or function of a body part or system is not caused in any part by the compensable injury, the loss is not due to the compensable injury and the worker is not eligible for an award for impairment.¶
(2) Eligibility for work disability. An award for impairment is modified by the factors of age, education, and adaptability if the worker is eligible for an award for work disability. A worker is eligible for an award for work disability if:¶
(a) The worker is eligible for an award for impairment;¶
(b) An attending physician ~~or authorized nurse practitioner~~ has not released the worker to the job held at the time of injury;¶
(c) The worker has not returned to the job held at the time of injury; and¶
(d) The worker is unable to return to the job held at the time of injury because the worker has a permanent work restriction that is caused in any part by the compensable injury.¶
(3) When a new or omitted medical condition has been accepted since the last arrangement of compensation, the extent of permanent disability must be redetermined.¶
(a) Redetermination includes the rating of the new impairment attributed to the accepted new or omitted medical condition and the reevaluation of the worker's social-vocational factors. The following applies to claims with a date of injury on or after Jan. 1, 2005:¶
(A) When there is a previous work disability award and there is no change in the worker's restrictions but impairment values increase, work disability must be awarded based on the additional impairment.¶
(B) When there is not a previous work disability award but the accepted new or omitted medical condition creates restrictions that do not allow the worker to return to regular work, the work disability must be awarded based on any previous and current impairment values.¶
(b) When performing a redetermination of the extent of permanent disability under this section, the amount of

impairment caused by a condition other than the accepted new or omitted condition is not re-evaluated and is given the same impairment value as established at the last arrangement of compensation.¶
(4) When a worker has a prior award of permanent disability under Oregon workers' compensation law, disability is determined under OAR 436-035-0015 (offset) for purposes of determining disability only as it pertains to multiple Oregon workers' compensation claims.¶
(5) Establishing impairment.¶
(a) Impairment is established based on objective findings of the attending physician under ORS 656.245(2)(b)(C) and OAR 436-010-0280.¶
(b) On reconsideration, when a medical arbiter is used, impairment is established based on objective findings of the medical arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should be used.¶
(c) A determination that loss of use or function of a body part or system is due to the compensable injury is a finding regarding the worker's impairment.¶
(d) A determination that loss of use or function of a body part or system is due to the compensable injury must be established by the attending physician or medical arbiter.¶
(6) Objective findings made by a consulting physician or other medical providers (e.g., occupational or physical therapists) at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings.¶
(7) If there is no measurable impairment under these rules, no award of permanent partial disability is allowed.¶
(8) Pain is considered in the impairment values in these rules to the extent that it results in valid measurable impairment. For example: The medical provider determines that giveaway weakness is due to pain attributable to the compensable injury. If there is no measurable impairment, no award of permanent disability is allowed for pain. To the extent that pain results in disability greater than that evidenced by the measurable impairment, including the disability due to expected waxing and waning of the worker's compensable injury, this loss of earning capacity is considered and valued under OAR 436-035-0012 and is included in the adaptability factor.¶
(9) Methods used by the examiner for making findings of impairment are the methods described in these rules and further outlined in Bulletin 239, and are reported by the p~~hysician~~rovider in the form and format required by these rules.¶
(10) Range of motion is measured using the goniometer, except when measuring spinal range of motion; then an inclinometer must be used. Reproducibility of abnormal motion is used to validate optimum effort.¶
(a) For obtaining goniometer measurements, center the goniometer on the joint with the base in the neutral position. Have the worker actively move the joint as far as possible in each motion with the arm of the goniometer following the motion. Measure the angle that subtends the arc of motion. To determine ankylosis, measure the deviation from the neutral position.¶
(b) There are three acceptable methods for measuring spinal range of motion: the simultaneous application of two inclinometers, the single fluid-filled inclinometer, and an electronic device capable of calculating compound joint motion. The examiner must take at least three consecutive measurements of mobility, which must fall within 10% or 5 degrees (whichever is greater) of each other to be considered consistent. The measurements must be repeated up to six times to obtain consecutive measurements that meet these criteria. Inconsistent measurements may be considered invalid and that portion of the examination disqualified. If acute spasm is noted, the worker should be re-examined after the spasm resolves.¶
(11) Validity is established for findings of impairment under the criteria noted in these rules and further outlined in Bulletin 239, unless the validity criteria for a particular finding is not addressed, or is determined by p~~hysician~~rovider opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment that are determined to be ratable under these rules are rated unless the p~~hysician~~rovider determines the findings are invalid. When findings are determined invalid, the findings receive a value of zero. If the validity criteria are not met but the p~~hysician~~rovider determines the findings are valid, the p~~hysician~~rovider must provide a written rationale, based on sound medical principles, explaining why the findings are valid. For purposes of this rule, the straight leg raising validity test (SLR) is not the sole criterion used to invalidate lumbar range of motion findings.¶
(12) Except for contralateral comparison determinations under OAR 436-035-0011(3), loss of opposition determination under OAR 436-035-0040, averaging muscle values under OAR 436-035-0011(8), and impairment determined under ORS 656.726(4)(f), only impairment values listed in these rules are to be used in determining impairment. Prorating or interpolating between the listed values is not allowed. For findings that fall between the listed impairment values, the next higher appropriate value is used for rating.¶
(13) Values found in these rules consider the loss of use, function, or earning capacity directly associated with the compensable injury. When a worker's impairment findings do not meet the threshold (minimum) findings established in these rules, no value is granted.¶
(a) Not all surgical procedures result in loss of use, function, or earning capacity. Some surgical procedures improve

the use and function of body parts, areas, or systems or ultimately may contribute to an increase in earning capacity. Accordingly, not all surgical procedures receive a value under these rules.¶
(b) Not all medical conditions or diagnoses result in loss of use, function, or earning capacity. Accordingly, not all medical conditions or diagnoses receive a value under these rules.¶
(14) Waxing and waning of signs or symptoms related to a worker's compensable injury are already contemplated in the values provided in these rules. There is no additional value granted for the varying extent of waxing and waning of the compensable injury. Waxing and waning means there is not an actual worsening of the condition under ORS 656.273.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.726, ORS 656.005, ORS 656.214, ORS 656.245, ORS 656.267, ORS 656.268, ORS 656.273

AMEND: 436-035-0009

RULE SUMMARY: Revised rule 0009 to remove the term “authorized nurse practitioner.”

CHANGES TO RULE:

436-035-0009
Calculating Disability Benefits (Date of Injury on or after 1/1/2005) ¶

(1) Permanent impairment is expressed as a percent of the whole person and the impairment value will not exceed 100% of the whole person.¶
(2) If the impairment results from injury to more than one extremity, area, or system, the whole person values for each are combined (not added) to arrive at a final impairment value.¶
(3) Only permanent impairment is rated for those workers with a date of injury prior to January 1, 2006, and who:¶
(a) Return to and are working at their regular work on the date of issuance;¶
(b) The attending physician ~~or authorized nurse practitioner~~ releases to regular work and the work is available, but the worker fails or refuses to return to that job; or¶
(c) The attending physician ~~or authorized nurse practitioner~~ releases to regular work, but the worker's employment is terminated for cause unrelated to the injury.¶
(4) Only permanent impairment is rated for those workers with a date of injury on or after January 1, 2006, and who have been released or returned to regular work by the attending physician ~~or authorized nurse practitioner~~.¶
(5) To calculate the impairment benefit due to the worker, use the following steps:¶
(a) Determine the percent of impairment under these rules.¶
(b) Multiply the percent of impairment determined in (a) by 100 per ORS 656.214.¶
(c) Multiply the result from (b) by the state's average weekly wage at the time of injury as defined by ORS 656.005 and illustrated in Bulletin 111.¶
(d) The result in (c) is the total impairment benefit, which is paid regardless of the worker's return to work status. In the absence of social-vocational factoring as a result of the worker's return to work status, this is also the permanent partial disability award.[Example not included. See ED. NOTE.]¶
(6) If the worker has not met the return or release to regular work criteria in section (3) or (4) of this rule, the worker receives both an impairment and work disability benefit, and the total permanent partial disability award is calculated as follows.¶
(a) Determine the percent of impairment as a whole person (WP) value under these rules.¶
(b) Determine the social-vocational factor, under OAR 436-035-0012, and add it to (a).¶
(c) Multiply the result from (b) by 150 per ORS 656.214.¶
(d) Multiply the result from (c) by worker's average weekly wage as calculated under ORS 656.210.¶
(A) Supplemental disability is not considered in the determination of the worker's average weekly wage when calculating work disability.¶
(B) The worker's average weekly wage can be no less than 50% and no more than 133% of the state's average weekly wage at the time of injury when determining work disability benefits.¶
(e) Add the result from (d) to the impairment benefit value, which would be calculated using the method in section (4) of this rule.¶
(f) The result from (e) is the permanent partial disability award that would be due the worker. [Example not included. See ED. NOTE.]¶
[ED. NOTE: Examples referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.005, 656.214, 656.268, 656.726

AMEND: 436-035-0011

RULE SUMMARY: Rule 0011 is revised to replace the term “physician” with “provider” in section (7) and subsection (7)(b)

CHANGES TO RULE:

436-035-0011
Determining Percent of Impairment ¶

(1) The total impairment rating for a body part cannot be more than 100% of the body part.¶
(2) When rating disability the movement in a joint is measured in active degrees of motion. Impairment findings describing lost ranges of motion are converted to retained ranges of motion by subtracting the measured loss from the normal of full ranges established in these rules.¶
(a) Range of motion values for each direction in a single joint are first added, then combined with other impairment findings. [~~Example not included.~~See ED. NOTE.]¶
(b) Range of motion values for multiple joints in a single body part (e.g., of a finger) are determined by finding the range of motion values for each joint (e.g., MCP, PIP, DIP) and combining those values for an overall loss of range of motion value for that body part. This value is then combined with other impairment values.¶
(3) The range of motion or laxity (instability) of an injured joint is compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease or when either joint's range of motion is zero degrees or is ankylosed. The strength of an injured extremity, shoulder, or hip may be compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease.~~¶~~
~~Instability example:¶~~
~~The injured knee is reported to have severe instability of the anterior cruciate ligament. The standards grant an impairment value of 15% for severe instability of the anterior cruciate ligament.¶~~
~~The contralateral knee is reported to have mild instability of the anterior cruciate ligament. The standards grant an impairment value of 5% for mild instability of the anterior cruciate ligament.¶~~
~~A proportion is established by subtracting the contralateral instability of 5% from the 15% for the injured joint which = 10% impairment for the instability.¶~~
~~Strength example:¶~~
~~The injured deltoid muscle is reported to have 3/5 strength. The standards note 3/5 strength = 50%.¶~~
~~The contralateral deltoid muscle is reported to have 4+/5 strength. The standards note 4+/5 strength = 10%.¶~~
~~A proportion is established by subtracting the contralateral strength of 10% from the 50% for the injured arm which = 40%. This percentage is then used to determine the loss of strength for the injured deltoid.¶~~
~~Range of motion examples:¶~~
~~Flexion (knee): 80° retained on injured side, the contralateral joint flexes to 140°.¶~~
~~A proportion is established to determine the expected degrees of flexion since 140° has been established as normal for this worker.¶~~
~~One method of determining this proportion is: 80/140 = X/150.¶~~
~~X = expected retained range of motion compared to the established norm of 150° upon which flexion is determined under these rules. X, in this case, equals 86°.¶~~
~~86° of retained flexion of the knee is calculated under these rules, after rounding, to 23% impairment.¶~~
~~Extension (knee): 35° retained on injured side, the contralateral joint extends to 15°. First, find the complement, i.e., 150 - 15 =135 (uninjured) and 150 - 35 = 115 (injured). Next, using the same method as for flexion, 115/135 = X/150, or, X = 127.77. Then, revert back, so, 150 - 127.77 = 22.23 rounded to 22° for an impairment value of 9%.~~ [See examples in attachment.]¶
(a) If the motion of the injured or contralateral joint exceeds the values for ranges of motion established under these rules, the values established under these rules are maximums used to establish impairment.¶
(b) When the contralateral joint has a history of injury or disease, the findings of the injured joint are valued based upon the values established under these rules.¶
(4) Specific impairment findings (e.g., weakness, reduced range of motion, etc.) are awarded in whole number increments. This may require rounding non-whole number percentages and contralateral comparison degrees of motion for given impairment findings before combining with any other applicable impairment value.¶
(a) Except for subsection (b) of this section, before combining, the sum of the impairment values is rounded to the nearest whole number. For the decimal portion of the number, point 5 and above is rounded up, below point 5 is rounded down. [~~Example not included.~~See ED. NOTE.]¶
(b) When the sum of impairment values is greater than zero and less than 0.5, a value of 1% will be granted. [~~Example not included.~~See ED. NOTE.]¶

(5) If there are impairment findings in two or more body parts in an extremity, the total impairment findings in the distal body part are converted to a value in the most proximal body part under the applicable conversion chart in these rules. This conversion is done prior to combining impairment values for the most proximal body part. [~~Example not included.~~ See ED. NOTE.]¶
(6) Except as otherwise noted in these rules, impairment values to a given body part, area, or system are combined as follows:¶
(a) The combined value is obtained by inserting the values for A and B into the formula A + B(1.0 - A). The larger of the two numbers is A and the smaller is B. The whole number percentages of impairment are converted to their decimal equivalents (e.g., 12% converts to .12; 3% converts to .03). The resulting percentage is rounded to a whole number as determined in section (1) of this rule. Upon combining the largest two percentages, the resulting percentage is combined with any lesser percentage(s) in descending order using the same formula until all percentages have been combined prior to performing further computations. After the calculations are completed, the decimal result is then converted back to a percentage equivalent. Example: .12 + .03(1.0 - .12) =.12 + .03(.88) =.12 + .0264 =.1464 = 14.6 = 15. [~~Example not included.~~ See ED. NOTE.]¶
(b) Impairment values for a given body part, area, or system must be combined before combining with other impairment values. If the given body part is an upper or lower extremity, ear(s), or eye(s) then the impairment value is to be converted to a whole person value before combining with other impairment values, except when the date of injury for the claim is prior to Jan. 1, 2005. [~~Example not included.~~ See ED. NOTE.]¶
(7) Loss of strength is determined using the modified 0 to 5 international grading system described below. The grade of strength is reported by the p~~hysician~~rovider and assigned a percentage value from the table in subsection (a) of this section. The impairment value of the involved nerve, which supplies (innervates) the weakened muscle, is multiplied by this value. Grades identified as "++" or "--" are considered either a "+" or "-", respectively.¶
(a) The grading is valued as follows: [~~Example not included.~~ See ED. NOTE.]¶
(b) When a p~~hysician~~rovider reports a loss of strength with muscle action (e.g., flexion, extension, etc.) or when only the affected muscle(s) is identified, anatomy texts or the AMA Guides to the Evaluation of Permanent Impairment may be referenced to identify the specific muscle(s), peripheral nerve(s) or spinal nerve root(s) involved. A copy of the standards referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.¶
(8) For muscles supplied (innervated) by the same nerve, the loss of strength is determined by averaging the percentages of impairment for each involved muscle to arrive at a single percentage of impairment for the involved nerve. [~~Example not included.~~ See ED. NOTE.]¶
(9) When multiple nerves have impairment findings found under these rules, these impairment values are first combined for an overall loss of strength value for the body part before combining with other impairment values.¶
(10) When a joint is ankylosed in more than one direction or plane, the largest ankylosis value is used for rating the loss or only one of the values is used if they are identical. This value is granted in lieu of all other range of motion or ankylosis values for that joint.¶
[~~Publications: Publication~~ED. NOTE: Examples referenced are available from the agency.]¶¶
[~~ED. NOTE: Example~~ Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.005, 656.214, 656.268, 656.726

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-035-0011.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336742

AMEND: 436-035-0260

RULE SUMMARY: Rule 0260 is revised to replace the term “physician” with “provider” in sections (1) and (5)

CHANGES TO RULE:

436-035-0260
Visual Loss ¶

(1) Visual loss due to a work-related illness or injury is rated for central visual acuity, integrity of the peripheral visual fields, and ocular motility. For ocular disturbances that cause visual impairment that is not reflected in visual acuity, visual fields or ocular motility refer to section (5) of this rule. Visual loss is measured with best correction, using the lenses recommended by the worker's p~~hysician~~rovider. For lacrimal system disturbances refer to OAR 436-035-0440.¶
(2) Ratings for loss in central visual acuity are calculated for each eye as follows:¶
(a) Reports for central visual acuity must be for distance and near acuity.¶
(b) The ratings for loss of distance acuity are as follows, reported in standard increments of Snellen notation for English and Metric 6: [Ratings not included. See ED. NOTE.]¶
(c) The ratings for loss of near acuity are as follows: reported in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation: [Ratings not included. See ED. NOTE.]¶
(d) Once the ratings for near and distance acuity are found, add them and divide by two. The value which results is the rating for lost central visual acuity.¶
(e) If a lens has been removed and a prosthetic lens implanted, an additional 25%, is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).¶
(f) If a lens has been removed and there is no prosthetic lens implanted, an additional 50% is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).¶
(g) The table below may be substituted for combining central visual acuity and the loss of a lens for a total central visual acuity. The table displays the percent loss of central vision for the range of near and distance acuity combined with lens removal for a total central visual acuity. The upper figure is to be used when the lens is present (as found in (d)), the middle figure is to be used when the lens is absent and a prosthetic lens has been implanted (as found in (e)), and the lower figure is to be used when the lens is absent with no implant (as found in (f)). If near acuity is reported in Revised Jaeger Standard or American Point-type, convert these findings to Near Snellen for rating purposes under (2)(c) of this rule when using this table.¶
(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using kinetic perimetry and a III/4e stimulus. The examiner must use a device that can produce the findings required to complete one of the following reporting methods: ¶
(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or¶
(b) Using a perimetric chart which indicates the extent of retained vision for each of the eight standard 45° meridians out to 90°. The directions and normal extent of each meridian are as follows: [Ratings not included. See ED. NOTE.]¶
(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.¶
(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.¶
(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.¶
(4) Ratings for ocular motility impairment resulting in binocular diplopia are determined as follows:¶
(a) Determine the single highest value of loss for diplopia noted on each of the standard 45° meridians as listed in the following table.¶
(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more is rated as 100% of the eye. As an example: Diplopia on looking horizontally off center from 30 degrees in a left direction is valued at 10%. Diplopia in the same eye when looking horizontally off center from 21 to 30 degrees in a right direction is valued at 20%. The impairments for diplopia in both ranges are added, so the impairment rating would be 10% plus 20% resulting in a total loss of ocular motility of 30%.¶
(5) To the extent that stereopsis (depth perception), glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields

or ocular motility will be combined with an additional 5% when in the opinion of the p~~hysician~~rovider the impairment is moderate, 10% if the impairment is severe.¶
(6) The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and loss of ocular motility and loss for other conditions specified in section (5) of this rule.¶
(7) The total rating for binocular loss is figured as follows:¶
(a) Find the percent of monocular loss for each eye.¶
(b) Multiply the percent of loss in the better eye by three.¶
(c) Add to that result the percent of loss in the other eye.¶
(d) Divide this sum by four. The result is the total percentage of binocular loss.¶
(e) This method is expressed by the formula 3(A) + B 4. "A" is the percent of loss in the better eye; "B" is the percent of loss in the other eye.¶
(8) Use the method (monocular or binocular) which results in the greater impairment rating.¶
(9) Enucleation of an eye is rated at 100% of an eye.¶
[ED. NOTE: Formula and Ratings referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.005, 656.214, 656.268, 656.726

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-035-0260.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336743

AMEND: 436-035-0360

RULE SUMMARY: Rule 0360 is revised to replace the term “physician” with “provider” in section (1)

CHANGES TO RULE:

436-035-0360
Spinal Ranges of Motion ¶

(1) For the purpose of determining impairment due to loss of spinal range of motion, sections (2) through (12) of this rule apply when the p~~hysician~~rovider uses an inclinometer to measure impairment.¶
(2) The following ratings are for loss of flexion in the cervical region: [Ratings not included. See ED. NOTE.]¶
(3) The following ratings are for loss of extension in the cervical region: [Ratings not included. See ED. NOTE.]¶
(4) The following ratings are for loss of right or left lateral flexion in the cervical region: [Ratings not included. See ED. NOTE.]¶
(5) The following ratings are for loss of right or left rotation in the cervical region: [Ratings not included. See ED. NOTE.]¶
(6) The following ratings are for loss of flexion in the thoracic region: [Ratings not included. See ED. NOTE.]¶
(7) The following ratings are for loss of right or left rotation in the thoracic region: [Ratings not included. See ED. NOTE.]¶
(8) The following ratings are for loss of flexion in the lumbosacral region: [Ratings not included. See ED. NOTE.]¶
(9) The following ratings are for loss of extension in the lumbosacral region: [Ratings not included. See ED. NOTE.]¶
(10) The following ratings are for loss of right or left lateral flexion of the lumbosacral region: [Ratings not included. See ED. NOTE.]¶
(11) For a total impairment value due to loss of motion, as measured by inclinometer, in any of the cervical, thoracic or lumbosacral regions, add (do not combine) values for loss of motion for each region.¶
(12) In order to rate range of motion loss and surgery in one region, combine (do not add) the total range of motion loss in that region with the appropriate total surgical impairment value of the corresponding region. Combine the value from each region to find the total impairment of the spine.¶
[ED. NOTE: Ratings referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.005, 656.214, 656.268, 656.726

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-035-0360.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336744

AMEND: 436-035-0380

RULE SUMMARY: Rule 0380 is revised to replace the term “physician” with “provider” in section (1)

CHANGES TO RULE:

436-035-0380
Cardiovascular System ¶

(1) Impairments of the cardiovascular system are determined based on objective findings that result in the following conditions: valvular heart disease, coronary heart disease, hypertensive cardiovascular disease, cardiomyopathies, pericardial disease, or cardiac arrhythmias. Each of these conditions will be described and quantified. In most circumstances, the p~~hysician~~rovider should observe the patient during exercise testing.¶
(2) Valvular Heart Disease: Impairment resulting from work related valvular heart disease is rated according to the following classes: [See attached class descriptions.]¶
(3) Coronary Heart Disease: Impairment resulting from work related coronary heart disease is rated according to the following classes: [See attached class descriptions.]¶
(4) Hypertensive Cardiovascular Disease: Impairment resulting from work related hypertensive cardiovascular disease is rated according to the following classes: [See attached class descriptions.]¶
(5) Cardiomyopathy: Impairment resulting from work related cardiomyopathies is rated according to the following classes: [See attached class descriptions.]¶
(6) Pericardial Disease: Impairment resulting from work related pericardial disease is rated according to the following classes: [See attached class descriptions.]¶
(7) Arrythmias: Impairment resulting from work related cardiac arrhythmias* is rated according to the following classes: [See attached class descriptions.]¶
(8) For heart transplants an impairment value of 50% is given. This value is combined with any other findings of impairment of the heart.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.726, ORS 656.005, ORS 656.214, ORS 656.268

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-035-0380.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336745

AMEND: 436-035-0385

RULE SUMMARY: Rule 0385 is revised to replace the term “physician” with “provider” in section (5)

CHANGES TO RULE:

436-035-0385
Respiratory System ¶

(1) For the purpose of this rule, the following definitions apply:¶
(a) FVC is forced vital capacity.¶
(b) FEV1 is forced expiratory volume in the first second.¶
(c) Dco refers to diffusing capacity of carbon monoxide.¶
(d) VO2 Max is measured exercise capacity.¶
(2) Lung impairment is rated according to the following classes:¶
(a) Class 1: 0% for FVC greater than or equal to 80% of predicted, and FEV1 greater than or equal to 80% of predicted, and FEV1/FVC greater than or equal to 70%, and Dco greater than or equal to 80% of predicted; or VO2 Max greater than 25 ml/(kg x min).¶
(b) Class 2: 18% for FVC between 60% and 79% of predicted, or FEV1 between 60% and 79% of predicted, or FEV1/FVC between 60% and 69%, or Dco between 60% and 79% of predicted, or VO2 Max greater than or equal to 20 ml/(kg x min) and less than or equal to 25 ml/(kg x min).¶
(c) Class 3: 38% for FVC between 51% and 59% of predicted, or FEV1 between 41% and 59% of predicted, or FEV1/FVC between 41% and 59%, or Dco between 41% and 59% of predicted, or VO2 Max greater than or equal to 15 ml/(kg x min) and less than 20 ml/(kg x min).¶
(d) Class 4: 75% for FVC less than or equal to 50% of predicted, or FEV1 less than or equal to 40% of predicted, or FEV1/FVC less than or equal to 40%, or Dco less than or equal to 40% of predicted, or VO2 Max less than 15 ml/(kg x min).¶
(3) Lung cancer - All persons with lung cancers as a result of a compensable industrial injury or occupational disease are to be considered Class 4 impaired at the time of diagnosis. At a re-evaluation, one year after the diagnosis is established, if the person is found to be free of all evidence of tumor, then the person should be rated under the physiologic parameters in OAR 436-035-0385(2). If there is evidence of tumor, the person is determined to have Class 4 impairment.¶
(4) Asthma - Reversible obstructive airway disease is rated under the classes of respiratory impairment described in section (2) of this rule. The impairment is based on the best of three successive tests performed at least one week apart at a time when the patient is receiving optimal medical therapy. In addition, a worker may also have impairment determined under OAR 436-035-0450.¶
(5) Allergic respiratory responses - For workers who have developed an allergic respiratory response to physical, chemical, or biological agents refer to OAR 436-035-0450. Methacholine inhalation testing is permitted at the discretion of the p~~hysician~~rovider. Where methacholine inhalation testing leaves the worker at risk, level of impairment may be based on review of the medical record.¶
(6) Impairment from air passage defects is determined according to the following classes: [See attached class descriptions.]¶
(7) Residual impairment from a lobectomy is valued based on the physiological parameters found under section (2) of this rule.¶
(8) For injuries that result in impaired ability to speak, the following classes are used to rate the worker's ability to speak in relation to: audibility (ability to speak loudly enough to be heard); intelligibility (ability to articulate well enough to be understood); and functional efficiency (ability to produce a serviceably fast rate of speech and to sustain it over a useful period of time).¶
(a) Class 1: 4% when speech can be produced with sufficient intensity and articular quality to meet most of the needs of everyday speech communication; some hesitation or slowness of speech may exist; certain phonetic units may be difficult or impossible to produce; listeners may require the speaker to repeat.¶
(b) Class 2: 9% when speech can be produced with sufficient intensity and articular quality to meet many of the needs of everyday speech communication; speech may be discontinuous, hesitant or slow; can be understood by a stranger but may have many inaccuracies; may have difficulty being heard in loud places.¶
(c) Class 3: 18% when speech can be produced with sufficient intensity and articular quality to meet some of the needs of everyday speech communication; often consecutive speech can only be sustained for brief periods; can converse with family and friends but may not be understood by strangers; may often be asked to repeat; has difficulty being heard in loud places; voice tires rapidly and tends to become inaudible after a few seconds.¶
(d) Class 4: 26% when speech can be produced with sufficient intensity and articular quality to meet few of the

needs of everyday speech communication; consecutive speech limited to single words or short phrases; speech is labored and impractically slow; can produce some phonetic units but may use approximations that are unintelligible or out of context; may be able to whisper audibly but has no voice.¶
(e) Class 5: 33% for complete inability to meet the needs of everyday speech communication.¶
(9) Workers with successful permanent tracheostomy or stoma should be rated at 25% impairment of the respiratory system.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.726, ORS 656.005, ORS 656.214, ORS 656.268

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-035-0385.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336746

AMEND: 436-035-0400

RULE SUMMARY: Rule 0400 is revised to replace the term “physician” with “provider” in section (3)

CHANGES TO RULE:

436-035-0400
Mental Illness ¶

(1) Accepted mental disorders resulting in impairment must be diagnosed by a psychiatrist or other mental health professional as provided for in a managed care organization certified under OAR chapter 436, Division 015.¶
(2) Diagnoses of mental disorders for the purposes of these rules follow the guidelines of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV (1994), published by the American Psychiatric Association. A copy of the standards referenced in this rule is available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301, 503-947-7810.¶
(3) The p~~hysician~~rovider describes permanent changes in mental function in terms of their affect on the worker's activities of daily living (ADLs), as defined in OAR 436-035-0005(1). Additionally, the p~~hysician~~rovider describes the affect on social functioning and deterioration or decompensation in work or work-like settings.¶
(a) Social functioning refers to an individual's capacity to interact appropriately, communicate effectively, and get along with other individuals.¶
(b) Deterioration or decompensation in work or work-like settings refers to repeated failure to adapt to stressful circumstances, which causes the individual either to withdraw from that situation or to experience exacerbations with accompanying difficulty in maintaining ADL, social relationships, concentration, persistence, pace, or adaptive behaviors.¶
(4) Loss of function attributable to permanent worsening of personality disorders may be stated as impairment only if it interferes with the worker's long-term ability to adapt to the ordinary activities and stresses of daily living. Personality disorders are rated as two classes with gradations within each class based on severity:¶
(a) Class 1: minimal (0%), mild (6%), or moderate (11%) when the worker shows little self-understanding or awareness of the mental illness; some problems with judgment; some problems with controlling personal behavior; some ability to avoid serious problems with social and personal relationships; and some ability to avoid self-harm.¶
(b) Class 2: minimal (20%), mild (29%), or moderate (38%) when the worker shows considerable loss of self control; an inability to learn from experience; and causes harm to the community or to the self.¶
(5) Loss of function attributable to permanent symptoms of affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders is rated under the following classes, with gradations within each class based on the severity of the symptoms/loss of function:¶
(a) Class 1: 0% when one or more of the following residual symptoms are noted:¶
(A) Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities.¶
(B) Depressive symptoms: The ADL can be carried out, but the worker might lack ambition, energy, and enthusiasm. There may be such depression-related, mentally-caused physical problems as mild loss of appetite and a general feeling of being unwell.¶
(C) Phobic symptoms: Phobias the worker already suffers from may come into play, or new phobias may appear in a mild form.¶
(D) Psychophysiological symptoms: Are temporary and in reaction to specific stress. Digestive problems are typical. Any treatment is for a short time and is not connected with any ongoing treatment. Any physical pathology is temporary and reversible. Conversion symptoms or hysterical symptoms are brief and do not occur very often. They might include some slight and limited physical problems (such as weakness or hoarseness) that quickly respond to treatment.¶
(b) Class 2: minimal (6%), mild (23%), or moderate (35%) when one or more of the following residual symptoms/loss of functions are noted:¶
(A) Anxiety symptoms: May require extended treatment. Specific symptoms may include (but are not limited to) startle reactions, indecision because of fear, fear of being alone, and insomnia. There is no loss of intellect or disturbance in thinking, concentration, or memory.¶
(B) Depressive symptoms: Last for several weeks. There are disturbances in eating and sleeping patterns, loss of interest in usual activities, and moderate retardation of physical activity. There may be thoughts of suicide. Self-care activities and personal hygiene remain good.¶
(C) Phobic symptoms: Interfere with normal activities to a mild to moderate degree. Typical reactions include (but are not limited to) a desire to remain at home, a refusal to use elevators, a refusal to go into closed rooms, and an obvious reaction of fear when confronted with a situation that involves a superstition.¶

(D) Psychophysiological symptoms: Require substantial treatment. Frequent and recurring problems with the organs get in the way of common activities. The problems may include (but are not limited to) diarrhea; chest pains; muscle spasms in the arms, legs, or along the backbone; a feeling of being smothered; and hyperventilation. There is no actual pathology in the organs or tissues. Conversion or hysterical symptoms result in periods of loss of physical function that occur more than twice a year, last for several weeks, and need treatment. Symptoms may include (but are not limited to) temporary hoarseness, temporary blindness, temporary weakness in the arms or the legs. These problems continue to return.¶
(c) Class 3: Minimal (50%), mild (66%), or moderate (81%) when one or more of the following residual symptoms/loss of functions are noted:¶
(A) Anxiety symptoms: Fear, tension, and apprehension interfere with work or the ADL. Memory and concentration decrease or become unreliable. Long-lasting periods of anxiety keep returning and interfere with personal relationships. The worker needs constant reassurance and comfort from family, friends, and co-workers.¶
(B) Depressive symptoms: Include an obvious loss of interest in the usual ADL, including eating and self-care. These problems are long-lasting and result in loss of weight and an unkempt appearance. There may be retardation of physical activity, a preoccupation with suicide, and actual attempts at suicide. The worker may be extremely agitated on a frequent or constant basis.¶
(C) Phobic symptoms: Existing phobias are intensified. In addition, new phobias develop. This results in bizarre and disruptive behavior. In the most serious cases, the worker may become home-bound, or even room-bound. Persons in this state often carry out strange rituals which require them to be isolated or protected.¶
(D) Psychophysiological symptoms: Include tissue changes in one or more body systems or organs. These may not be reversible. Typical reactions include (but are not limited to) changes in the wall of the intestine that results in constant digestive and elimination problems. Conversion or hysterical symptoms include loss of physical function that occurs often and lasts for weeks or longer. Evidence of physical change follows such events. A symptomatic period (18 months or more) is associated with advanced negative changes in the tissues and organs. These include (but are not limited to) atrophy of muscles in the legs and arms. A common symptom is general flabbiness.¶
(6) Psychotic disorders are rated based on perception, thinking process, social behavior, and emotional control. Variations in these aspects of mental function are rated under the following classifications with gradations within each class based on severity:¶
(a) Class 1: minimal (0%), mild (6%), or moderate (11%) when one or more of the following is established:¶
(A) Perception: The worker misinterprets conversations or events. It is common for persons with this problem to think others are talking about them or laughing at them.¶
(B) Thinking process: The worker is absent-minded, forgetful, daydreams too much, thinks slowly, has unusual thoughts that recur, or suffers from an obsession. The worker is aware of these problems and may also show mild problems with judgment. It is also possible that the worker may have little self-understanding or understanding of the problem.¶
(C) Social behavior: Small problems appear in general behavior, but do not get in the way of social or living activities. Others are not disturbed by them. The worker may be over-reactive or depressed or may neglect self-care and personal hygiene.¶
(D) Emotional control: The worker may be depressed and have little interest in work or life. The worker may have an extreme feeling of well-being without reason. Controlled and productive activities are possible, but the worker is likely to be irritable and unpredictable.¶
(b) Class 2: minimal (20%), mild (29%), or moderate (38%) when one or more of the following is established:¶
(A) Perception: Workers in this state have fairly serious problems in understanding their personal surroundings. They cannot be counted on to understand the difference between daydreams, imagination, and reality. They may have fantasies involving money or power, but they recognize them as fantasies. Because persons in this state are likely to be overly excited or suffering from paranoia, they are also likely to be domineering, peremptory, irritable, or suspicious.¶
(B) Thinking process: The thinking process is so disturbed that persons in this state might not realize they are having mental problems. The problems might include (but are not limited to) obsessions, blocking, memory loss serious enough to affect work and personal life, confusion, powerful daydreams or long periods of being deeply lost in thought to no set purpose.¶
(C) Social behavior: Persons in this state can control their social behavior if they are asked to do so. However, if left on their own, their behavior is so bizarre that others may be concerned. Such behavior might include (but is not limited to) over-activity, disarranged clothing, and talk or gestures which neither make sense nor fit the situation.¶
(D) Emotional control: Persons in this state suffer a serious loss of control over their emotions. They may become extremely angry for little or no reason, they may cry easily, or they may have an extreme feeling of well-being, causing them to talk too much and to little purpose. These behaviors interfere with living and work and cause concern in others.¶
(c) Class 3: minimal (50%), mild (63%), or moderate (75%) when one or more of the following is established:¶

(A) Perception: Workers in this state suffer from frequent illusions and hallucinations. Following the demands of these illusions and hallucinations leads to bizarre and disruptive behavior.¶
(B) Thinking process: Workers in this state suffer from disturbances in thought that are obvious even to a casual observer. These include an inability to communicate clearly because of slurred speech, rambling speech, primitive language, and an absence of the ability to understand the self or the nature of the problem. Such workers also show poor judgment and openly talk about delusions without recognizing them as such.¶
(C) Social behavior: Persons in this state are a nuisance or a danger to others. Actions might include interfering with work and other activities, shouting, sudden inappropriate bursts of profanity, carelessness about excretory functions, threatening others, and endangering others.¶
(D) Emotional control: Workers in this state cannot control their personal behavior. They might be very irritable and overactive or so depressed they become suicidal.¶
(d) Class 4: 90% for workers who usually need to be placed in a hospital or institution. Medication may help them to a certain extent and the following is established:¶
(A) Perception: Workers become so obsessed with hallucinations, illusions, and delusions that normal self-care is not possible. Bursts of violence may occur.¶
(B) Thinking process: Communication is either very difficult or impossible. The worker is responding almost entirely to delusions, illusions, and hallucinations. Evidence of disturbed mental processes may include (but are not limited to) severe confusion, incoherence, irrelevance, refusal to speak, the creation of new words or using existing words in a new manner.¶
(C) Social behavior: The worker's personal behavior endangers both the worker and others. Poor perceptions, confused thinking, lack of emotional control, and obsessive reaction to hallucinations, illusions, and delusions produce behavior that can result in the worker being inaccessible, suicidal, openly aggressive and assaultive, or even homicidal.¶
(D) Emotional control: The worker may have either a severe emotional disturbance in which the worker is delirious and uncontrolled or extreme depression in which the worker is silent, hostile, and self-destructive. In either case, lack of control over anger and rage might result in homicidal behavior.¶
[Publications: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.005, 656.214, 656.268, 656.726

AMEND: 436-060-0005

RULE SUMMARY: Revised rule 0005 to remove the definition of “authorized nurse practitioner”

CHANGES TO RULE:

436-060-0005
Definitions ¶

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purpose of these rules unless the context requires otherwise:¶
(1) "Aggravation" means an actual worsening of the compensable conditions after the last award or arrangement of compensation that satisfies the requirements of ORS 656.273.¶
(2) ~~"Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.¶~~
~~(3)~~ "Board" means the Workers' Compensation Board and includes its Hearings Division.¶
(43) "Business days" means Monday through Friday, excluding legal holidays. Legal holidays are those listed in ORS 187.010 and 187.020.¶
(~~5~~4) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.¶
(~~6~~5) "Dependent" means any of the individuals listed under ORS 656.005(10) who, at the time of an accident, depended in whole or in part for support on the earnings of a worker who dies as a result of an injury.¶
(~~7~~6) "Designated paying agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.¶
(~~8~~7) "Director" means the director of the Department of Consumer and Business Services or the director's designee.¶
(~~9~~8) "Disposition" or "claim disposition" means the written agreement to release rights or obligations under ORS 656.236.¶
(~~10~~9) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(1~~1~~0) "Employer" means a subject employer under ORS 656.023.¶
(1~~2~~1) "Inpatient" means a worker who is admitted to a hospital before and extending past midnight for treatment and lodging.¶
(1~~3~~2) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon; or an employer or employer group certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407.¶
(1~~4~~3) "Mailing date," unless otherwise specified, means:¶
(a) The date a document is postmarked;¶
(b) The date automatically produced by electronic transmission (e.g., email or facsimile);¶
(c) The date a hand-delivered document is received by the recipient; or¶
(d) The date of a phone or in-person request, when allowed under these rules.¶
(1~~5~~4) "Physical rehabilitation program" means any services provided to a worker to prevent the compensable injury from causing continuing disability.¶
(1~~6~~5) "Regularly employed" means a worker is receiving a regular wage as defined in section (19) of this rule. For workers who are paid a daily wage, "regularly employed" means actual employment or availability for such employment.¶
(1~~7~~6) "Service company" means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.¶
(1~~8~~7) "Suspension of compensation" means a period of time where:¶
(a) No temporary disability, permanent total disability, or medical and related service benefits accrue or are payable; and¶
(b) Vocational assistance and payment of permanent partial disability benefits will be stayed.¶
(1~~9~~8) "Wages" is as defined in ORS 656.005(27) and, in these rules, is categorized as either irregular wages or regular wages. Wages do not include expenses incurred due to the job and reimbursed by the employer (e.g., meals, lodging, per diem, equipment rental).¶
(a) "Irregular wages" means a variable pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes but is not limited to:¶
(A) Tips;¶

(B) Commissions;¶
(C) Monies paid on unscheduled or unpredictable intervals, including, but not limited to, workers who are seasonally employed, on call, paid hourly at varying hours, or paid by piece rate; and¶
(D) The reasonable value of any in-kind considerations only if the considerations will not continue during the period of disability.¶
(b) "Regular wages" means a constant and uniform pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes, but is not limited to, wages paid on a daily or weekly basis. Hourly wages may be considered regular if the same number of hours are worked each pay period.¶
(~~20~~19) "Wage earning agreement" means the verbal or written contract of hiring or terms of employment made between the worker and employer.¶
(2~~1~~0) "Written" means expressed in writing, including electronic transmission.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.726(4), ORS 656.005

AMEND: 436-060-0010

RULE SUMMARY: Revised rule 0010 to remove the term “authorized nurse practitioner”

CHANGES TO RULE:

436-060-0010
Employer Responsibilities ¶

(1) General. A subject employer must accept notice of a claim for workers' compensation benefits from a worker or the worker's attorney under ORS 656.265.¶
(a) Form 801, "Report of Job Injury or Illness," must be readily available for workers to report their injuries. The employer must provide Form 801 to the worker:¶
(A) Immediately upon request by the worker or worker's attorney under ORS 656.265(6); or¶
(B) Upon receiving notice or knowledge of an accident that may involve a compensable injury under ORS 656.262(3)(a).¶
(b) Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," signed by the worker, is written notice of an accident that may involve a compensable injury. The signed Form 827 will start the claim process, but does not relieve the worker or employer of the responsibility of filing Form 801.¶
(c) Form 3283, "A Guide for Workers Recently Hurt on the Job," may be printed on the back of Form 801, and must be provided by the employer to the worker if any of the following circumstances occur:¶
(A) The worker files a claim for workers' compensation benefits.¶
(B) The worker is evaluated at an on-site medical service facility to assess the nature or extent of a work injury and the employer has notice or knowledge of the work injury. ¶
(d) If a worker provides notice of a claim using an electronic form, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records necessary to process the claim under OAR 436-010-0240.¶
(2) Employer reporting time frame. An employer, except a self-insured employer, must report a claim to its insurer no later than five days after the date the employer has notice or knowledge of any claim or accident that may result in a compensable injury. The date an employer has knowledge of an accident that may result in a compensable injury is the earliest date any supervisor or manager of the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.¶
(3) Reporting requirements. The report must provide the information requested on Form 801, and include at least:¶
(a) The worker's name and address;¶
(b) The employer's legal name and address; and¶
(c) The information required under ORS 656.262 and 656.265.¶
(4) Injuries not requiring medical services. The employer is not required to notify the insurer of an accident that does not require the worker to seek treatment from a licensed medical service provider, subject to the following:¶
(a) The employer must report the claim to the insurer under section (2) of this rule, if:¶
(A) The worker chooses to file a claim;¶
(B) The worker signs a Form 801;¶
(C) The worker or employer is billed for treatment; or¶
(D) The employer learns that the injury has resulted in medical services, disability or death. For the purposes of this paragraph, the date of that knowledge under section (2) of this rule is the date the employer received notice or knowledge of the medical services, disability, or death; and¶
(b) If the employer does not give the insurer notice under this section:¶
(A) The employer must maintain records for five years showing the name of the worker, the date of the accident, the nature of the injury and treatment provided; and¶
(B) These records must be available for inspection by the director, the worker or the worker's attorney, if any, and the insurer.¶
(5) Civil penalty for failure to report claims. The director may assess a civil penalty under OAR 436-060-0200 against an employer that:¶
(a) Is late in reporting more than ten percent of its total claims to its insurer during any quarter; or¶
(b) Intentionally or repeatedly pays compensation instead of reporting claims or accidents that may result in a compensable injury to its insurer.¶
(6) Worker's right to choose medical service provider. The worker may choose a medical service provider, or attending physician~~, or authorized nurse practitioner~~ under ORS 656.245, 656.260, OAR 436-010 and 436-015. Except as provided under ORS 656.260 and OAR 436-015, if an employer restricts the worker's choice of medical

service provider the director may impose a civil penalty of up to $2,000.
Statutory/Other Authority: ORS 656.265(6), 656.726(4), ORS 656.745
Statutes/Other Implemented: ORS 656.745, 656.245, 656.260, 656.262, 656.265

AMEND: 436-060-0020

RULE SUMMARY: Revised rule 0020 to:

-Remove the term “authorized nurse practitioner”

-Clarify that the reference to “physician” means “attending physician”

CHANGES TO RULE:

436-060-0020
Payment of Temporary Total Disability Compensation ¶

(1) Employer payment of temporary disability. An employer may pay temporary disability compensation with the approval of the insurer. If the insurer approves an employer to make such payment:¶
(a) The insurer continues to be responsible for determining the worker's entitlement to compensation, and ensuring timely payment of compensation;¶
(b) The employer must provide the insurer with payment documentation that is adequate to meet the insurer's responsibilities; and¶
(c) The insurer must reimburse the employer for any temporary disability compensation paid to the worker under this section.¶
(2) Persons who have withdrawn from the workforce. No temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:¶
(a) A person who, before a claim reopening under ORS 656.267, 656.273 or 656.278, was not working and made no reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.¶
(b) A person who was a full-time student for at least six months in the 52 weeks before the date of injury who elects to return to school full time, unless the person can establish a prior customary pattern of working while attending school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.¶
(3) Authorization of temporary disability compensation. No compensation is due and payable after the worker's attending physician ~~or authorized nurse practitioner~~ ceases to authorize temporary disability, or for any period of time when temporary disability benefits are not authorized by a medical service provider under ORS 656.245(2)(b). Temporary disability compensation is authorized when:¶
(a) The medical service provider provides the insurer or employer with oral or written verification of the worker's inability to work;¶
(b) Documents in the insurer's possession at claim closure reasonably reflect the worker's inability to work. For the purposes of this rule "documents" and "possession" have the same meaning as in OAR 436-060-0017(1); or¶
(c) The director determines, at reconsideration of claim closure, there is sufficient contemporaneous medical documentation to reasonably reflect the worker's inability to work under ORS 656.268.¶
(4) Lack of verification of inability to work. No temporary disability is due and payable for any period of time during which the insurer has requested from the worker's attending physician or ~~authorized nurse practitioner~~ verification of the worker's inability to work and the ~~physician or authorized nurse practitioner~~attending physician cannot verify it, unless the worker has been unable to receive treatment for reasons beyond the worker's control.¶
(a) Before withholding temporary disability under this section, the insurer must ask the worker whether a reason beyond the worker's control prevented the worker from receiving treatment.¶
(A) If no valid reason is found or the worker does not respond or cannot be located, the insurer must document its file regarding those findings.¶
(B) The insurer must provide the director a copy of the documentation within 20 days, if requested.¶
(b) If the attending physician ~~or authorized nurse practitioner~~ is unable to verify the worker's inability to work, the insurer may not end temporary disability benefits until written notice has been mailed or delivered under OAR 436-060-0015(7).¶
(c) When verification of temporary disability is received from the attending physician ~~or authorized nurse practitioner~~, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of temporary disability, unless otherwise denied.¶
(5) Suspension of benefits. An insurer may suspend temporary disability benefits without authorization from the director when all of the following circumstances apply:¶
(a) The worker missed a regularly scheduled appointment with the attending physician ~~or authorized nurse practitioner~~;¶
(b) The insurer sent a letter by certified mail to the worker and a letter to the worker's attorney, at least 10 days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's

attending physician~~ or authorized nurse practitioner~~, stating the time and date of the appointment, and giving the following notice in bold and formatted as follows:¶

~~You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice under Oregon law.* ¶~~

~~¶~~

~~If you have any questions you may call: ¶~~

~~- [Insurer] at [Insurer phone number] ¶~~

~~- Workers' Compensation Division at 800-452-0288 (toll-free) ¶~~

~~- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)¶~~

~~¶~~

~~*Oregon Revised Statute 656.262(4)(e)¶~~

~~(c) The insurer verifies that the worker has missed the rescheduled appointment; and¶~~

~~(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice in bold and formatted as follows:¶~~

~~We have suspended your temporary disability benefits, because you missed a regular appointment with your doctor. ¶~~

~~¶~~

~~When we arranged a new appointment for [date], we notified you in a letter that was sent by certified mail. ¶~~

~~¶~~

~~The letter warned you that we would suspend your benefits if you did not attend, and you did not attend the new appointment. ¶~~

~~¶~~

~~To resume your benefits:¶~~

~~- You must schedule and attend an appointment with your doctor, and ¶~~

~~- Your doctor must verify that you are still unable to work.~~ [See attachment.]¶

(c) The insurer verifies that the worker has missed the rescheduled appointment; and¶

(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice in bold and formatted as follows: [See attachment.]¶

(6) Verbal release to work. If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician~~ or authorized nurse practitioner~~, and the worker has not been informed of the release by the attending physician or ~~authorized nurse practitioner or~~ returned to work, the insurer must:¶

(a) Document the facts;¶

(b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and¶

(c) Advise the worker of their reinstatement rights under ORS chapter 659A.¶

(7) Temporary disability from two or more claims. When a worker is due concurrent temporary disability under ORS 656.210 or ORS 656.212 as a result of two or more accepted claims:¶

(a) The director may order one of the insurers to pay the entire amount of temporary disability due; or make a pro rata distribution between two or more of the insurers;¶

(b) The insurers may request for the director to make a pro rata distribution of compensation due. The request must be in writing, and the insurer must provide a copy to the worker and the worker's attorney, if any;¶

(c) The director's pro rata order does not apply to:¶

(A) Any periods of interim compensation payable under ORS 656.262; or¶

(B) Any benefits due under ORS 656.214 or 656.245;¶

(d) Claims subject to the pro rata order must be closed under OAR 436-030 and ORS 656.268, when appropriate;¶

(e) The pro rata distribution ordered by the director only applies to benefits due as of the date all claims involved are in an accepted status. The order pro-rating compensation will not apply to periods where any claim involved is in a deferred status;¶

(f) The insurers may not prorate temporary disability without the approval of the director, except when the claims involve the same worker, the same employer, and the same insurer. When the insurer prorates temporary disability under this subsection the worker must receive compensation at the highest temporary disability rate of the claims involved.¶

(8) Premature closure. If a closure under ORS 656.268 has been found to be premature and there was an open-ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS

656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.¶
(9) Incorrectly denied claims. If a denied claim has been determined to be compensable by final order, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the authorization for temporary disability was open-ended at the time of denial, and there are no other lawful bases to terminate temporary disability.
Statutory/Other Authority: ORS 656.210(2), ORS 656.245, ORS 656.262, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.262, ORS 656.210, ORS 656.212, ORS 656.307

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-060-0020.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336751

AMEND: 436-060-0030

RULE SUMMARY: Revised rule 0030 to remove the term “authorized nurse practitioner”

CHANGES TO RULE:

436-060-0030
Payment of Temporary Partial Disability Compensation ¶

(1) Rate of temporary partial disability. The amount of temporary partial disability compensation due a worker must be determined by multiplying the worker's rate of compensation for temporary total disability by the percentage of wages lost by the worker post injury.¶
(a) To calculate the rate of temporary disability, the insurer must:¶
(A) Subtract the worker's post-injury wages from the worker's wages at the time of injury under OAR 436-060-0025;¶
(B) Divide the difference under paragraph (A) by the worker's wages at the time of injury under OAR 436-060-0025 to arrive at the percentage of loss of wages; and¶
(C) Multiply the worker's current rate of compensation for temporary total disability by the percentage of loss of wages in paragraph (B).¶
(b) As used in this rule "post-injury wages" means the sum of:¶
(A) The wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater;¶
(B) Any unemployment benefits received; and¶
(C) Any wages received for paid leave, except wages paid in addition to temporary disability compensation with the worker's consent under OAR436-060-0025(1);¶
(c) If a worker is not eligible for supplemental disability under OAR 436-060-0035, wages from a secondary employer must only be included in post-injury wages to the extent that the wages from the secondary employer post-injury exceed the wages from the secondary employer at the time of injury.¶
(d) If the worker's rate of temporary total disability compensation is based on an assumed wage, the rate of temporary partial disability must be calculated by multiplying the rate of temporary total disability by the percentage of hours lost by the worker post injury.¶
(2) If the worker returns to employment. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation from the date an injured worker returns to regular or modified employment, prior to claim closure.¶
(a) If the worker is with a new employer, and the insurer asks the worker to provide wage information, the worker is responsible for providing documented evidence of the amount of any wages being earned; and¶
(b) If the worker fails to provide documentation, the insurer may assume that post-injury wages are the same as or higher than the worker's wages at time of injury.¶
(3) If the worker fails to begin employment. Except when the worker refuses modified work under ORS 656.268(4)(c), the insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date a worker fails to begin regular or modified employment, if the following conditions have been met:¶
(a) The employer or insurer:¶
(A) Notified the attending physician ~~or authorized nurse practitioner~~ of the physical tasks to be performed by the injured worker;¶
(B) Notified the attending physician ~~or authorized nurse practitioner~~ of the location of the modified work offer; and¶
(C) Asked the attending physician ~~or authorized nurse practitioner~~ if the worker can, as a result of the compensable injury, physically commute to and perform the job.¶
(b) The attending physician ~~or authorized nurse practitioner~~ agreed the employment appears to be within the worker's capabilities, and considering the compensable injury the worker is physically able to commute the lesser of the distance from:¶
(A) The worker's residence at the time of injury to the work site; or¶
(B) The worker's residence at the time of the modified work offer to the work site; and¶
(c) The employer or insurer confirmed the offer of employment in writing to the worker stating:¶
(A) The beginning time, date, and place;¶
(B) The duration of the job, if known;¶
(C) The wages;¶
(D) An accurate description of the physical requirements of the job;¶

(E) The attending physician ~~or authorized nurse practitioner~~ has found the job to be within the worker's capabilities and the commute to be within the worker's physical capacity;¶
(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:¶
(i) The offer is at a site more than 50 miles from the location where the worker was injured or where the worker customarily reported for work, unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or the employment pattern before the injury;¶
(ii) The offer is not with the employer at injury;¶
(iii) The offer is not at a work site of the employer at injury;¶
(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or¶
(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and¶
(G) The following notice in bold and formatted as follows:~~¶~~
~~If you refuse this offer of work for any of the reasons listed in this notice, you should: ¶~~
~~¶~~
~~- Write to the insurer or employer, and¶~~
~~- Tell them your reasons for refusing the job. ¶~~
~~¶~~
~~If the insurer reduces or stops your temporary total disability, you may appeal by requesting a hearing. To request a hearing, send a letter objecting to the insurer's actions to: ¶~~
~~¶~~
~~Worker's Compensation Board ¶~~
~~2601 25th Street SE, Suite 150¶~~
~~Salem OR 97302-1280~~ [See attachment.]¶
(4) If the worker has been terminated from employment. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment from the date the worker's attending physician ~~or authorized nurse practitioner~~ approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:¶
(a) The employer has a written policy of offering modified work to injured workers;¶
(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;¶
(c) The attending physician ~~or authorized nurse practitioner~~ has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and¶
(d) The attending physician ~~or authorized nurse practitioner~~ agrees the employment appears to be within the worker's capabilities.¶
(5) If the worker is in violation of federal immigration law. The insurer must stop paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment when the attending physician ~~or authorized nurse practitioner~~ approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:¶
(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1) of this rule;¶
(b) The attending physician ~~or authorized nurse practitioner~~ has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and¶
(c) The attending physician ~~or authorized nurse practitioner~~ agrees the employment appears to be within the worker's capabilities.¶
(6) If the modified job no longer exists or offer is withdrawn. Temporary partial disability must be paid at the temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer.¶
(a) Temporary disability paid under this section must be calculated under (1) of this rule, accounting for any post-injury wages.¶
(b) This section applies to situations including, but not limited to, termination of temporary employment, layoff, or plant closure.¶
(c) A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim is subject to this section.¶

(d) For the purpose of this rule, when a worker who has been doing modified work quits the job, or the employer terminates the worker for violation of work rules or other disciplinary reasons, it is not a withdrawal of a job offer by the employer, but must be considered the same as the worker refusing wage earning employment under ORS 656.325(5)(a).¶
(e) This section does not apply to those situations described in sections (3), (4), and (5) of this rule.¶
(7) Termination of temporary partial disability. When the worker's disability is partial only and temporary in character, temporary partial disability compensation under ORS 656.212 must continue until:¶
(a) The attending physician ~~or authorized nurse practitioner~~ verifies the worker can no longer perform the modified job and is again temporarily totally disabled;¶
(b) The compensation is terminated by order of the director or by claim closure under ORS 656.268; or¶
(c) The compensation is lawfully suspended, withheld, or terminated for any other reason.¶
(8) Verbal release to work. If temporary disability benefits end because the insurer or employer negotiates a verbal release of the worker to return to any type of work with the worker's attending physician ~~or authorized nurse practitioner~~, and the worker has not been informed of the release by the attending physician or ~~authorized nurse practitioner or~~ returned to work, the insurer must:¶
(a) Document the facts;¶
(b) Communicate the release to the worker by mail within seven days. The communication to the worker of the negotiated return-to-work release may be contained in an offer of modified employment; and¶
(c) Advise the worker of their reinstatement rights under ORS chapter 659A.¶
(9) Changes in the rate of compensation. When the insurer stops paying temporary total disability compensation and starts paying temporary partial disability compensation, or changes the compensation rate or the method of computation of benefits under this rule, the insurer must send written notice to the worker and worker's attorney, if any, under OAR 436-060-0015.
Statutory/Other Authority: ORS 656.212, 656.704, 656.726(4)
Statutes/Other Implemented: ORS 656.212, 656.704, 656.726(4), 656.268, 656.325(5)

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-060-0030.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336752

AMEND: 436-060-0035

RULE SUMMARY: Revised rule 0035 to update the rule reference for the definition of “insurer”

CHANGES TO RULE:

436-060-0035
Supplemental Disability for Workers with Multiple Jobs at the Time of Injury ¶

(1) For the purpose of this rule:¶
(a) "Primary job" means the job at which the injury occurred, or the job where the worker was employed at the time of medical verification that the worker is unable to work because of disability caused by occupational disease;¶
(b) "Secondary job" means any other job held by the worker in Oregon subject employment at the time of injury;¶
(c) "Temporary disability" means wage loss replacement for the primary job;¶
(d) "Supplemental disability" means wage loss replacement for the secondary jobs that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210; and¶
(e) "Insurer" has the same meaning as OAR 436-060-0005(1~~3~~2), and also includes service companies.¶
(2) Election to process and pay supplemental disability. An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The insurer is not required to inform the director of its election if it elects to process and pay supplemental disability, unless the insurer's last notice to the director was that it would not process and pay supplemental disability. If the insurer informs the director of its election, the insurer must report its election to the director under OAR 436-060-0011(12).¶
(a) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.¶
(b) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election.¶
(c) If the insurer has elected to process and pay supplemental disability benefits:¶
(A) The insurer must determine the worker's ongoing entitlement to supplemental disability;¶
(B) The insurer must pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due;¶
(C) The insurer must maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury; and¶
(D) The director will reimburse the insurer for supplemental disability paid under OAR 436-060-0500.¶
(d) If the insurer has elected not to process and pay supplemental disability benefits:¶
(A) The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director;¶
(B) The assigned processing administrator must determine the worker's ongoing entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days; and¶
(C) The insurer and assigned processing administrator must cooperate and communicate, as necessary, to coordinate benefits due.¶
(i) The assigned processing administrator must provide the insurer with any verifiable documentation of wages from a secondary job received from the worker; and¶
(ii) The insurer and assigned processing administrator must retain documentation of shared information.¶
(3) Eligibility for supplemental disability. A worker who was employed at one or more secondary jobs with Oregon subject employers at the time of injury or medical verification of an occupational disease may be eligible to receive supplemental disability if:¶
(a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim;¶
(b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210; and¶
(c) The worker provides verifiable documentation of the wages from any secondary jobs at the time of injury or medical verification of an occupational disease within 60 days of the mailing date of the request for documentation sent under section (4) of this rule. For each secondary job, the documentation must:¶
(A) Identify the Oregon subject employer for each secondary job;¶
(B) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or medical verification of occupational disease; and¶
(C) Provide adequate information to calculate the average weekly wage under OAR 436-060-0025.¶
(4) Determination of eligibility. Upon receiving notification of a worker's secondary job the insurer must determine

the rate of temporary disability compensation for wages at the primary job under OAR 436-060-0025, and:¶
(a) If the rate of temporary disability compensation meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits; or¶
(b) If the rate of temporary disability is less than the maximum temporary disability rate, the worker may be eligible for supplemental disability benefits. If the worker may be eligible for supplemental disability benefits, the insurer must:¶
(A) Mail the worker a request for verifiable documentation of the worker's wages from any secondary jobs within five business days of notice or knowledge that the worker may be eligible for supplemental disability benefits;¶
(i) The request must inform the worker what verifiable documentation the worker must submit to the insurer or assigned processing administrator, to determine the worker's eligibility for supplemental disability;¶
(ii) The request must clearly state that if the insurer or assigned processing administrator does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker will be found ineligible for supplemental disability;¶
(B) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule, the insurer must also send a copy of the request to the assigned processing administrator. In addition to the requirements of this section, the request must also:¶
(i) Contain the name, address, email address, and telephone number of the assigned processing administrator;¶
(ii) Clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator; and¶
(C) The insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability within 14 days of:¶
(i) Receipt of the worker's verifiable documentation; or¶
(ii) The end of the 60-day period in the insurer's request, if the worker does not provide verifiable documentation.¶
(c) Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).¶
(5) Notification of eligibility determination. The insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the determination to the worker and the worker's attorney, if any, in writing. If the worker is found ineligible for supplemental disability, the letter must also advise the worker of the reason why they are not eligible, and how to appeal if the worker disagrees with the determination.¶
(6) Calculation of supplemental disability. The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding the weekly averages of the worker's wages from each secondary job as calculated under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:¶
(a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;¶
(b) No supplemental disability is due for jobs where the rate of compensation is based on an assumed wage;¶
(c) In no case may an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;¶
(d) The worker's scheduled days off for the primary job must be used to calculate and pay supplemental disability; and¶
(e) No three-day waiting period applies to supplemental disability benefits.¶
(7) Partial disability. When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job:¶
(a) The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due to the worker under OAR 436-060-0030 based on the worker's wages from both the primary and secondary jobs;¶
(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting the rate of partial disability due based on wages from only the primary job from the total rate of compensation due to the worker;¶
(c) If the worker receives post-injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due; and¶
(d) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.¶
(8) If temporary disability is not due from the primary job. Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.¶
(a) A nondisabling claim will not change to disabling status due to payment of supplemental disability.¶

(b) When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to request a hearing by the board within 60 days of the notice, if the worker disagrees.¶
(9) Worker's responsibilities. A worker who is eligible for supplemental disability under this rule has an ongoing responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.¶
(10) Hearings. If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing under OAR 436-060-0008.¶
(a) If the worker requests a hearing on the insurer's or the assigned processing administrator's decision concerning the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker must submit the request for a hearing of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule.¶
(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.¶
(11) Sanctions. An insurer that elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.¶
(12) Third party recovery. In the event of a third party recovery:¶
(a) Previously reimbursed supplemental disability benefits are a portion of the paying agency's lien; and¶
(b) Remittance on recovered benefits must be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.
Statutory/Other Authority: ORS 656.210, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.210, ORS 656.726(4), ORS 656.212, ORS 656.325(5), ORS 656.704

AMEND: 436-060-0095

RULE SUMMARY: Revised rule 0095 to remove the term “authorized nurse practitioner”

CHANGES TO RULE:

436-060-0095
Medical Examinations; Suspension of Compensation; and Independent Medical Examination Notice ¶

(1) General. A worker must submit to independent medical examinations reasonably requested by the insurer or the director.¶
(a) The conditions of the examination must be consistent with conditions described in OAR 436-010-0265.¶
(b) If the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1), the director may suspend compensation by order:¶
(A) The worker must have the opportunity to dispute the suspension of compensation before the director will issue the order; and¶
(B) Compensation will be suspended until the examination has been completed. The worker is not entitled to compensation during or for the period of suspension.¶
(c) Any action of a worker's observer allowed under OAR 436-010-0265(6) that obstructs the examination may be considered an obstruction of the examination by the worker for the purpose of this rule.¶
(d) The director may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.¶
(e) The director may impose a monetary penalty against the worker under OAR 436-010-0265.¶
(2) Number of examinations. The insurer may request no more than three separate independent medical examinations for each opening of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(8).¶
(3) Scheduling and notice to worker. The insurer may contract with a third party to schedule independent medical examinations. When an examination is scheduled by the insurer, or by a third party at the request of the insurer:¶
(a) The worker and the worker's attorney, if any, must be simultaneously notified in writing of the scheduled medical examination;¶
(b) The notice must be mailed at least 10 days before the examination;¶
(c) If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice must be sent on the insurer's stationery; ¶
(d) The insurer must include with each appointment notice it sends to the worker:¶
(A) Form 3921, "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement; and¶
(B) Form 3923, "Important Information about Independent Medical Exams"; and¶
(e) The notice sent for each appointment, including those which have been rescheduled, must contain the following:¶
(A) The name of the examiner or facility;¶
(B) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;¶
(C) The date, time, and place of the examination;¶
(D) The first and last name of the attending physician ~~or authorized nurse practitioner~~ and verification that the attending physician ~~or authorized nurse practitioner~~ was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician ~~or authorized nurse practitioner~~, whichever is appropriate;¶
(E) If applicable, confirmation that the director has approved the examination;¶
(F) A statement that the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;¶
(G) A statement that an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence;¶
(H) A statement that the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of

an observer; and¶
(I) The following notice in bold and formatted as follows:¶
~~You must attend this examination. If there is any reason you cannot attend, you must tell us as soon as possible before the date of the examination. ¶~~
~~¶~~
~~If you disagree with the location of this appointment, you must contact the Workers' Compensation Division at 800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. ¶~~
~~¶~~
~~Your workers' compensation benefits may be suspended under Oregon laws and rules* if you: ¶~~
~~¶~~
~~- Do not attend the examination, ¶~~
~~- Do not have a good reason for not attending the examination, or ¶~~
~~- Do not cooperate with the examination. ¶~~
~~¶~~
~~You may be charged a $100 penalty if you do not attend the examination without good reason or if you do not notify the insurer before the examination. The penalty is taken out of future benefits. ¶~~
~~¶~~
~~If you have any questions you may call: ¶~~
~~- [Insurer] at [Insurer phone number] ¶~~
~~- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶~~
~~- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)¶~~
~~¶~~
~~*Oregon Revised Statute 656.325 and Oregon Administrative Rules, Chapter 436, division 60~~ [See attachment.]¶
(4) Reimbursement of costs. When a worker attends an independent medical examination the insurer must reimburse the worker for reasonable costs in accordance with OAR 436-009-0025 regardless of claim acceptance, deferral, or denial.¶
(5) Forwarding of reports from provider. Following completion of the examination, the insurer must forward a copy of the examiner's signed report to the attending physician ~~or authorized nurse practitioner~~ within three business days of the insurer's receipt of the report.¶
(6) Requests to authorize suspension. The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial. The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service in the same manner as a summons. The request must include the following information:¶
(a) That the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095;¶
(b) The claim status and any accepted or newly claimed conditions;¶
(c) What specific actions of the worker prompted the request;¶
(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;¶
(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;¶
(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;¶
(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;¶
(h) A copy of the notice required in section (3) and a copy of any written verification received under subsection (6)(g) of this rule;¶
(i) Any other information that supports the request; and¶
(j) The following notice in bold and formatted as follows:¶
~~Notice to worker:¶~~
~~¶~~
~~If the Workers' Compensation Division grants this request, you may lose all or part of current or future benefits. ¶~~
~~¶~~
~~If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately. ¶~~
~~¶~~
~~- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶~~

~~¶~~
~~- Address your letter to: ¶~~
~~¶~~
~~Workers' Compensation Division ¶~~
~~350 Winter Street NE ¶~~
~~PO Box 14480 ¶~~
~~Salem OR 97309-0405 ¶~~
~~¶~~
~~If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.~~ [See attachment.]¶
(7) Effective date of suspension. If the director authorizes the suspension of compensation, the suspension will be effective from the date the worker fails to attend an examination or such other date the director deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.¶
(8) Reinstatement of benefits. The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.¶
(9) Claim closure. If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034.¶
(10) Denial of suspension. If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.¶
(11) Other actions by the director. The director may also take the following actions concerning the suspension of compensation:¶
(a) Modify or set aside the order of consent before or after a request for hearing is filed;¶
(b) Order payment of compensation previously suspended when the director finds the suspension to have been made in error; and¶
(c) Reevaluate the necessity of continuing a suspension.¶
(12) Final orders. An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.
Statutory/Other Authority: ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325, ORS 656.704, ORS 656.726(4)

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-060-0095.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336754

AMEND: 436-060-0105

RULE SUMMARY: Revised rule 0105(3) to:

-Remove the term “authorized nurse practitioner”

-In section (3), replace the term “physician” with “medical service provider as defined under OAR 436-010-0005(26).”

CHANGES TO RULE:

436-060-0105
Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits ¶

(1) General. The director may suspend compensation by order when the worker commits insanitary or injurious acts that imperil or delay recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.¶
(a) The worker must have the opportunity to dispute the suspension of compensation before the director will issue an order.¶
(b) The worker is not entitled to compensation during or for the period of suspension.¶
(2) Notice to worker. The insurer must demand in writing the worker either immediately cease all actions which imperil or delay recovery or immediately begin to change the inappropriate behavior, and participate in activities needed to help the worker recover from the injury. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy must be sent simultaneously to the worker's attorney and attending physician:¶
(a) A description of the unacceptable actions;¶
(b) Why such conduct is inappropriate, including the fact that the conduct is harmful or delays the worker's recovery, as appropriate;¶
(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and¶
(d) The following notice of the consequences should the worker fail to correct the problem in bold and formatted as follows:~~¶~~
~~If you continue this inappropriate conduct after the above date: ¶~~
~~¶~~
~~- We will ask that your workers' compensation benefits be suspended, and ¶~~
~~- Your permanent disability award, if any, may be reduced under ORS 656.325 and OAR 436-060.~~ [See attachment.]¶
(3) Failure or refusal to accept medical treatment. For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under ~~a physician's~~the care or~~f~~ a~~uthorized nurse practitioner's care~~ medical service provider as defined under OAR 436-010-0005 or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the ~~physician or authorized nurse practition~~medical service provider that is designed to help the worker reach maximum recovery and become medically stationary.¶
(4) Request for suspension of benefits. The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c) of this rule. If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.¶
(a) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney, if any, by registered or certified mail or by personal service as for a summons.¶
(b) The request must include the following information:¶
(A) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;¶
(B) A description of the actions of the worker that prompted the request, including whether such actions continue;¶
(C) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided any reasons, whichever is appropriate;¶
(D) How, when, and with whom the worker's failure to comply or refusal to comply was verified;¶
(E) A copy of the notice required in section (2) of this rule;¶
(F) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all recommendations from the attending physician~~ or authorized nurse practitioner~~; and¶

(G) The following notice in bold and formatted as follows:¶
~~Notice to worker: ¶~~
~~¶~~
~~If the Workers' Compensation Division decides to suspend your benefits and you do not correct your unacceptable actions, or show us a good reason why they are acceptable, we will close your claim. ¶~~
~~¶~~
~~If you think this request to suspend your benefits is wrong, write to the Workers' Compensation Division immediately. ¶~~
~~¶~~
~~- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶~~
~~¶~~
~~- Address your letter to: ¶~~
~~¶~~
~~Workers' Compensation Division ¶~~
~~350 Winter Street NE ¶~~
~~PO Box 14480 ¶~~
~~Salem OR 97309-0405 ¶~~
~~¶~~
~~If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.~~ [See attachment.]¶
(c) Any delay in obtaining confirmation or in requesting the suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the division.¶
(d) If the director approves authorization of suspension of compensation:¶
(A) An order will be issued suspending compensation from a date established under subsection (2)(c) of this rule until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the director may require the worker to demonstrate cooperation before reinstating compensation;¶
(B) The insurer must make all reasonable efforts to assist the worker to reinstate benefits when the worker demonstrates the willingness to make such efforts;¶
(C) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests;¶
(i) When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed;¶
(ii) If the worker makes no effort to reinstate benefits within 60 days of the mailing date of the suspension order, the insurer must close the claim under OAR 436-030-0034;¶
(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;¶
(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error;¶
(F) The director may re-evaluate the necessity of continuing a suspension; and¶
(G) The order will become final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.¶
(e) If the director denies the insurer's request for suspension of compensation, the insurer will be notified of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.¶
(5) Requests to reduce benefits. The director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation program or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits must be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate.¶
(a) When an insurer submits a request to reduce benefits under this section, the insurer must:¶
(A) Specify the basis for the request;¶
(B) Include all supporting documentation;¶
(C) Send a copy of the request, including the supporting documentation, to the worker and the worker's attorney, if any, by certified mail; and¶
(D) Include the following notice in bold and formatted as follows:¶
~~Notice to worker: ¶~~
~~¶~~
~~If the Workers' Compensation Division grants this request, you may lose all or part of your benefits. ¶~~
~~¶~~

~~If you think this request to reduce your benefits is wrong, write to the Workers' Compensation Division immediately. ¶~~
~~¶~~
~~- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶~~
~~¶~~
~~- Address your letter to: ¶~~
~~¶~~
~~Workers' Compensation Division ¶~~
~~350 Winter Street NE ¶~~
~~PO Box 14480 ¶~~
~~Salem OR 97309-0405¶~~
~~¶~~
~~If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.~~ [See attachment.]¶
(b) The director will make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.
Statutory/Other Authority: ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325, ORS 656.704, ORS 656.726(4)

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-060-0105.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336755

AMEND: 436-060-0137

RULE SUMMARY: Revised rule 0137 to remove the term “authorized nurse practitioner”

CHANGES TO RULE:

436-060-0137
Vocational Evaluations for Permanent Total Disability Benefits; and Suspension of Compensation ¶

(1) Requests for vocational evaluations. A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director.¶
(2) Allowed number of vocational evaluations. The insurer may request no more than three separate vocational evaluations without authorization from the director. Insurers that fail to obtain authorization from the director for additional vocational evaluations may be assessed a civil penalty.¶
(a) To request authorization the insurer must:¶
(A) Submit a written request for authorization that includes:¶
(i) The reasons for an additional vocational evaluation;¶
(ii) The conditions to be evaluated;¶
(iii) The dates, times, places, and purposes of previous evaluations;¶
(iv) Copies of previous vocational evaluation notification letters to the worker; and¶
(v) Any other information requested by the director;¶
(B) Provide a copy of the request to the worker and the worker's attorney, if any.¶
(b) The director will review the request and determine if additional information is needed.¶
(A) Upon receipt of a request for additional information from the director, the parties will have 14 days to respond.¶
(B) If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.¶
(c) The director's decision approving or denying more than three vocational evaluations may be appealed by requesting a hearing by the board within 60 days of the order.¶
(d) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.¶
(3) Notice to worker. The insurer must notify the worker of the evaluation at least 10 days before the date of evaluation.¶
(a) The notice sent for each evaluation, including evaluations that have been rescheduled, must contain the following:¶
(A) The name of the vocational assistance provider or facility;¶
(B) A statement of the specific purpose for the evaluation;¶
(C) The date, time and place of the evaluation;¶
(D) The first and last name of the attending physician or ~~authorized nurse practitioner or~~ a statement that there is no attending physician~~ or authorized nurse practitioner~~, whichever is appropriate;¶
(E) If applicable, confirmation that the director has approved the evaluation;¶
(F) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and¶
(G) The following notice in bold and formatted as follows:¶
~~You must attend this evaluation. ¶~~
~~¶~~
~~If there is any reason you cannot attend, you must tell us as soon as possible before the date of the evaluation. ¶~~
~~¶~~
~~Your workers' compensation benefits may be suspended under Oregon laws and rules* if you: ¶~~
~~¶~~
~~- Do not attend the evaluation, ¶~~
~~- Do not cooperate with the evaluation, or ¶~~
~~- Do not have good reason for not attending. ¶~~
~~¶~~
~~If you have any questions you may call: ¶~~
~~- [Insurer] at [Insurer phone number] ¶~~

~~- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶~~
~~- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free). ¶~~
~~¶~~
~~*Oregon Revised Statute 656.206 and Oregon Administrative Rules Chapter 436, division 60~~ [See attachment.]¶
(b) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must meet the requirements of this section.¶
(4) Reimbursements of costs. The insurer must pay the costs of the vocational evaluation and related services necessary to allow the worker to attend the evaluation, including a reasonable cost of public transportation or use of a private vehicle, and when necessary, a reasonable cost of child care, meals, lodging and other related services. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.¶
(5) Suspension of compensation. When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director, the director may suspend the worker's compensation by order, under the following conditions:¶
(a) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service;¶
(b) The request must include the following information:¶
(A) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;¶
(B) What specific actions of the worker prompted the request;¶
(C) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;¶
(D) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;¶
(E) Any reasons given by the worker for failing to attend, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;¶
(F) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension;¶
(G) A copy of the letter required in section (3) of this rule and a copy of any written verification received under paragraph (F) of this subsection;¶
(H) Any other information that supports the request; and¶
(I) The following notice in bold and formatted as follows:~~¶~~
~~Notice to worker: ¶~~
~~¶~~
~~If the Workers' Compensation Division grants this request, you may lose all or part of your benefits. ¶~~
~~¶~~
~~If you think this request to suspend your compensation is wrong, write to the Workers' Compensation Division immediately. ¶~~
~~¶~~
~~- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you. ¶~~
~~¶~~
~~- Address your letter to: ¶~~
~~¶~~
~~Workers' Compensation Division ¶~~
~~350 Winter Street NE ¶~~
~~PO Box 14480 ¶~~
~~Salem OR 97309-0405 ¶~~
~~¶~~
~~If you have any questions, you may call: ¶~~
~~- [Insurer] at [Insurer phone number]¶~~
~~- Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585 ¶~~
~~- Ombuds Office for Oregon Workers at 800-927-1271 (toll-free)~~ [See attachment.]¶
(c) If the director suspends compensation:¶
(A) The suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the director determines is appropriate until the date the worker attends the evaluation;¶
(B) The worker is not entitled to compensation during or for the period of suspension;¶

(C) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance;¶
(D) The director may modify or set aside the suspension order before or after filing of a request for hearing;¶
(E) The director may order payment of compensation previously suspended where the director finds the suspension to have been made in error; and¶
(F) The director may re-evaluate the necessity of continuing a suspension;¶
(d) If the insurer fails to comply with this rule, the director may deny the request for suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified; and¶
(e) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the board.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.206

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 436-060-0137.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336756

AMEND: 436-060-0147

RULE SUMMARY: Revised rule 0147 to:
-Remove the term “authorized nurse practitioner”
-In section (2), to replace the term “physicians” with “medical service providers as defined under OAR 436-010-0005(26).”
-In section (3), to replace the term “physicians” with “medical service providers as defined under OAR 436-010-0005(26).”
-In section (3), clarify the insurer must send the names of an authorized nurse practitioners the worker saw before the rule changed to implement HB 4040 (2026).

CHANGES TO RULE:

436-060-0147
Worker Requested Medical Examination ¶

(1) Eligibility. The worker is eligible for a worker requested medical examination if:¶
(a) The worker has made a timely request for a board hearing on a denial of compensability;¶
(b) The denial is based on one or more independent medical examination reports; and¶
(c) The attending physician ~~or authorized nurse practitioner~~ does not concur with the report or reports.¶
(2) Request for exam. The worker must submit a request for the exam to the division. A copy of the request must be sent simultaneously to the insurer.¶
(a) The request must include:¶
(A) The name, address, and claim identifying information of the worker;¶
(B) A list of ~~physicians~~medical service providers as defined under OAR 436-010-0005, including names and addresses, who have previously provided medical services to the worker on the claim, or who have previously provided medical services to the worker related to the claimed conditions;¶
(C) The date the worker requested a hearing and a copy of the hearing request;¶
(D) A copy of the insurer's denial letter; and¶
(E) Documents that demonstrate that the attending physician ~~or authorized nurse practitioner~~ does not concur with the independent medical examination report or reports, if available.¶
(b) The director will determine the worker is eligible for an exam if the eligibility criteria in section (1) of this rule are met and:¶
(A) The worker or insurer provides documents that demonstrate that the attending physician ~~or authorized nurse practitioner~~ does not concur with the independent medical examination report or reports; or¶
(B) The director has not received documents that demonstrate the attending physician ~~or authorized nurse practitioner~~ does or does not concur with the report or reports, and at least 30 days after the worker's request for hearing under subsection (1)(a) of this rule have passed.¶
(3) Required documentation. The insurer must send to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all ~~physicians or nurse practitioners~~medical service providers as defined under OAR 436-010-0005 who have:¶
(a) Acted as the worker's attending physician or acted as the worker's authorized nurse practitioner as defined under OAR 436-060-0005(2) in effect on Jan. 1, 2026;¶
(b) Provided medical consultations or treatment to the worker;¶
(c) Examined the worker at an independent medical examination requested by the insurer under ORS 656.325; or¶
(d) Reviewed the worker's medical records on the claim.¶
(4) Penalty for failure to provide documentation. Failure to provide the required documentation described in section (3) of this rule in a timely manner may subject the insurer to civil penalties under OAR 436-060-0200.¶
(5) Selection of physicians. If the director determines the worker is eligible for the exam, the director will notify all parties in writing of the physician selected, or will provide the worker or the worker's attorney a list of appropriate physicians. If the director provides a list of physicians, the following applies:¶
(a) The worker's or the worker's attorney's response must be in writing, signed, and delivered to the director within 14 days of the mailing date of the list;¶
(b) The worker or the worker's attorney may eliminate the name of one physician from the list;¶
(c) If the worker or the worker's attorney does not respond as provided in this section, the director will select a physician; and¶
(d) The director will notify the parties in writing of the physician selected.¶

(6) Scheduling the exam. The worker or the worker's attorney must schedule the exam with the selected physician, and notify the insurer and the board of the scheduled exam date within 14 days of the date of the director's notice in section (5) of this rule. The exam is not required to take place within the 14-day notification period. An unrepresented worker may consult with the Ombuds Office for Oregon Workers for assistance.¶
(7) Required medical records. The insurer must send the physician the worker's complete medical and diagnostic record on the claim and the original questions asked of the independent medical examination physicians no later than 14 days before the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider send the diagnostic records to the selected physician at least 14 days before the scheduled exam.¶
(8) Exam questions. The worker, or the worker's attorney, must communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days before the scheduled date of the exam. An unrepresented worker may consult with the Ombuds Office for Oregon Workers for assistance.¶
(9) Physician's response. Upon completion of the exam the physician must address the original independent medical examination questions and the questions from the worker or the worker's attorney under section (8) of this rule and send the report to the worker's attorney, if any, or the worker, and the insurer within 14 days.¶
(10) Payment of physician. The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Medical services to workers must be delivered in accordance with OAR 436-010.¶
(11) Failure to attend exam. If the worker does not attend the scheduled worker requested medical exam, the insurer must pay the physician for the missed exam under OAR 436-009-0010(13). The insurer is not required to pay for another exam unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.¶
(12) Reimbursement for services. The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.325(1)

AMEND: 436-060-0150

RULE SUMMARY: Revised rule 0150 to remove the term “authorized nurse practitioner”

CHANGES TO RULE:

436-060-0150
Timely Payment of Compensation ¶

(1) General. Benefits are considered paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail, or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent.¶
(2) Saturday, Sunday, or legal holidays. Payments due on a Saturday, Sunday, or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day before, or the first working day after, the Saturday, Sunday, or legal holiday. Subsequent payments may revert back to the payment schedule in place before the Saturday, Sunday, or legal holiday.¶
(3) Withheld compensation. Compensation withheld under ORS 656.268(13) and (14), and ORS 656.596(2), will not be considered late if the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.¶
(4) Timely payment of temporary disability. Insurers must timely process the first payment of temporary disability compensation. The first payment of temporary disability on a claim must also include all temporary disability benefits due as of the date of payment, unless there is a reasonable basis to exclude those benefits at the time the payment issued. The director may assess a penalty under OAR 436-060-0200 against an insurer that does not make the first payment of temporary disability under the time frames of this section, or does not accurately report timeliness of first payment information.¶
(a) The payment of temporary disability benefits must be made no later than the 14th day after:¶
(A) The date of the employer's notice or knowledge of the claim and of the worker's disability, if the attending physician ~~or authorized nurse practitioner~~ has authorized temporary disability compensation. Temporary disability accrued before the date of the employer's notice or knowledge of the claim is due within 14 days of claim acceptance;¶
(B) The date the attending physician ~~or authorized nurse practitioner~~ authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim and of the worker's disability;¶
(C) The start of authorized vocational training under ORS 656.268(10), if the insurer has previously closed the claim;¶
(D) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;¶
(E) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of temporary disability. If the insurer has appealed a reconsideration order, the appeal stays payment of temporary disability benefits except those that accrue from the date of the order, under ORS 656.313;¶
(F) The date of a notice of claim closure issued by the insurer that finds the worker entitled to temporary disability;¶
(G) The date a notice of closure is set aside by a reconsideration order;¶
(H) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the board is the signature date, and from the courts, it is the date of the appellate judgment;¶
(I) The date the director refers a claim to the insurer for processing under ORS 656.029;¶
(J) The date the director refers a noncomplying employer claim to an assigned claims agent under ORS 656.054;¶
(K) The date a claim disposition agreement is disapproved by the Worker's Compensation Board or administrative law judge, if temporary disability benefits are otherwise due;¶
(L) The date the director designates a paying agent under ORS 656.307;¶
(M) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; or¶
(N) The date an insurer voluntarily rescinds a denial of a disabling claim.¶
(b) Subsequent payments of temporary disability benefits must be made:¶
(A) At least once each 14 days and include all benefits due for the period ending no more than seven days before the payment date; or¶
(B) In accordance with the employer's payroll schedule and pay period. If temporary disability benefits are paid under this paragraph, the insurer's claim file must include written documentation of the payroll schedule and pay

period before the payments are issued.¶
(5) Timely payment of permanent disability.¶
(a) The first payment of permanent disability must be paid no later than the 30th day after:¶
(A) The date of a notice of claim closure issued by the insurer;¶
(B) The date of any litigation order that orders payment of permanent total disability. Permanent total disability benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the board is the signature date, and from the courts, it is the date of the appellate judgment;¶
(C) The date of any director's order, including, but not limited to, a reconsideration order, that orders payment of compensation for permanent disability;¶
(D) The date any litigation order authorizing permanent partial disability becomes final;¶
(E) The date a claim disposition agreement is disapproved by the board or administrative law judge, if permanent disability benefits are otherwise due; or¶
(F) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(10) and OAR 436-060-0040(3).¶
(b) Subsequent payments of permanent disability must be made on a regular and predictable monthly schedule.¶
(A) The insurer may adjust the monthly payment schedule, but must inform the worker or beneficiary before making the adjustment.¶
(B) No payment period may exceed one month without the director's approval.¶
(6) Timely payment of death benefits.¶
(a) Payment of bills submitted under OAR 436-060-0075(1) must be made no later than the 30th day after the date of the insurer's receipt the bill, or the date of claim acceptance, whichever is later.¶
(b) The first payment of monthly benefits to eligible beneficiaries under OAR 436-060-0075 must be paid no later than the 30th day after:¶
(A) The date of a notice of acceptance issued by the insurer; or¶
(B) The date of any litigation order that orders death benefits. Death benefits accruing from the date of the order must begin no later than the 30th day after:¶
(i) The signature date of an order from the board; or¶
(ii) The date of an appellate judgment from the courts.¶
(c) Subsequent payments of monthly benefits to eligible beneficiaries under OAR 436-060-0075 must be made on a regular and predictable schedule, subject to the following:¶
(A) The insurer may adjust the monthly payment schedule, but must inform the beneficiary before making the adjustment; and¶
(B) No payment period may exceed one month without the director's approval.¶
(d) Notwithstanding subsection (c), the insurer may make a payment in advance with the consent of the beneficiary.¶
(e) Payment of monthly benefits due to a worker's death during a period of permanent total disability under OAR 436-060-0075(7) must follow the monthly schedule established under subsection (5)(b) of this rule.¶
(7) Notice to worker or beneficiary regarding payments. The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes, and must:¶
(a) Notify the worker or beneficiary in writing of the specific purpose and the time period covered by each payment of temporary disability benefits; and¶
(b) Notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover with the first payment of permanent disability or death benefits. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or death benefit payment.¶
(8) Maintenance of records. The insurer must maintain records of compensation paid for each claim in which benefits are due and payable.¶
(9) Request for reimbursement. If the worker submits a request for reimbursement, the insurer must respond as required under OAR 436-009-0025(1).¶
(10) Claim disposition agreements. Any amounts due under a claim disposition agreement must be paid no later than the 14th day after the board or administrative law judge provides notice of its approval under OAR 438-009-0028, unless otherwise stated in the agreement.¶
(11) Claims under other jurisdictions. When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon:¶
(a) The worker is entitled to the full amount of compensation due under Oregon law;¶
(b) The total amount paid or awarded under the other jurisdiction's law must be credited against the compensation due under Oregon law;¶
(c) If Oregon compensation is more than the compensation paid or awarded under the other jurisdiction's law, or

compensation paid the worker under another law is recovered from the worker, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law;¶
(d) Upon learning that the worker has a claim under the jurisdiction of another workers' compensation law, the insurer must request written documentation of the amount paid or awarded to the worker; and¶
(e) Payment under this section is due within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.126, ORS 656.204, ORS 656.208, ORS 656.262(4), ORS 656.268(10), ORS 656.273, ORS 656.278, ORS 656.289, ORS 656.307, ORS 656.313