



# Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
350 Winter St. NE  
PO Box 14480  
Salem, OR 97309-0405  
1-800-452-0288, (503) 947-7810  
TTY (503) 947-7993  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

August 20, 2007

## Proposed Changes to Workers' Compensation Rules

The 2007 Oregon Legislature passed a number of bills affecting workers' compensation laws. The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436 to make these rules consistent with the revised laws. In addition, the department proposes changes to make the rules easier to understand, to streamline regulations, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public hearing.

- When is the hearing?** September 24, 2007, 2:00 p.m.
- Where is the hearing?** Labor & Industries Building  
350 Winter Street NE, Room 260 (2<sup>nd</sup> Floor),  
Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:  
Fred Bruyns, rules coordinator  
Workers' Compensation Division  
350 Winter Street NE (for courier or in-person delivery)  
PO Box 14480, Salem, OR 97309-0405  
Email - [fred.h.bruyns@state.or.us](mailto:fred.h.bruyns@state.or.us)  
Phone - (503) 947-7717; Fax - (503) 947-7581

The closing date for written comments is September 27, 2007.

### How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

<http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules>

Or call (503) 947-7627 to get free paper copies

### Questions?

Contact Fred Bruyns, (503) 947-7717.

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING HEARING**

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services (DCBS),  
Workers' Compensation Division

OAD CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns  
Rules Coordinator

PO Box 14480, Salem, OR 97309-0405;  
350 Winter Street NE, Rm 27, Salem, OR 97301-3879

Address

(503) 947- 7717  
Fax (503) 947-7581

Telephone

**RULE CAPTION**

**Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.**

Hearing date	Time	Location	Hearings Officer
September 24, 2007	2:00 p.m.*	Room 260 (2 <sup>nd</sup> Floor, Labor & Industries Building) 350 Winter Street NE, Salem, Oregon	Fred Bruyns

**\*NOTE: The hearing will begin at 2:00 p.m. and end when all present who wish to testify have done so. Written testimony will be accepted through September 27, 2007.**

**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:** OAR 436-105-0511; 436-105-0512; 436-160-0400; 436-160-0410; 436-160-0420; 436-160-0430

**AMEND:** OAR 436-040; 436-105; 436-110; 436-120; and

436-009-0005	436-015-0005	436-030-0175	436-050-0100	436-060-0008	436-160-0004
436-009-0010	436-015-0030	436-030-0185	436-050-0175	436-060-0010	436-160-0005
436-009-0020	436-015-0040	436-035-0005	436-050-0200	436-060-0015	436-160-0006
436-009-0030	436-015-0120	436-035-0110	436-050-0400	436-060-0018	436-160-0010
436-009-0040	436-030-0007	436-035-0350	436-050-0410	436-060-0055	436-160-0020
436-010-0005	436-030-0020	436-035-0390	436-050-0420	436-060-0060	436-160-0030
436-010-0210	436-030-0035	436-035-0420	436-050-0440	436-060-0140	436-160-0040
436-010-0220	436-030-0115	436-035-0500	436-050-0450	436-060-0147	436-160-0050
436-010-0230	436-030-0135	436-045-0008	436-050-0455	436-060-0150	436-160-0060
436-010-0240	436-030-0145	436-045-0030	436-050-0460	436-160-0001	436-160-0070
436-010-0265	436-030-0155	436-050-0003	436-050-0470	436-160-0002	436-160-0080
436-010-0280	436-030-0165	436-050-0005	436-050-0480	436-160-0003	436-160-0090

**REPEAL:** 436-030-0440; 436-030-0450; 436-030-0460; 436-030-0550; 436-030-0570;  
436-110-0326; 436-110-0327; 436-110-0380; 436-120-0730

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656;  
HB 2943 - OL 2007, ch. 300

Stats. Implemented

**RULE SUMMARY**

**Amendments to implement changes in the Workers' Compensation Law, including:**

- Replacing the term "Handicapped Workers" with "Workers with Disabilities" (SB 83);
- Updating name of Board of Medical Examiners for the State of Oregon to "Oregon Medical Board" (SB 147);

- Including “administrative law judge” as a person who may approve or disapprove a claims disposition agreement (SB 253);
- Describing restrictions affecting emergency room physicians’ rights to be attending physicians and authorize temporary disability benefits (SB 504);
- Deleting requirement that managed care organizations send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director’s review and approval; deleting related definitions (SB 563);
- Explaining how DCBS will publish the maximum reimbursable amount for medical services for non-disabling claims (SB 762);
- Amending penalty provisions affecting managed care organizations; deleting procedures for temporary rule promulgation to address disability in individual claims (when medical conditions are not addressed by current standards), and addressing such conditions in the director’s order on reconsideration, and providing that penalties will not be assessed if an increase in compensation results from such an order; describing how insurers must process requests for a lump sum payments of permanent partial disability awards (HB 2218);
- Describing the authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians (HB 2756);
- Referring to ORS 656.427 regarding time frames for termination of guaranty contracts; defining “premium” (HB 2783);
- Adopting standards of professional conduct for health care providers who perform independent medical examinations, which apply if the provider’s professional regulatory board has not adopted standards for performing such examinations (HB 2943);

**General amendments to OAR chapter 436, including:**

- Using plain language to add clarity to a number of rules;
- Shortening some rules by removing unnecessary descriptions of DCBS procedures;

**Amendments to OAR 436, 009, “Oregon Medical Fee and Payment Rules” and OAR 436-160, “Electronic Data Interchange” (EDI), to improve the quality of medical billing data for use by DCBS and its customers, including:**

- Requiring hospitals and other health care providers to include sufficient data on their billings so insurers and DCBS can identify the providers;
- Requiring insurers to report medical billing data to DCBS using standards for electronic data interchange adopted by the International Association of Industrial Accident Boards and Commissions;
- Listing the data elements reportable to DCBS; testing procedures for EDI; phase-in dates for EDI and when insurers and self-insured employers are subject; procedures for requesting deferral of EDI reporting;

**Amendment to OAR 436-010, “Medical Services,” to remove obsolete medical utilization guideline:**

- Regarding frequency of treatment in OAR 436-010-0230;

**Amendments to OAR 436-030, “Claim Closure and Reconsideration,” to eliminate conflicts between statute and rules, streamline processing, delete obsolete rules, and reduce litigation, including:**

- Restricting reconsideration of claim closure to issues raised by the parties plus requirements under ORS 656.268(1);
- Requiring insurers to submit documents related to reconsideration of claim closure in chronological order;
- Removing the limitation on attorney fees from OAR 436-030-0175(4);
- Deleting obsolete rules OAR 436-030-0440, 0450; 0460, 0550, and 0570; the relevant subject matter from these rules has been addressed in other rules in OAR 436-030 and 436-035 (since approximately 1988), but the rules have remained in the Oregon Administrative Rules published by the Secretary of State;

**Amendments to OAR 436-035, “Disability Rating Standards,” to clarify or correct certain provisions, and to provide for rating disability for a medical condition not currently addressed by the standards, including:**

- Clarifying the definition of “direct medical sequela”;
- Correcting the description of impairment involving angulation or malalignment of the humerus;
- Clarifying how to rate impairment for surgery involving one or more discs or vertebrae;
- Eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed;

- Provide standards for rating impairment for vaginal prolapse;

**Amendments to OAR 436-050, “Employer/Insurer Coverage Responsibility,” to clarify certain provisions and ensure appropriate oversight of worker leasing company licensing and practices, including:**

- Clarifying time frames and process for cancellation of self-insurance;
- Revising regulations affecting worker leasing companies, including:
  - Relevant definitions;
  - The application and license renewal process;
  - Reporting and record-keeping;
  - Grounds for disqualification, suspension of license, and revocation of license by the director;
  - Appeal rights for persons refused approval or renewal of a worker leasing license;
  - Reapplication following disqualification for, or revocation of, license;
  - Continuation of a disqualification, suspension, or revocation of a worker leasing license applicable to any new worker leasing company created through the sale, transfer, or conveyance of ownership or of the worker leasing company’s assets to another person or controlling person;
  - Penalties under ORS 656.990;

**Amendments to OAR 436-060, “Claims Administration,” to eliminate inconsistencies in DCBS rules and clarify or streamline certain provisions, including:**

- Revising time frame for employers’ first aid record-keeping (to be consistent with Oregon OSHA requirements);
- Reducing the documentation a worker must submit when appealing an insurer’s refusal to reclassify a claim;
- Clarifying conditions under which the insurer must notify health care providers when a workers’ compensation claim is denied or partially denied;

**Amendments to OAR 436-105, “Employer-at-Injury Program” (EAIP), to promote increased use of the EAIP and therefore earlier return to work of injured workers with their employers at injury, by streamlining program administration, setting an appropriate fee payable to insurers for administration of the program, and expanding some incentives, including:**

- Providing that a medical release remains in effect until another medical release is issued by the worker’s medical service provider;
- Providing that a worker is eligible for EAIP services while the claim is “deferred” (prior to acceptance or denial);
- Providing insurers greater discretion to determine appropriate EAIP worksite modifications and EAIP purchases;
- Providing insurers greater discretion to determine what is appropriate training; eliminating the requirement that EAIP purchases for training are limited to “accredited” or “licensed” training or courses;
- Increasing maximum reimbursable amount for EAIP purchases for tools and equipment;
- Allowing insurers to submit more than one reimbursement request per EAIP;
- Stating the administrative fee payable to the insurer for its administration of EAIP services (formerly not prescribed by rule);

**Amendments to OAR 436-110, “Preferred Worker Program” (PWP) to promote increased use of the PWP and therefore facilitate the return to work of injured workers and improve return-to-work outcomes (wages, tenure, etc.), by streamlining program administration, creating new PWP incentives, and expanding some existing incentives, including:**

- Redefining and simplifying “date of hire” and “reimbursable wages”;
- Shortening and simplifying the wording that must appear on notices to workers about potential PWP benefits;
- Issuing PWP identification cards with no expiration date - workers could offer the initial and any subsequent employers three full years of premium exemption and claim cost reimbursement;
- Eliminating the requirement that a modification of regular work be “substantial” in order for a worker to be eligible for PWP benefits other than Worksite Modification;
- Removing the restriction that Wage Subsidies may not be combined with subsidies from other sources, with the exception of subsidies under OAR 436-120;
- Revising the name of “Obtained Employment Purchases” to “Employment Purchases”;
- Allowing Employment Purchases while a worker is receiving vocational assistance under OAR 436-120;

- Allowing replacement of Employment Purchases;
- Increasing the maximum expenditure for an Employment Purchase for tools and equipment;
- Providing Employment Purchases needed to create a new worksite;
- Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment;
- Allowing a second use of Wage Subsidy and a second use of each category of Employment Purchase for a different job with the same employer (formerly two wage subsidies could not be used with the same employer);
- Eliminating forms currently required for Worksite Modifications costing \$2,500 or less;
- Eliminating the general requirement for competitive bids for Worksite Modification;

**Amendments to OAR 436-120, “Vocational Assistance to Injured Workers,” to improve sufficiency of certain notices, clarify time frames for submitting information to DCBS, streamline return-to-work plan development process, clarify or define certain provisions, and delete obsolete provisions, including:**

- Describing how the Workers’ Compensation Division will determine the timeliness of any document that must be sent to the division in vocational matters;
- Requiring that notices of eligibility for vocational assistance, training, or direct employment services explain the rights of the worker to request a return-to-work plan conference;
- Requiring that notice must be in writing when an insurer notifies a worker that an eligibility determination is postponed while awaiting information about permanent restrictions;
- Requiring that if an insurer ends a worker’s eligibility because lack of suitable employment is not due to the limitations caused by the injury, the insurer must have obtained new information that did not exist or that the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility;
- Including among the reasons a worker would be ineligible for vocational assistance or for which eligibility would end, that the worker is unavailable for vocational assistance due to short-term incarceration;
- Eliminating all time frames related to return-to-work plan development except that a plan must be approved within 45 days (direct employment) or 90 days (training) under OAR 436-120-0500(1) & (2);
- Updating the vocational fee schedule (consistent with changes in state average weekly wage and Bulletin 124);
- Eliminating the requirement that insurers request administrative approval for vocational services when the insurer is entitled to claims cost reimbursement under OAR 436-110;
- Repealing the rule: “Reimbursement of Vocational Assistance Costs for Pre-1986 Injuries”; and
- Defining “show-cause hearing” for the purposes of OAR 436-120-0915(3).

**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](mailto: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.

September 27, 2007  
Last Day for Public Comment

John L. Shilts  
Authorized Signer and Date

8-14-07

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.

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:	)
436-009, Oregon Medical Fee and Payment Rules	)
436-010, Medical Services	)
436-015, Managed Care Organizations	)
436-030, Claim Closure and Reconsideration	)
436-035, Disability Rating Standards	)
436-040, Workers with Disabilities Program	)
436-045, Reopened Claims Program	)
436-050, Employer/Insurer Coverage Responsibility	)
436-060, Claims Administration	)
436-105, Employer-at-Injury Program	)
436-110, Preferred Worker Program	)
436-120, Vocational Assistance to Injured Workers	)
436-160, Electronic Data Interchange	)

**Rule Caption:**

Proposed rules affecting workers' compensation insurance, claims processing, medical treatment, and return-to-work assistance.

**Statutory Authority:** ORS 656.726(4)

**Other Authority:**

**Statutes Implemented:** ORS chapter 656, as amended by enrolled: Senate Bill (SB) 83 – Oregon Laws (OL) 2007, ch. 70; SB 147 - OL 2007, ch. 86; SB 253 - OL 2007, ch. 491; SB 504 - OL 2007, ch. 505; SB 563 - OL 2007, ch. 423; SB 762 - OL 2007, ch. 518; House Bill (HB) 2218 - OL 270; HB 2756 - OL 2007, ch. 252; HB 2783 - OL 2007, ch. 656; HB 2943 - OL 2007, ch. 300

**Need for the Rule(s):** Chapter 436 must be amended to be consistent with the Workers' Compensation Law, as amended by legislation passed by the 2007 Oregon Legislature. Some of that legislation required the director to make rules to implement revised laws. The department is proposing additional changes to make the rules easier to understand, to streamline regulations affecting stakeholders, and to expand return-to-work incentives for the Employer-at-Injury Program and Preferred Worker Program.

**Documents Relied Upon, and where they are available:** "Issues" documents as presented to advisory committees; advisory committee meeting minutes; written advice from advisory committee members.

These records are available for public inspection in the Administrator's Office, Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

**Fiscal and Economic Impact, including Statement of Cost of Compliance:** The following is a list of significant estimated fiscal/economic impacts on persons and organizations affected by proposed rule amendments:

**Amendments to implement changes in the Workers' Compensation Law**

- Senate Bill 504 restricts emergency room physicians' rights to be attending physicians and authorize temporary disability benefits. Overall emergency-room treatment charges can be substantially higher than charges for visits to primary care physicians. In addition, early referral to primary care physicians should improve insurers' ability

to keep track of authorization of temporary disability benefits and to promote return-to-work. The agency estimates that these changes should result in a small reduction in insurers' claims costs.

- Senate Bill 563 eliminates the requirement that managed care organizations (MCOs) send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval. In the "Statement of Need and Fiscal Impact" filed with the Secretary of State on 8/14/06, DCBS estimated reporting costs for such reporting based on advice from MCOs. The low-high range of estimated reporting costs was then \$100 per year to \$50,000 per year per MCO, potentially \$400/year to \$200,000/year for the four active MCOs. The agency projects elimination of these reporting costs for MCOs.
- House Bill 2756 provides authority and limitations for several types of providers - chiropractors, naturopaths, podiatrists, and physician assistants - when acting as attending physicians. Because we cannot project how many injured workers will choose these providers as their attending physicians, we cannot now project the fiscal impacts. However, DCBS will monitor the effects of HB 2756 to identify impacts over time.
- House Bill 2783 requires insurers to notify the employer of termination of a guaranty contract 45 days in advance instead of the 30 days currently required. In addition, HB 2783 allows for a shorter notice requirement of only 10 days if the termination is based on nonpayment of premium. The agency projects some reductions in costs for insurers, because they can shorten their liability under the 10-day notice provision. The agency projects that these savings will be greater than any increased costs due to the 45-day notice provision, because insurers can adjust notice procedures in order to end liability, in most cases, by a date certain. The agency projects a small positive impact for employers subject to the 45-day notice, as it will give them more time to shop for cost-effective workers' compensation insurance coverage.

**In addition to changes to implement changes in the Workers' Compensation Law:**

**Amendments to OAR 436, 009, "Oregon Medical Fee and Payment Rules" and OAR 436-160, "Electronic Data Interchange" (EDI)**

- The agency projects that proposed rule changes will not have a significant fiscal impact on Oregon health care providers, as providers already send sufficient data to insurers on standard billing forms. The agency projects some fiscal impacts for insurers and self-insured employers, smaller for those companies already using EDI in other states and greater for Oregon-only reporters. The advisory committee did not express concerns about implementation costs. However, the agency projects significant costs for some insurers and self-insured employers in order to prepare for EDI, and also projects that these costs will eventually be exceeded by savings due to efficiencies inherent in electronic communication.

**Amendments to OAR 436-035, "Disability Rating Standards"**

- The agency projects that eliminating provision that if a value of impairment is determined for damage to the brain, no additional value for speech or psychiatric impairment is allowed, will have a positive economic impact on affected workers and an equal increased cost to affected insurers. However, this combination of medical conditions is very rare and the impact is not expected to be significant overall.

**Amendments to OAR 436-050, "Employer/Insurer Coverage Responsibility"**

- The agency projects that proposed rules affecting worker leasing companies will add a small cost to submit additional information with the application for initial license or renewal of license.
- Conversely, the purpose of these rule changes is to create a level playing field for leasing companies by preventing or removing unfair competition by companies that cannot or will not comply with worker leasing laws and rules. Successfully preventing unfair competition would have a positive economic effect on leasing companies that do comply with the laws and rules. Relative to taking no action, the agency projects a small positive economic impact on worker leasing companies.

**Amendments to OAR 436-105, "Employer-at-Injury Program" (EAIP) and OAR 436-110, "Preferred Worker Program" (PWP)**

- The agency projects that expanded benefits and administrative fees for the EAIP will cost the Workers' Benefit Fund (maximum/annual):
  - Reimbursement of EAIP costs before the claim is accepted or denied (if ultimately denied) ..... \$700,000.00
  - Increased reimbursable amount for EAIP purchases for tools and equipment ..... \$300,000.00
  - Proposed fee payable to insurers for administration of the EAIP ..... \$480,000.00
  - Total ..... \$1,480,000.00
- The agency projects that expanded benefits for the PWP will cost the Workers' Benefit Fund (maximum/annual):
  - Providing Employment Purchases needed to create a new worksite ..... \$100,000.00
  - Creating a miscellaneous category of Employment Purchase that may be used to help a worker find, accept, or retain employment ..... \$100,000.00
  - Total ..... \$200,000.00
- The agency projects that issuing PWP identification cards with no expiration date will increase use of premium exemption and thus increase costs to the Workers' Benefit Fund. However, the impact would be very minor in the near term and increase gradually over time. The agency does not have a basis to project how many workers will use their cards for future employment, but will monitor this closely.
- Additional proposed changes that expand access to reemployment incentives will have lesser impacts on the Workers' Benefit Fund; however, the agency does not have a basis to project how extensively these incentives will be used.
- All moneys paid out of the Workers' Benefit Fund would have a positive economic impact on Oregon employers and insurers. In addition to the direct dollar transfer, by promoting early return to work, the proposed rules may reduce claims costs. In addition, the proposed changes should positively affect injured workers by promoting early return to work, which produces better long-term employment outcomes.
- The Workers' Benefit Fund has adequate reserves to cover any increased costs resulting from proposed rule changes.

**Regarding: Additional proposed changes:**

- The agency estimates that additional changes will not have any significant negative economic impacts on any persons or businesses, including small businesses. Because a number of the proposed rule changes streamline processes, the agency projects a small overall positive economic impact of proposed rule changes not otherwise described.

---

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

Representatives from small businesses participated in the stakeholder advisory committees.

**Cost of compliance effect on small businesses:**

**Estimated number of small businesses subject to the proposed rule:**

One managed care organization. (Of the four managed care organizations certified and active in the Oregon workers' compensation system, one managed care organization meets the definition of a small business under ORS 183.310.)

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

The proposed rule amendments will affect managed care organizations.

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

**Reporting:** Proposed rule changes would require less reporting by managed care organizations, who will no longer have to send to the director copies of all new or amended treatment standards, protocols, and guidelines for the director's review and approval.

**Record-keeping:** Proposed rule changes may substantially reduce record keeping by a managed care organization only if organization keeps a running record of updated treatment standards, protocols, and guidelines for the purpose of reporting the updates to the director.

**Other administrative activities and costs of professional services:** For managed care organizations that contract with companies that specialize in provision of guidelines and protocols, there is the potential for reduced professional services costs.

**Extent of economic impact:** The agency projects a substantial reduction in reporting costs for MCOs.

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

**Equipment:** The proposed rule changes do not require the purchase of equipment to achieve compliance.

**Supplies:** The proposed rule changes do not require the purchase of supplies to achieve compliance.

**Labor:** The proposed rule changes do not require increased labor costs to achieve compliance.

**Administration:** The proposed rule changes do not require increased administrative costs to achieve compliance.

**Extent of economic impact:** No increased costs for these categories.

**Administrative Rule Advisory Committee consulted:**

Yes. Advisory committees met on 6/21/07, 7/10/07, 7/16/07, 7/17/07, 7/19/07, 7/20/07, 7/23/07, 7/26/07, 7/31/07

The agency asked the advisory committee for advice on the impact of the discussed changes on costs, including any significant adverse impacts on small businesses.

*John L. Shilts*

8-14-07

---

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

---

Printed name

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION



**Medical Services**  
***Proposed Oregon Administrative Rules***  
**Chapter 436, Division 010**

Summer/Fall 2007

**TABLE OF CONTENTS**

<b>Rule</b>		<b>Page</b>
436-010-0005	Definitions.....	1
436-010-0210	Who May Provide Medical Services and Authorize Timeloss .....	5
436-010-0220	Choosing and Changing Medical Providers.....	7
436-010-0230	Medical Services And Treatment Guidelines .....	10
436-010-0240	Reporting Requirements for Medical Providers .....	12
436-010-0265	Independent Medical Examinations (IME).....	16
436-010-0280	Determination of Impairment.....	21
<del>Appendix A</del>	<del>Rural Hospitals.....</del>	<del>25</del>
Appendix A	Matrix of health care provider types .....	27
Appendix B	Independent Medical Examination Medical Service Provider Training Curriculum Requirements.....	28
<b>Appendix C</b>	<b><u>Independent Medical Examination Standards.....</u></b>	<b>31</b>

**Revisions are marked as follows:**

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

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

**HISTORY LINES:** These rules include only the most recent "History" lines. A rule's history line shows when the rule was last revised and its effective date. To obtain a "Chapter 436 revision history index," please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site:

<http://www.wcd.oregon.gov/policy/rules/history.html>

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

**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~~ **Oregon Medical Board** 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;~~

**(c) For the purpose of these rules:**

**(A) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A); and**

**(B) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B); or,**

**(ed)** 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.

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

(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.~~

~~(14)~~ **(14)** "Health Care Practitioner or Health Care Provider" has the same meaning as a "medical service provider."

~~(15)~~ **(15)** "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

~~(16)~~ **(16)** "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

~~(17)~~ **(17)** "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.

~~(18)~~ **(18)** "Hospital" means an institution licensed by the State of Oregon as a hospital.

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

(~~20~~19) “Initial Claim” means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the “initial claim” means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(~~21~~20) “Inpatient” means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(~~22~~21) “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~~22) “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~~23) “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~~24) “Managed Care Organization” or “MCO” means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(~~26~~25) “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~~26) “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~~27) “Medical Service Provider” means a person duly licensed to practice one or more of the healing arts.

(~~29~~28) “Medical Provider” means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(~~30~~29) “Medical Treatment” means the management and care of a patient for the purpose

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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)~~**30** "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)~~**31** "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)~~**32** "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)~~**33** "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)~~**34** "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)~~**35** "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)~~**36** "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)~~**37** "Usual Fee" means the medical provider's fee charged the general public for a

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

given service.

(4038) “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.

(4139) “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:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

#### **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.~~ **Type A and B attending physicians may authorize time loss and manage medical services subject to the limitations of ORS chapter 656. (See “Matrix for health care provider types” Appendix A)**

**(2) Emergency room physicians may only authorize time loss for not more than 14 days when they refer the worker to a primary care physician. However an emergency room physician also in private practice, apart from the duties of an emergency room physician, may qualify as a type A attending physician. For the purpose of this rule, private practice means a physician who treats individuals on an established patient basis.**

~~(23)~~ 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. **An MCO may allow greater latitude for the provider types to treat a worker enrolled under ORS 656.260.**

~~(34)~~ 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~~

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

~~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 for practice.~~

~~(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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

schedule may not be paid by the insurer.

(98) 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.

(109) 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:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

**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. An attending physician must specify any limitations regarding the referral within such document. Unless the documented referral limits the referral to consultation only, the referral is deemed to include attending physician authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate. Nothing in this rule diminishes the attending physician's responsibility to fulfill all their duties under ORS chapter 656, including authorizing temporary disability. 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,

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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 **a type B attending physician or an authorized nurse practitioner** has expired; **(See "Matrix for health care provider types" Appendix A)**;
  - (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 (i) 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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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.

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

(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:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

**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.

(b) The consent form must be written in a way that allows the worker to understand it and to overcome language or cultural differences.

(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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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, drugs 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 is 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.

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

(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:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

**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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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.~~ **The attending physician or authorized nurse practitioner must notify the worker, insurer, and all other health care providers involved in the worker's treatment when the worker is determined medically stationary. The medically stationary date must be the date of the exam, and not a projected date. The notice must provide:**

**(a) The medically stationary date; and**

**(b) Whether the worker is released to any kind of work.**

(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:

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

(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 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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

**436-010-0265 Independent Medical Examinations (IME)**

(1) The insurer may obtain three medical examinations of the worker by medical service providers of 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 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 providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the 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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

authorization will be 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 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.

(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) An elective surgery consultation obtained in accordance with OAR 436-010-0250(3);

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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

656.206(5);

(e) A 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;

(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 to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(8) A medical 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 ensure the medical service provider has:

(a) An Invasive Medical Procedure Authorization (Form 440-3227), if applicable; and

(b) A Worker IME Survey (Form 440-0858), with instructions to give the form(s) to the worker at the time of the IME.

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

(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) Any medical service provider wishing to perform an IME or a Worker Requested Medical Exam (WRME) 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 providers maintained by the Director of the Department of Consumer and Business Services under ORS 656.~~325~~**328**.

(a) To be on the director's list to perform IMEs or WRMEs, 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~~**Medical Board**.

(B) Complete a director-approved three-hour initial training course regarding IMEs. The training curriculum must include, at a minimum, all topics listed in Appendix B.

(i) Any party may request the director to place a provider on the director's list with less than the three-hour training. At the director's discretion, providers may be placed on the director's list to perform IMEs with less than the three-hour required training when extraordinary circumstances exist in a given case or if the worker and the insurer agree that a certain provider may perform the examination. Providers placed on the director's list in this circumstance are limited to being on the director's list only for the time required for the examination at issue.

(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 the three-hour training unreasonable in a given case.

(C) Submit the Application for Independent Medical Exam Medical Service Provider 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 completed a director-approved initial training course regarding IMEs. By signing and submitting the application form, the provider 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~~ **independent medical examination standards** published by the American Board of Independent Medical Examiners in effect as of January 1, 2006 **in Appendix C, which apply** if the provider's regulatory board does not adopt standards of conduct for IMEs. **Providers on the director's list of authorized IME providers as of June 7, 2007, remain authorized to perform IMEs and do not need to reapply;** and

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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

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

(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 **of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards** ~~guidelines of professional conduct for performing IMEs under sub-paragraph (a)(C)(i) of this section~~ **published in Appendix C, whichever applies;**

(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 his or her 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 medical service provider conducting the examination will determine the conditions under which the examination will be conducted. Subject to the provider's approval, the worker may use a video camera or tape recorder to record the examination.

(15) If there is a finding by the director, an administrative law judge, the Workers' Compensation Board, or the court, that the IME was performed by a provider who was not on the director's list of authorized IME providers at the time of the examination, the insurer shall not use the IME report nor shall the report be used in any subsequent proceeding.

(16) Except as provided in subsection (a) of this section, a worker may elect to have an observer present during the IME.

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

(b) The worker must submit a signed observer form (440-3923A) to the examining 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.

(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 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 provider must verify that the injured worker and any observer have been

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**  
**WORKERS' COMPENSATION DIVISION**  
*Proposed Rules MEDICAL SERVICES*

---

notified of the requirement in sub-section (b).

(17) Upon completion of the examination, the examining medical service provider must:

(a) Give the worker a copy of the IME Survey (Form 440-0858) on the day of the examination; and

(b) Send 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.

(18) 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.

(19) 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 appropriate regulatory board.

(20) Training must be approved by the director before it is given. Any party may submit medical service provider IME training curriculum to the director for approval. The curriculum must include training outline, goals, objectives, specify the method of training and the number of training hours, and must include all topics addressed in Appendix B.

(21) Within 21 days of the IME training, the training supplier must send the director the date of the training and a list of all medical providers who completed the training, including names, license numbers, and addresses.

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

**Stat. Auth:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

**Hist:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

**Amended 6/7/07 as Admin. Order 07-053, eff. 6/7/07 (temporary)**

#### **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).~~ **On disabling claims, when the worker becomes medically stationary, the attending physician must complete a closing exam. The physician may refer the worker to a consulting physician for all or part of the closing exam. For workers under the care of a type B attending physician or an authorized nurse**

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
*Proposed Rules MEDICAL SERVICES*

---

**practitioner, the provider must refer the worker to a type A attending physician to do a closing exam if there is a likelihood the worker has permanent impairment. The closing exam must be completed under OAR 436-030 and OAR 436-035.**

(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. **The attending physician or authorized nurse practitioner has 14 days from the medically stationary date to send the closing report to the insurer. Within eight days of the medically stationary date, the attending physician may arrange a closing exam with a consulting physician. This exam does not count as 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 **When an attending physician requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report for the concurrence or objections of the attending physician. The attending physician must also state, in writing, whether they agree or disagree with all or part of the findings of the exam. Within seven days of receiving the report, the attending physician must make any comments in writing and send the report to the insurer. (See "Matrix for Health Care Provider types" Appendix A)**

(4) Closing reports for examinations performed by a physician other than the attending physician under this rule 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.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
*Proposed Rules MEDICAL SERVICES*

---

~~(54) The physician conducting the examination must provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007. **The attending physician must specify the worker's residual functional capacity. The attending physician may refer the worker for a second level physical capacity exam or work capacity exam (as described in OAR 436-009-0070(4).**~~

**(a) A physical capacity exam must be completed 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 work capacity exam must be completed when there is a 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.**

~~(65) 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 **If the insurer issues a major contributing cause denial on the accepted claim and the worker is not medically stationary, the health care provider must do a closing exam, or in the case of a type B attending physician or authorized nurse practitioner, refer the worker to a type A attending physician for a closing exam. (See "Matrix for Health Care Provider types" Appendix A)**~~

**(6) The closing report must address the accepted conditions and must include:**

**(a) Objective findings of permanent impairment; and**

**(b) A statement of the validity of the impairment findings.**

(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.~~

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
*Proposed Rules MEDICAL SERVICES*

---

~~(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:** Amended 6/15/06 as Admin. Order 06-054, eff. 7/1/06

## 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 General Hospital	94220 E Fourth St Gold Beach, OR 97444-7772	(541) 247-6621	(541) 247-2012
A	Good Shepherd Medical Center	610 NW 11 <sup>th</sup> 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 9 <sup>th</sup> 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 Pochonias 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 1 <sup>st</sup> 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 5 <sup>th</sup> 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 19 <sup>th</sup> 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
B	Peace Harbor Hospital	400 Ninth St	(541)	(541)

## Appendix A

Type	Name	Mailing Address	Phone	FAX
		Florence, OR 97439	997-8412	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 10 <sup>th</sup> 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 11 <sup>th</sup> 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 A - Matrix of health care provider types \***

	<b><u>Attending physician status (primarily responsible for treatment of a worker's injury)</u></b>	<b><u>Provide compensable medical services for initial injury or illness</u></b>	<b><u>Authorize payment of time loss (temporary disability) and release the worker to work</u></b>	<b><u>Establish impairment findings (permanent disability)</u></b>	<b><u>Provide compensable medical services for aggravation of injury or illness</u></b>
<b><u>Type A attending physician</u></b> Medical doctor, Doctor of Osteopathy Oral and maxillo-facial surgeon	<b><u>Yes</u></b>	<b><u>Yes</u></b>	<b><u>Yes</u></b>	<b><u>Yes</u></b>	<b><u>Yes</u></b>
<b><u>Type B attending physician</u></b> Chiropractor Naturopathic Physician Podiatrist Physician Assistant	<b><u>Yes, for a total of 60 days or 18 visits, from the date of the initial visit on the initial claim with any Type B provider.</u></b>	<b><u>Yes, for a total of 60 days or 18 visits from the date of the initial visit on the initial claim with any Type B provider.</u></b>  <b><u>Or, if authorized by an attending physician and under a treatment plan.</u></b>	<b><u>Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.</u></b>	<b><u>No</u></b>	<b><u>No</u></b>  <b><u>Unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)</u></b>
<b><u>Emergency Room Physicians</u></b>	<b><u>No, if the physician refers the worker to a primary care physician</u></b>	<b><u>Yes</u></b>	<b><u>ER physicians may authorize time loss for up to 14 days only, including retroactive authorization</u></b>	<b><u>No if worker referred to a primary care physician</u></b>	<b><u>Yes</u></b>
<b><u>Authorized nurse practitioner</u></b>	<b><u>No</u></b>	<b><u>Yes, for 90 days from the date of the first visit to any authorized nurse practitioner on the initial claim.</u></b>  <b><u>Or if authorized by attending physician.</u></b>	<b><u>Yes, for 60 days from the date of the first visit on the initial claim.</u></b>	<b><u>No</u></b>	<b><u>No</u></b>  <b><u>Unless authorized by the attending physician</u></b>
<b><u>Other Health Care Providers e.g. acupuncturists</u></b>	<b><u>No</u></b>	<b><u>Yes, for 30 days or 12 visits from the first visit on the initial claim</u></b>  <b><u>Thereafter, services must be provided under a treatment plan and authorized by the attending physician.</u></b>	<b><u>No</u></b>	<b><u>No</u></b>	<b><u>No, unless referred by the attending physician and under a written treatment plan</u></b>

**\* This matrix does not apply to Managed Care Organizations**

revised 8/09/07

## **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)
  - Arbitrator 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 in Appendix C, 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.

## Appendix C

### INDEPENDENT MEDICAL EXAMINATION STANDARDS

As developed by the Independent Medical Examination Association

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
  - a. Remind the examinee of the party who requested the examination.
  - b. Explain to the examinee that a physician-patient relationship will not be sought or established.
  - c. Tell the examinee the information provided during the examination will be documented in a report.
  - d. Review the procedures that will be used during the examination.
  - e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
  - f. Answer the examinee's questions about the examination process.
6. During the examination:
  - a. Ensure the examinee has privacy to disrobe.
  - b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
  - c. Examine the condition being evaluated sufficient to answer the requesting party's questions.
  - d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

