DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

Medical Services
PROPOSED Oregon Administrative Rules
Chapter 436, Division 010

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Proposed revisions are marked as follows:

Deleted text has a "strike-through" style, as in ~~Deleted~~

Added text is bold and underlined, as in **Added**

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services, Workers' Compensation Division	OAR CHAPTER 436
Agency and Division	**Administrative Rules Chapter Number**
Fred Bruyns	(503) 947- 7717 Fax (503) 947-7581
Rules Coordinator	**Telephone**

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RULE CAPTION

Proposed amendment of workers' compensation rules affecting injured workers, employers, medical providers, insurers, and others.

May 22, 2006	10:00 a.m.*	Room 260 (2nd Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	**Time**	**Location**	**Hearings Officer**

***NOTE: The hearing will begin at 10:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through May 26, 2006.**

The site of the hearing is accessible for individuals with mobility impairments. Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

ADOPT: None

AMEND: OAR

436-010-0005	436-010-0230	436-010-0275	436-055-0070	436-060-0035
436-010-0210	436-010-0240	436-010-0280	436-055-0085	436-060-0095
436-010-0220	436-010-0265	436-055-0008	436-055-0110	436-070-0020

REPEAL: 436-055-0120

ORS 656.726(4)
Stat. Auth.

Other Authority

ORS chapter 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, ch. 26; ORS 656.325, Enrolled SB 311 – OL 2005, ch. 675
Stats. Implemented

RULE SUMMARY

Proposed substantive amendments affect:

- (OAR 436-010-0220) Referrals to a specialist physician by an attending physician or authorized nurse practitioner – the authority of the specialist physician to provide services and treatment without specific authorization by the attending physician or nurse practitioner (specialist physician is defined in OAR 436-010-0005(38);
- (OAR 436-010-0230) Informed consent for attendance by an employer representative at a worker's medical exam – requirement that the consent form be written in a way that enables the worker to understand it; the worker has the right to refuse such attendance;
- (OAR 436-010-0230) Reimbursement for medications dispensed by physicians and authorized nurse practitioners – removal of the 10-day supply limitation;

- (OAR 436-010-0265) Independent medical examinations (IMEs) – criteria for addition to the list of qualified physicians; exemptions; criteria for removal from list; training curriculum requirements;
- (OAR 436-010-0265) IMEs - consequences for failing to use a qualified provider from the director's list or obtaining more than three examinations without the director's approval;
- (OAR 436-010-0265) Seven-day time frame for IME provider to send examination report to the insurer – elimination of time frame;
- (OAR 436-010-0265 & 436-060-0095) Survey of injured worker's IME experience – requirements that the insurer send an IME survey form: (1) to the worker with the appointment notice and (2) to the IME provider with the invasive procedure authorization form; requirement that the IME provider give a survey form to the worker to complete after the examination; the survey to be a postage-paid (by the State of Oregon) self-mailer, for delivery to the Workers' Compensation Division;
- (436-010-0275) Insurer-managed care organization (MCO) communication – requirement that the insurer pass along information to the MCO if the information was sent to the insurer in error;
- (OAR 436-055-0008) Hearings on workers' compensation matters currently processed by the Office of Administrative Hearings – transfer to the Workers' Compensation Board.
- (OAR 436-055-0085) Training for renewal of claims examiner certification - for director approval, a training curriculum does not need to cover all of the components listed in OAR 436-055-0085(2);
- (OAR 436-070-0020, making some temporary changes permanent) Failure to File Notice or Notice of Audit Findings – criteria for issuance of a Failure to File Notice or Notice of Audit Findings.

Request for public comment: The Workers' Compensation Division requests public comment on whether other options should be considered for achieving the rules' substantive goals while reducing the negative economic impact of the rules on business.

Address questions to:
Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyns@state.or.us

Proposed rules are available on the Workers' Compensation Division's Web site:
http://wcd.oregon.gov/policy/rules/rules.html#proprules
or from WCD Publications, 503-947-7627 or fax 503-947-7630.

May 26, 2006	*John L. Shilts* *4-13-06*
Last Day for Public Comment	Authorized Signer and Date
	John L. Shilts, Administrator, Workers' Compensation Division
	Printed name

*The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

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Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Consumer and Business Services, Workers' Compensation Division	OAR CHAPTER 436
Agency and Division	**Administrative Rules Chapter Number**

In the Matter of
The Amendment of OAR:)
436-010, Medical Services)
436-055, Certification of Claims Examiners)
436-060, Claims Administration)
436-070, Workers' Benefit Fund Assessment)

Rule Caption:
Proposed amendment of workers' compensation rules affecting injured workers, employers, medical providers, insurers, and others.

Statutory Authority: ORS 656.726(4)

Other Authority:

Statutes Implemented: ORS chapter 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, ch. 26; ORS 656.325, Enrolled SB 311 – OL 2005, ch. 675

Need for the Rule(s): The majority of the proposed rule changes are for implementation of 2005 legislation, especially Senate Bill 311, affecting independent medical examinations. Section 5 of SB 311 becomes operative on July 1, 2006. The agency proposes additional changes based on recommendations from customers and stakeholders, experience with disputed issues, and the goals of regulatory streamlining.

Documents Relied Upon, and where they are available: "Issues" documents as presented to stakeholder advisory committees; advisory committee meeting minutes; written advisory committee input in response to the agency's request for input on potential amendments.

Fiscal and Economic Impact, including Statement of Cost of Compliance: (References to "insurer" in this analysis mean the workers' compensation insurer or self-insured employer; "agency" means the Department of Consumer and Business Services and the Workers' Compensation Division; "workers' compensation system" means the agency, employers, injured workers, insurers, medical providers, vocational providers, and others in any way involved in or affected by workers' compensation laws and rules.)

The following is a list of significant changes and their estimated fiscal and economic impact on persons and organizations affected by proposed changes to chapter 436:

- **(OAR 436-010-0220) Referrals to a specialist physician by an attending physician or authorized nurse practitioner – the authority of the specialist physician to provide services and treatment without specific authorization by the attending physician or nurse practitioner**

  The proposed rule change does not affect common industry practices. However, some recently disputed cases reflect uncertainty about the authority of specialist physicians. The agency projects this clarification will not have a significant fiscal impact for insurers or for medical providers. To the extent this clarification prevents an acceleration of litigation, it will avert an increase in litigation costs within the workers' compensation system.

- **(OAR 436-010-0230) Informed consent for attendance by an employer representative at a worker's medical exam – requirement that the consent form be written in a way that enables the worker to understand it; the worker has the right to refuse such attendance**

The proposed rule change does not affect common industry practices. Most insurers recognize and take steps to overcome language and cultural barriers.

The agency projects that this rule change is cost-neutral. Any increased costs associated with this rule change should be offset by enhanced efficiency in claims handling and reduced litigation.

- **(OAR 436-010-0230) Reimbursement for medications dispensed by physicians and authorized nurse practitioners – removal of the 10-day supply limitation**

  The agency projects that the proposed rule change will have a minor negative fiscal impact on Oregon pharmacists and a minor (equivalent) positive impact on Oregon physicians and nurse practitioners. At a 2003 Pharmacy Fee Advisory Task Force meeting, a pharmacy representative estimated that workers' compensation pharmacy represented about 1% of total pharmacy in Oregon. According to expert advice from members of the rulemaking advisory committee, probably only a small number of medical providers will choose to dispense medications, and then generally limit dispensing to a few drugs for inflammation and pain control. **Therefore, the agency projects** the extent of any impact to be less than $1/10^{th}$ of one percent of pharmacy sales.

  Insurers who use pharmacy benefit managers (PBMs) may incur some increased costs due to physician dispensing, to the extent their PBMs bill at less than 88% of the average wholesale price under OAR 436-009-0090. **The agency projects** that such impact will be minor, but cannot project specific costs because we do not know how much physician dispensing will occur and whether affected workers will (later in the claim) use the PBM services offered.

  The proposed rule change will reduce out-of-pocket expenses for injured workers who obtain medications directly from their physicians. Reportedly, some workers do not fill their prescriptions at pharmacies because they cannot afford to pay for the drugs out-of-pocket. Lack of appropriate medication affects treatment outcomes. To the extent the proposed change will encourage early treatment, it should improve outcomes and reduce overall medical and claim costs for insurers.

  The agency projects that the proposed change will have a small positive fiscal and economic impact on the workers' compensation system as a whole.

- **(OAR 436-010-0265) Independent medical examinations (IMEs) – criteria for addition to the list of qualified physicians; exemptions; criteria for removal from list; training curriculum requirements**

  ORS 656.325, as revised by Enrolled Senate Bill 311 (2005), requires the director to develop training requirements and educational materials for IME providers. Private companies and the agency will provide training required for a provider to be added to the director's list of authorized IME providers. The cost for training now available is $0 to $325, though the higher dollar amount is for a two-day educational conference*, of which IME training is just one component. In 2004, the agency identified 407 IME providers for the purpose of a survey, but the true number of IME providers for Oregon workers is likely closer to 500. If the average cost of initial training is $100, the dollar cost to providers will be approximately $50,000. In addition, providers will have to take about four hours away from their practices, though some training is offered in the evening or on videotape. At $100 per hour for time away, the cost for 500 IME providers would be $100 x 4 hours x 500 = $200,000. The agency will require continuing education for IME providers, but the time and extent of such training will vary depending on whether relevant laws and rules are changed. The options for continuing education will be less costly and less demanding on time away from medical practice, in part because pre-recorded and possibly web-based training will be available. The annual cost of continuing education should be less than $50,000.

  *The May 2006 educational conference will be presented by the Workers' Compensation Division and the International Workers' Compensation Foundation, a nonprofit corporation dedicated to workers' compensation research and education. 19 providers have registered as of 3/27/06. Prior to 4/1/06, the cost is $225. After 3/31/06, the cost is $275. Late registration cost is $325.

  The agency projects direct and indirect dollar cost to IME providers for initial IME training of approximately

$250,000 during the first year, and no more than $50,000 per year in subsequent years. With the exception of the educational conference, the agency will not charge for training. Other training providers to date are themselves Oregon medical providers or associations of providers; for these trainers the fiscal impact may be positive, depending on the trainer's cost of providing the training.

The agency projected in its analysis of Senate Bill 311 (when SB 311 was being considered by the Oregon Legislature) increased agency costs for administration of IME programs of $525,608 for the 2005-07 biennium and $635,090 for the 2007-09 biennium.

- **(OAR 436-010-0265) Independent medical examinations (IMEs) - consequences for failing to use a qualified provider from the director's list or obtaining more than three examinations without the director's approval**

  The proposed rule changes will raise costs for insurers that do not comply with statutory limitations on independent medical examinations, because:
  a) In some cases, the claims processor may not be allowed to use an IME report to make decisions about the claim. However, the fiscal impact is limited, because the IME report may be used unless someone objects to its use and the director then finds that the insurer violated ORS 656.325(1).
  b) DCBS may issue civil penalties to insurers who violate ORS 656.325(1). ORS 656.745 provides for penalties up to $2,000 per violation and up to $10,000 in aggregate for a three-month period.

  The agency projects that the increased costs for Oregon insurers who do not comply with ORS 656.325 will be offset by:
  a) Use of trained and authorized IME providers, with improved IME reports;
  b) Increased compliance with statutory IME limits.

- **(OAR 436-010-0265) Seven-day time frame for IME provider to send examination report to the insurer – elimination of the time frame**

  The agency is rarely asked to enforce the existing time frame. Market forces will favor IME providers who report examination results to insurers within reasonable time frames.

  The agency projects that this proposed rule change will have no fiscal or economic impact on any party.

- **(OAR 436-010-0265 & 436-060-0095) Survey of injured worker's IME experience – requirements that the insurer send an IME survey form: (1) to the worker with the appointment notice and (2) to the IME provider with the invasive procedure authorization form; requirement that the IME provider give a survey form to the worker to complete after the examination; the survey to be a postage-paid (by the State of Oregon) self-mailer, for delivery to the Workers' Compensation Division**

  The agency will bear the costs of printing the survey and distribution to insurers and medical providers upon request. We estimate agency costs to be no more than $5,000 annually.

  Insurers must include the survey with each appointment notice (for the worker) and with each invasive procedure authorization form (for the medical provider). Based on information obtained from insurers and agency testing of mailing weights, inclusion of the survey with the appointment notice will sometimes increase mailing weight to greater than 1 oz (but less than 2 oz), depending on whether the appointment notice is printed on one or two sheets of paper. Some insurers may be able to hold mailings to one ounce by printing the appointment notice on one sheet of paper, front and back. However, the survey will potentially increase the cost of each mail piece by $0.24 (the same postage increase whether regular or certified mail). 15,000 (estimated annual) IMEs x $0.24 = $3,600 annually.

  We estimate a handling cost of $0.25 per examination for insurers and an equal amount for IME providers. This would entail a cost to insurers of $0.25 x 15,000 (estimated annual) IMEs = $3,750 annually and a cost to IME providers of $3,750 annually.

The agency projects that the proposed rule changes would increase postage and handling costs for insurers and medical providers by approximately $11,100.

A key purpose of the survey is to gather data needed to monitor the effects of legislative reform. In addition, because the worker's evaluation of his or her IME experience will be mailed to the agency, use of the IME survey form may promote improvements in the quality of IMEs. Improvements could offset some or all of the survey costs by improving cooperation with the IME process and reducing litigation.

The agency projects that this proposed rule change would increase costs for insurers and medical providers by no more than the amounts listed above, and that the net economic impact to the workers' compensation system may be neutral or positive.

- **(436-010-0275) Insurer-managed care organization (MCO) communication – requirement that the insurer pass along information to the MCO if the information was sent to the insurer in error**

  The agency projects that this proposed rule change will not have a significant fiscal impact on any party.

- **(OAR 436-055-0008) Hearings on workers' compensation matters currently processed by the Office of Administrative Hearings – transfer to the Workers' Compensation Board**

  Proposed rules do not substantially alter the actions required of the parties to a hearing.

  The agency projects that this proposed rule change will not have a significant fiscal impact on any party.

- **(OAR 436-055-0085) Training for renewal of claims examiner certification - for director approval, a training curriculum does not need to cover all of the components listed in OAR 436-055-0085(2)**

  The agency projects that this proposed rule change will have a small positive fiscal impact on companies that provide training to claims examiners and to insurers who provide training in-house.

- **(OAR 436-070-0020, making some temporary changes permanent) Failure to File Notice or Notice of Audit Findings – criteria for issuance of a Failure to File Notice or Notice of Audit Findings**

  The proposed change is important for the efficient administration of the Workers' Benefit Fund assessments collection program.

  The agency projects that this proposed rule change will not have a significant fiscal impact on any party.

- **The agency estimates that additional proposed rule changes will not have any significant fiscal or economic impact on any persons or businesses, including small businesses.**

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Cost of compliance effect on small businesses:

Identify the types of businesses and industries with small businesses subject to the proposed rule:

Medical providers who perform IMEs for Oregon injured workers.

Estimated number of small businesses subject to the proposed rule:

The agency does not have an exact count of medical providers in Oregon. Our data system only includes medical providers required to carry workers' compensation insurance and thus excludes sole proprietors who do not elect to be covered. However, based on available information, we estimate the number of small medical providers exceeds 8,200.

Describe the projected reporting, record-keeping and other administrative activities required for compliance with the proposed rule, including costs of professional services

Record-keeping: The proposed rule changes do not impose record-keeping requirements. However, although the revised IME laws and related rules do not specify how medical offices are to keep track of staff who are authorized to provide IMEs, most offices will maintain records in order to monitor their own compliance with ORS 656.325(1). The agency will publish a list of authorized IME providers to its Web site.

Reporting: The proposed changes will require reporting of IME training attendance to the agency. The agency will use this information to verify completion of the training required for providers to be added to the director's list of authorized providers under ORS 656.325(1).

Administrative activities: The proposed changes would increase administrative activities related to handling of the IME survey, as well as the use of professional services in the form of IME training necessary to be added to the list of authorized IME providers under ORS 656.325(1).

Identify the equipment, supplies, labor and increased administration required for compliance with the proposed rule:

Equipment: The proposed rule changes do not require equipment purchases or modifications.

Supplies: The proposed rule changes do not require increased purchase of supplies.

Labor: The proposed rule changes affect labor costs indirectly, by requiring medical providers to obtain IME training, and such training may require time away from the medical practice.

Increased administration: The proposed rule changes may result in some increased costs for administration in medical offices, primarily in order to monitor staff compliance with IME training requirements.

How were small businesses involved in the development of this rule?

Representatives from small businesses participated in the stakeholder advisory committee. Small businesses affected by these rules are primarily medical providers.

Reduction of economic impact on small businesses:

After considering advice from the rulemaking advisory committees and the available data, the agency finds no basis to say that these impacts would be "significantly adverse" (under ORS 183.540), but we invite public testimony on the probable extent of the impacts.

****

Administrative Rule Advisory Committee consulted:

Yes. The agency met with committees on February 24, 2006 and March 3, 2006 to discuss potential changes to OAR 436-010, 436-055, and 436-060. The agency conducted a telephone, e-mail, and facsimile survey of an advisory committee for OAR 436-070 during March 2006.

John L. Shilts *4-13-06*
Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division
Printed name

EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010

436-010-0005 Definitions

For the purpose of these rules, OAR 436-009, and OAR 436-015, unless the context otherwise requires:

(1) "Administrative Review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

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

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

(b) A medical doctor, doctor of osteopathy, or oral surgeon practicing in and licensed under the laws of another state;

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

(d) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician of chiropractic practicing and licensed under the laws of another state; or

(e) Any medical service provider authorized to be an attending physician in accordance with a managed care organization contract.

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

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

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

(6) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied.

(7) "Current Procedural Terminology" or "CPT"® means the Current Procedural

Terminology codes and terminology most recently published by the American Medical Association unless otherwise specified in these rules.

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

(9) "Days" means calendar days.

(10) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

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

(12) "Eligible" means an injured worker who has filed a claim and is employed by an employer who is located in an MCO's authorized geographical service area, covered by an insurer who has a contract with that MCO. "Eligible" also includes a worker with an accepted claim having a date of injury prior to contract when that worker's employer later becomes covered by an MCO contract.

(13) "Enrolled" means an eligible injured worker has received notification from the insurer that the worker is being required to treat under the auspices of the MCO. However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

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

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

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

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

(18) "Home Health Care" means medically necessary medical and medically related services provided in the injured worker's home environment. These services might include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

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

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

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

(22) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(23) "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.

(24) "Mailed or Mailing Date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

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

(26) "Medical Evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, x-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material utilized, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(27) "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.

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

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

(30) "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.

(31) "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician under ORS 656.005 and subsections (2)(c) and (2)(d) of this rule.

(32) "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as

emergency room services, observation room, or short stay surgical treatments which do not result in admission are also considered outpatient services.

(33) "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.

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

(35) "Physical Restorative Services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia, a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the highest functional ability consistent with the worker's condition. Physical restorative services are not services to replace medical services usually prescribed during the course of recovery.

(36) "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.

(37) "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

(38) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensable injury.

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

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

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.000 et seq.; 656.005
Hist: Filed 10/20/76 as Admin. Order 4-1976, eff 11/1/76
Amended 6/5/78 as Admin. Order 7-1978, eff 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff 2/1/80
Amended 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-005, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 6/26/86 as Admin. Order 4-1986, eff 7/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff 3/16/87
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 7/20/90 as Admin. Order 14-1990, eff 7/20/90 (Temp)
Amended 8/17/90 as Admin. Order 17-1990, eff 8/17/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0210 Who May Provide Medical Services and Authorize Timeloss

(1) Attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of these rules. However, an MCO may designate any medical service provider as an attending physician who may provide medical services to an enrolled worker in accordance with ORS 656.260.

(2) Authorized primary care physicians and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO.

(3) Attending physicians and authorized nurse practitioners may prescribe treatment or services to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment or services to be carried out by persons not licensed to provide a medical service or treat independently only when such services or treatment is rendered under the physician's direct control and supervision. Reimbursement to a worker for home health care provided by a worker's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(4) Physician assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are contained in ORS 442.470. A list of rural hospitals is provided in Appendix A.

(5) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(4)(a), nor under the direct control and supervision of the attending physician.

(6) A physician assistant, licensed under ORS 677.515, may provide services when the **Board of Medical Examiners approves the** physician assistant ~~is approved~~ for practice ~~by the Board of Medical Examiners~~.

(7) Effective October 1, 2004, in order to provide any compensable medical service under ORS chapter 656, a nurse practitioner licensed under ORS 678.375 to 678.390 must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request and must have been assigned an authorized nurse practitioner number by the director. An authorized nurse practitioner may:

(a) Provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without authorization of an attending physician; and

(b) Authorize temporary disability benefits for a period of up to 60 days from the date of the first nurse practitioner visit on the initial claim.

(8) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer must give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

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

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the medical service provider in writing of the following:

(A) The Oregon fee schedule requirements;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon injured workers; and

(C) Billings for compensable services in excess of the maximum allowed under the fee schedule may not be paid by the insurer.

(9) After giving prior approval, if the out-of-state physician does not comply with these rules, the insurer may object to the worker's choice of physician and must notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by

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

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.005(12), 656.245,656.260
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff 8/20/84;
Renumbered from OAR 436-69-301, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 9/6/88 as Admin. Order 6-1988, eff 9/15/88
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-050 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 10/25/99 as Admin. Order 99-061, eff 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0220 Choosing and Changing Medical Providers

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

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

(b) Authorizes time loss,

(c) Monitors ancillary care and specialized care, and

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

(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers must be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable. **When the attending physician or authorized nurse practitioner refers the worker to a specialist physician, the referral must be written. Unless the documented referral limits the referral to consultation only, the referral is deemed to include authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate.** Fees for services by more than one physician at the same time are

payable only when the service is sufficiently different that separate medical skills are needed for proper care.

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

(a) Emergency services by a physician;

(b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner;

(d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change medical service providers to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:

(A) When the physician terminates practice or leaves the area;

(B) When a physician is no longer willing to treat an injured worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the physician;

(D) When the 90 day period for treatment or services by an authorized nurse practitioner has expired;

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

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

(g) A Worker Requested Medical Examination;

(h) Whether a worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines; or

(i) When a worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence.

(4) When a worker has made an initial choice of attending physician or authorized nurse practitioner and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer must inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable services rendered prior to notice to the worker. If an attending physician or authorized nurse practitioner begins treatment without being informed that the worker has been given the required notification, the insurer must pay for appropriate services rendered prior to the time the insurer notifies the medical service provider that further payment will not be made and informs the worker of the right to seek approval of the director.

(5)(a) If a worker not enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of medical service provider or a Form 827 indicating the worker is choosing to change his or her attending physician or authorized nurse practitioner, the insurer must notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer must advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the request, the insurer must notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer must provide the reasons and give notification that the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician or authorized nurse practitioner issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of Form 2332.

(6) Upon receipt of a worker's request for an additional change of attending physician or authorized nurse practitioner, the director may notify the parties and request additional information. Upon receipt of a written request from the director for additional information, the parties will have 14 days to respond in writing.

(7) After receipt and review, the director will issue an order advising whether the change is approved. The change of attending physician or authorized nurse practitioner will be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

(a) Whether there is medical justification for a change, including whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(b) Whether the worker has moved to a new area and wants to establish an attending

physician or authorized nurse practitioner closer to the worker's residence.

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

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.252, 656.260
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-401, 5/1/85
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-060 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0230 Medical Services And Treatment Guidelines

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

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

(a) The consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present. ~~The worker has the right to refuse such attendance.~~

(b) The consent form must be written in a way that allows the worker to understand it.

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

(3) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services. Unless otherwise provided for by statute, or within utilization and treatment standards under an MCO contract, treatment typically does not exceed 15 office visits by any and all attending physicians or authorized nurse practitioners in the first 60 days from first date of treatment, and two visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment.

(4) (a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician will not be reimbursed

unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A).

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

(c) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a chiropractor, naturopath, acupuncturist, or podiatrist will be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

(d) Unless otherwise provided for within utilization and treatment standards under an MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days, and 4 visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment or services. The attending physician or authorized nurse practitioner must document the need for medical services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

(5) The attending physician or authorized nurse practitioner, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, must complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner must notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker will be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. ~~Except in an emergency, d~~**D**rugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable ~~only for the initial supply to treat the worker with the medication up to a maximum of 10 days,~~ subject to the **requirements of the provider's licensing board,** this rule**,** and OAR 436-009-0090. Compensation for certain drugs are limited as provided in OAR 436-009-0090.

(7) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker or they are provided in accordance with a utilization and treatment standard adopted by the director. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

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

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

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

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

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

(10) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

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

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

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.252
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Amended 8/20/84 as Admin. Order 5-1984, eff 8/20/84
Amended 4/29/85 as Admin. Order 2-1985, eff 6/3/85;
Renumbered from OAR 436-69-110, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 2/20/87 as Admin. Order 2-1987, eff 3/16/87

Amended 6/15/87 as Admin. Order 3-1987, eff 6/15/87
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 9/6/88 as Admin. Order 6-1988, eff 9/15/88
Amended 8/21/89 as Admin. Order 2-1989, eff 9/1/89
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-040, 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Filed 2/11/99 as Admin. Order 99-052, eff. 2/11/99 (Temp)
Amended 4/28/99 as Admin. Order 99-055, eff 4/28/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0240 Reporting Requirements for Medical Providers

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records under ORS 656.252 and diagnostic records required under ORS 656.325. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, this authorization does not authorize the release of information regarding:

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

(b) The release of HIV related information otherwise protected by ORS 433.045(3). HIV related information should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition(s).

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

(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim must complete the first medical report (Form 827) in every detail, to include the worker's name, address, and social security number (SSN), and information required by ORS 656.252 and 656.254. The medical service provider must mail it to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period).

(a) Diagnoses stated on Form 827 and all subsequent reports must conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(b) The worker's SSN will be used by the director to carry out its duties under ORS chapter 656. The worker may voluntarily authorize additional use of the worker's SSN by various government agencies to carry out their statutory duties.

(4) All medical service providers must notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. The worker must also be notified that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the worker's chart notes.

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

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

(7) Progress reports are essential. When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports must be in accordance with OAR 436-009-0015 (11), 436-009-0070 (2) or (3), whichever applies

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

(9) 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.

(10) The medical provider must respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, original diagnostic studies, including, but not limited to, actual films, and any or all necessary records needed to review the efficacy of medical treatment or medical services, frequency, and necessity of care. The medical provider must be reimbursed for copying documents in accordance with OAR 436-009-0070 (1). If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

(11) The attending physician or authorized nurse practitioner must inform the insurer and the worker of the anticipated date of release to work, the anticipated date the worker will become medically stationary, the next appointment date, and the worker's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report. The insurer must not consider the anticipated date of becoming medically stationary as a release to return to work.

(12) At the time the attending physician or authorized nurse practitioner declares the worker medically stationary, the attending physician or authorized nurse practitioner must notify the worker, the insurer, and all other medical providers who are providing services to the worker. For disabling claims, if the worker has been under the care of an authorized nurse practitioner,

the authorized nurse practitioner must follow the requirements of OAR 436-010-0280 regarding the determination and reporting of permanent impairment and closing examinations. The attending physician must send a closing report to the insurer within 14 days of the examination in which the worker is declared medically stationary, except where a consulting physician examines the worker. The procedures and time frames for a consulting physician to perform the closing exam are provided in OAR 436-010-0280.

(13) The attending physician or authorized nurse practitioner must advise the worker, and within five days provide the insurer with written notice, of the date the injured worker is released to return to regular or modified work. The physician or nurse must not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

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

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

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

(15) The attending physician, authorized nurse practitioner, or the MCO may request consultation regarding conditions related to an accepted claim. The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for consultation. This requirement does not apply to diagnostic studies performed by radiologists and pathologists. The attending physician, authorized nurse practitioner, or MCO must provide the consultant with all relevant clinical information. The consultant must submit a copy of the consultation report to the attending physician, authorized nurse practitioner, the MCO, and the insurer within 10 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report. MCO requested consultations that are initiated by the insurer, which include examination of the worker, must be considered ~~insurer~~ **independent** medical examinations subject to the provisions of OAR 436-010-0265.

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

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

(a) The new provider is responsible for:

(A) Submitting Form 827 to the insurer not later than five days after the change or the date of first treatment; and

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

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

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

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

(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0070(1), but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.

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

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

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

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

(c) A worker or the worker's representative may request all or part of the record. A summary may substitute for the actual record only if the patient agrees to the substitution. Upon request, the entire health information record in the possession of the medical provider will be provided to the worker or the worker's representative. This includes records from other healthcare providers, except that the following may be withheld:

(A) Information which was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information;

(B) Psychotherapy notes;

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

(D) Other reasons specified by federal regulation.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254, 656.273
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Renumbered from OAR 436-69-101, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 7/20/90 as Admin. Order 14-1990, eff 7/20/90 (Temp)

Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-030, 5/3/96 as WCD Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0265 Independent Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by ~~physicians~~ **medical service providers** of ~~their~~ **its** choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. Effective July 1, 2006, the insurer must choose a ~~physician~~**provider** to perform the independent medical examination from the director's list **described** in section (13) of this rule. A claim for aggravation, Board's Own Motion, or reopening of a claim where the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "independent medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician **or authorized nurse practitioner.** The examination may be conducted by one or more ~~medical~~ providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the ~~medical~~ providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer must first notify and request authorization from the director. ~~Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty.~~ The process for requesting such authorization ~~will be~~ **is** as follows:

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

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

(c) An insurer that fails to first notify and request authorization from the director may be assessed a civil penalty.

(d) An insurer shall not use any IME report for any claims processing purpose and the report shall not be considered in any subsequent proceeding if the report is challenged and there is a finding that the IME:

(A) Exceeded the limitation of three IMEs without prior approval from the director; or

(B) Was performed by a provider who was not on the director's list of authorized IME providers at the time of the exam.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) A consultation requested by the Managed Care Organization (MCO) for the purpose

of clarifying or refining a plan for **continuing** medical services as provided under its contract.

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

(7) When **the insurer requires** a worker ~~is required~~ to attend an IME ~~by a physician of the insurer's choice~~, the insurer must comply with the notification and reimbursement requirements ~~contained~~ **found** in OAR 436-009-0025 and 436-060-0095.

(8) A medical ~~service~~ provider who unreasonably fails to timely provide diagnostic records required for an IME in accordance with OAR 436-010-0230(9) and 436-010-0240(10) may be assessed a penalty under ORS 656.325.

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

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

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

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

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

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

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

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

(11) When scheduling an IME, the insurer must provide **an** ~~Form 440-3227 (~~Invasive Medical Procedure Authorization~~)~~ **(Form 440-3227) and the Worker IME Survey (Form 440-0858),** to the medical service provider, **with instructions to give the form(s) to the worker at the time of the IME.**

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

(13) Effective July 1, 2006, any ~~physician~~**medical service provider** ~~licensed in Oregon~~ wishing to perform an IME **or a Worker Requested Medical Exam under ORS 656.325(1)(e) and OAR 436-060-0147** for a workers' compensation claim must meet the director's criteria and be included on the list of authorized ~~physicians~~**providers** maintained by the Director of the Department of Consumer and Business Services under ORS 656.325.

(a) To be on the director's list to perform IMEs, a medical service provider must:

(A) Hold a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon Board of Medical Examiners.

(B) Attend a director-approved three-hour initial training course regarding IMEs. The training curriculum must include, at a minimum, all topics addressed in Appendix B. In addition, providers must attend any other mandatory training as determined by the director.

(i) Exemption from the required training may be granted, at the director's discretion, if the worker and the insurer agree that a certain provider may perform the examination or when extraordinary circumstances exist in a given case.

(ii) When determining if extraordinary circumstances exist in a given case, the director may consider, but is not limited to, such factors as: medical specialty needed; number of IMEs the provider has performed in a calendar year; where the worker lives; and factors that would make required training unreasonable in a given case.

(C) Submit the director's Application for Independent Medical Exam Physician Authorization (Form 440-3930) to the director. On the application, the provider must supply his or her license number, the name of the training vendor, and the date the provider attended a director-approved initial training course regarding IMEs. By signing and submitting the application form, the physician agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or the guidelines of professional conduct for IMEs published by the American Board of Independent Medical Examiners in effect as of January 1, 2006, if the provider's regulatory board does not adopt standards of conduct for IMEs; and

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

(b) Any party may make a written request to the director to add a provider to the director's list.

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

(A) Violated the applicable standards or guidelines of professional conduct for performing IMEs under sub-paragraph (a)(C)(i) of this section;

(B) Failed to comply with the requirements of this rule, as determined by the director;

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

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

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

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

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

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

(15)~~(a)~~ **Except as provided in subsection (a) of this section,** ~~A~~ **a** worker may elect to have an observer present during the IME~~, except for a psychological examination~~.

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

(b) The worker must submit a signed **observer** form (**440-3923A)** to the examining ~~physician~~ **provider** acknowledging that the worker understands the worker may be asked sensitive questions during the examination in the presence of the observer~~;~~**. If the worker does not sign form 440-3923A, the provider may exclude the observer** unless the ~~physician~~ **provider** otherwise approves~~, an observer is not allowed in the examination if this requirement is not met~~.

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

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

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

~~(15)~~ **(16)** Upon completion of the examination, the examining ~~physician(s)~~ **medical service provider** must:

(a) ~~Send a copy of the report to the insurer within seven days of the exam date~~. **Provide the worker a copy of the Worker IME Survey (Form 440-0858), on the day of the exam.**

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

(c) Sign a statement at the end of the report verifying who performed the examination and dictated the report, the accuracy of the content of the report, and acknowledging that any false statements may result in sanction by the director.

~~(16)~~ **(17)** The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

(18) ~~(17) Prior to the examination date, a physician selected to complete a Worker Requested Medical Examination under OAR 436-060-0147 must be on the list of IME~~

~~physicians maintained by the director under ORS 656.325.~~ **A complaint about an IME may be sent to the director for investigation. The director will determine the appropriate action to take in a given case, which may include consultation with or referral to the regulatory board.**

~~(18)~~ **(19)** Insurer claims examiners must be trained and certified in accordance with OAR 436-055~~-0085~~ regarding appropriate interactions with IME **medical service** providers.

(20) Any party may submit medical service provider training curriculum to the director for approval. The curriculum must include training goals, objectives, an outline of the training and specify the number of training hours. Training must be approved by the director before it is given. Training curriculum must include all topics addressed in Appendix B of these rules. Within 21 days of the training, the training provider must supply the director with the date of the training and a list of all attendees, including names, license numbers, and addresses.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Filed 12/16/98 as Admin. Order 98-060, eff 1/1/99
Filed 2/11/99 as Admin. Order 99-052, eff. 2/11/99 (Temp)
Amended 4/28/99 as Admin. Order 99-055, eff 4/28/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 9/27/02 as Admin. Order 02-061, eff 11/01/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

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

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

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

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

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

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

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

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

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

and the MCO of enrollment. The notice must:

(a) Notify the worker of the eligible attending physicians within the relevant MCO geographic service area and describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

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

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

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

(e) 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;

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

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

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

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

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

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

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

(b) If the MCO does not have a dispute resolution process for that issue, the insurer must

notify the parties in writing to seek administrative review before the director.

(9) The insurer must also notify the MCO of**:**

(a) T~~t~~he name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, and ~~must keep~~ **also notify** the MCO ~~informed~~ of any changes **in the information; and**

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

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

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

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

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Filed 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

436-010-0280 Determination of Impairment

(1) The attending physician or authorized nurse practitioner must notify the insurer of the date on which the worker became medically stationary from the compensable injury or illness and whether or not the worker is released to any form of work. The medically stationary date should not be a projected date and should relate to an examination. On disabling claims, when finding or notification that the worker is medically stationary, a determination of permanent impairment for claim closure must be done under OAR 436-030-0020(2). An authorized nurse practitioner must refer the worker to a licensed physician who qualifies as an attending physician to complete a closing examination if there is a reasonable expectation of permanent impairment under ORS 656.214(1)(a) and OAR 436-030-0020(2)(b).

(2) A report must be submitted to the insurer by the attending physician or authorized nurse practitioner within 14 days of the examination in which the worker was determined

medically stationary unless:

(a) The attending physician does not wish to perform the closing examination, in which case, he or she must arrange or request the insurer arrange, within eight days of the examination in which the worker is declared medically stationary, for the worker to be examined by a consulting physician for all or any part of the closing examination; or

(b) The authorized nurse practitioner refers the worker for a closing examination, in which case he or she must arrange or request the insurer arrange, within eight days of the examination in which the worker is declared medically stationary, for the worker to have a closing examination under section (1) of this rule. ~~A closing examination scheduled and performed under this subsection is not an IME or a change of attending physician.~~

(3) An examination must be performed when the attending physician or authorized nurse practitioner is notified by the insurer that the worker's accepted injury is no longer the major contributing cause of the worker's condition and a denial has been issued.

(a) The attending physician must submit a closing report within 14 days of the examination. If the attending physician refers the worker to a consulting physician for all or any part of the closing examination, the examination must be scheduled within five days of the denial notification.

(b) The authorized nurse practitioner must either refer the worker for a closing examination or provide a written statement, in accordance with sections (1) and (2) of this rule.

(4) ~~Under this rule, c~~**<u>C</u>**losing reports for examinations performed by a physician other than the attending physician **<u>under this rule</u>** must be submitted to the attending physician within seven days of the examination asking whether or not the physician concurs with the report and requesting a description of any finding or conclusion with which the attending physician disagrees. The attending physician must review the report and, within seven days of receipt of the report, concur in writing or provide a report to the insurer describing any finding/conclusion with which the attending physician disagrees.

(5) The physician conducting the examination must provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007.

(6) The closing examination report does not include any rating of impairment or disability, but describes impairment findings to be rated by either the insurer or the director. Physicians must provide comments regarding the validity of the examination findings as they pertain to the accepted compensable conditions.

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

(8) The attending physician must specify the worker's residual functional capacity or refer the worker for completion of a second level PCE or WCE (as described in OAR 436-009-0070 (4) pursuant to the following:

(a) A PCE when the worker has not been released to return to regular work, has not

returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A WCE when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(9) When the worker's condition is not medically stationary and a denial has been issued because the worker's accepted injury is no longer the major contributing cause of the worker's condition, the physician must estimate the worker's future impairment and residual functional capacity according to OAR 436-035-0014.

(10) A closing examination scheduled and performed under section (2) of this rule is not an IME or a change of attending physician.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)(B)
Stats. Implemented: ORS 656.245, 656.252
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff 1/16/84
Renumbered from OAR 436-69-601, 5/1/85
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95
Amended and renumbered from OAR 436-010-080 5/3/96 as Admin. Order 96-060, eff 6/1/96
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02
Amended 12/12/03 as Admin. Order 03-069, eff 1/1/04 (Temp)
Amended 3/4/04 as Admin. Order 04-055, eff. 4/1/04
Amended 3/23/05 as Admin. Order 05-052, eff. 4/1/05
Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06
Amended xx/xx/xx as Admin. Order xx-xxx, eff. xx/xx/xx

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Appendix A
Rural Hospitals

Type	**Name**	**Mailing Address**	Phone	FAX
A	Blue Mountain Hospital	170 Ford Road John Day, OR 97845-2009	(541) 575-1311	(541) 575-1255
A	Curry ~~County~~ **General** Hospital	94220 E Fourth St Gold Beach, OR 97444-7772	(541) 247-6621	(541) 247-2012
A	Good Shepherd Medical Center	610 NW 11th Hermiston, OR 97836-6601	(541) 567-6483	(541) 567-4384
A	Grande Ronde Hospital	PO Box 3290 LaGrande, OR 97850-7290	(541) 963-8421	(541) 963-1476
A	Harney District Hospital	557 W. Washington Burns, OR 97720-1497	(541) 573-7281	(541) 573-8353
A	Holy Rosary Medical Center	351 SW 9th Ontario, OR 97914-2693	(541) 881-7000	(541) 881-7183
A	Lake District Hospital	700 South J St Lakeview, OR 97630-1623	(541) 947-2114	(541) 947-2912
A	Pioneer Memorial Hospital	PO Box 9 Heppner, OR 97836-0009	(541) 676-9133	(541) 676-2900
A	St. Anthony Hospital	1601 SE Court Ave Pendleton, OR 97801-3217	(541) 276-5121	(541) 278-3227
A	St. Elizabeth Hospital	3325 Pocahonias Rd Baker City, OR 97814-1464	(541) 523-6461	(541) 523-8151
A	Tillamook County General Hospital	1000 Third Tillamook, OR 97141-3498	(503) 842-4444	(503) 842-3062
A	Wallowa Memorial Hospital	401 NE 1st St Enterprise, OR 97828	(541) 426-3111	(541) 426-4095
B	Ashland Community Hospital	PO Box 8 Ashland, OR 97520-0062	(541) 482-2441	(541) 488-5387
B	St. Charles - Redmond	1253 N Canal Blvd Redmond, OR 97756-1395	(541) 548-8131	(541) 548-9504
B	Columbia Memorial Hospital	2111 Exchange St Astoria, OR 97103-3329	(503) 325-4321	(503) 338-7586
B	Coquille Valley Hospital	940 E 5th St Coquille, OR 97423-1699	(541) 396-3101	(541) 396-5760
B	Cottage Grove Community Hospital	1340 Birch Ave Cottage Grove, OR 97424-1498	(541) 942-0511	(541) 942-6528
B	Lebanon Community Hospital	PO Box 739 Lebanon, OR 97355-0739	(541) 258-2101	(541) 451-7071
B	Lower Umqua Hospital	600 Ranch Road Reedsport, OR 97467-1795	(541) 271-2171	(541) 271-2941
B	Mid-Columbia Medical Center	1700 E 19th St The Dalles, OR 97058-3398	(541) 296-1111	(541) 296-7600
B	Mountain View Hospital	470 NE A St Madras, OR 97741-1899	(541) 475-3882	(541) 475-4804

Appendix A

B	Peace Harbor Hospital	400 Ninth St Florence, OR 97439	(541) 997-8412	(541) 997-9155
B	Pioneer Memorial Hospital	1201 N Elm Prineville, OR 97754-1299	(541) 447-6254	(541) 447-6705
B	Providence Hood River Hospital	PO Box 149 Hood River, OR 97031-0055	(541) 386-3911	(541) 387-6462
B	Providence Newberg Hospital	501 Villa Road Newberg, OR 97132-1887	(503) 537-1555	(503) 537-1800
B	Providence Seaside Hospital	725 S Wahanna Rd Seaside, OR 97138-7725	(503) 717-7000	(503) 717-7505
B	Samaritan North Lincoln Hospital	PO Box 767 Lincoln City, OR 97367-0767	(541) 994-3661	(541) 996-7386
B	Samaritan Pacific Communities Hospital	PO Box 945 Newport, OR 97365-0072	(541) 265-2244	(541) 574-1832
B	Santiam Memorial Hospital	1401 N 10th Ave Stayton, OR 97383-1399	(503) 769-2175	(503) 769-5877
B	Silverton Hospital	342 Fairview Silverton, OR 97381-1993	(503) 873-1500	(503) 873-1534
B	Southern Coos Hospital	900 11th St SE Bandon, OR 97411-9114	(541) 347-2426	(541) 347-3923
B	West Valley Hospital	PO Box 378 Dallas, OR 97338-0378	(503) 623-8301	(503) 623-7345
C	Mercy Medical Center	2700 Stewart Parkway Roseburg, OR 97470-1281	(541) 673-0611	(541) 677-4803
C	Three Rivers Community Hospital	715 NW Dimick Grants Pass, OR 97526-1596	(541) 476-6831	(541) 955-5410
C	Willamette Valley Medical Center	2700 Three Mile Lane McMinnville, OR 97128-6255	(503) 472-6131	(503) 472-8691

There are two additional hospitals that appear to be rural hospitals; however, because they were federally designated referral hospitals prior to January 1, 1989, they do not meet the statutory definition of a rural hospital. See ORS 442.470.

Type	Name	Address	Phone	FAX
	Bay Area Hospital	1775 Thompson Road Coos Bay, OR 97420	(541) 269-8111	(541) 267-7057
	Merle West Medical Center	2865 Daggett Ave Klamath Falls, OR 97601	(541) 882-6311	(541) 885-6725

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

A. Overview

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

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

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

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

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

Appendix B

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

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

B. Provider Code of Professional Conduct

IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:

1. the guidelines adopted by the appropriate health professional regulatory board, OR
2. the "Guidelines of Conduct" published by the American Board of Independent Medical Examiners in effect on January 1, 2006, if the appropriate regulatory board hasn't adopted standards for professional conduct regarding IMEs.

C. Report writing

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

D. Communication

What is appropriate communication between claims examiners and medical providers?

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

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

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

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

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

Appendix B

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

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

J. Other necessary information as determined by the director.