



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 or 503-947-7810
www.wcd.oregon.gov

Sept. 15, 2009

Proposed Changes to Workers' Compensation Rules

The Department of Consumer and Business Services, Workers' Compensation Division proposes changes to OAR chapter 436.

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? Oct. 26, 2009, 9:00 a.m.

Where is the hearing? Labor & Industries Building
350 Winter Street NE, Room F (basement)
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
Phone: 503-947-7717; Fax: 503-947-7514

The closing date for written comments is Oct. 29, 2009.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –

<http://wcd.oregon.gov/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.

Department of Consumer & Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

PO Box 14480, Salem, OR 97309-0405;

503-947-7717

Fred Bruyns 350 Winter Street NE, Rm 27, Salem, OR 97301-3879

Fax 503-947-7514

Rules Coordinator

Address

Telephone

RULE CAPTION

Workers' compensation claims administration, medical services and billing, reemployment assistance, and attorney fees

10-26-2009	9:00 a.m.*	Room F (basement), Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing date	Time	Location	Hearings Officer

***NOTE: The hearing will begin at 9:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through Oct. 29, 2009.**

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 436-001-0420; 436-001-0430; 436-001-0440

AMEND: OAR 436-030; 436-060; 436-105; 436-110; 436-120; and
OAR 436-001-0003; 436-001-0019; 436-009-0010; 436-009-0070; 436-010-0008; 436-010-0240; 436-010-0265;
436-010-0280; 436-140-0005; 436-150-0005; 436-150-0010; 436-150-0030; 436-160-0310; 436-160-0340

REPEAL: OAR 436-075-0110

AMEND AND RENUMBER: From OAR 436-001-0265 to 436-001-0400; from 436-001-0265 to 436-001-0410

ORS 656.726(4)

Stat. Auth.

Other Authority

ORS chapter 656, as amended by Oregon Laws (OL) 2009: House Bill (HB) 2045 – OL 2009, ch. 32; HB 2195 – OL 2009, ch. 35; HB 2197 – OL 2009, ch. 36; HB 2705 – OL 2009, ch. 312; HB 2707 – OL 2009, ch. 313; HB 3345 – OL 2009, ch. 526; and ORS chapter 656, as amended by OL 2007, Senate Bill 559, ch. 241

Stats. Implemented

RULE SUMMARY

NOTE: "Insurer" in this summary includes self-insured employers. The agency proposes to amend OAR chapter 436 to improve organization, clarity and consistency, and to eliminate redundancy. More specifically:

The agency proposes to amend OAR chapter 436, division 001, "Procedural Rules Governing Rulemaking and Hearings." These proposed rules: Implement House Bill 3345 by raising the maximum attorney fee payable under ORS 656.385 from \$2,000 to \$3,000, and making corresponding changes to the attorney fee matrix. The proposed rules consolidate rules related to attorney fees into OAR 436-001 and remove them from OAR 436-010, 060, and 120.

The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules." These proposed rules: Clarify the types of identification numbers providers must include on their medical bills; allow a medical service provider to submit bills for independent medical examinations in the form or format agreed to by the insurer and the medical service provider.

The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules: Implement HB 2045 by including chiropractors among those health care providers who may make findings of impairment (when serving as the worker's attending physician); implement HB 2197, which allows a medical service

provider who is not qualified to be an attending physician to provide compensable medical service to an injured worker for a period of 30 days or for 12 visits from the date of the first visit on the initial claim (rather than the date of injury), whichever first occurs, without the authorization of an attending physician; defer to OAR 436-001 for awarding attorney fees under ORS 656.385; require use of a release form (in addition to Form 801 or 827) for release of HIV-related information; clarify requirements for collection of the workers' Social Security number on Form 827; allow and describe use of Form 827 to make claims for new or omitted medical conditions; require the health care provider to give the worker a copy of Form 3283 when giving the worker a copy of Form 827. (The agency prints nearly all 827s used by workers and providers, and will print Form 3283 as an attachment to Form 827.)

The agency proposes to amend OAR chapter 436, division 030, "Claim Closure and Reconsideration." These proposed rules: Require that a Notice of Closure include information about a worker's right to be represented by an attorney (now stated in ORS 656.270, to be repealed effective 1/1/2010 – HB 2197) and right to request a vocational eligibility evaluation (related to limits to requirements for vocational eligibility evaluations in HB 2705); clarify procedures for administrative claim closure; provide that requests for reconsideration of claim closures may be made by telephone; explain that the 14-day time frames for parties to submit certain records relevant to the reconsideration process begin with the director's notice of the start date of the reconsideration; require that evidence stored by the parties on audio media may be submitted to the director (for the purpose of reconsideration) only in transcribed form.

The agency proposes to amend OAR chapter 436, division 060, "Claims Administration." These proposed rules: Specify when and how to issue claim-related notices after a worker is deceased, regardless of the cause of death; clarify requirements for the worker's employer to give the worker a copy of Form 3283, "A guide for workers recently hurt on the job," when the worker files a claim; lengthen the time period that an ongoing request by the claimant's attorney for future claim-related documents remains in effect; specify that time limits for sending most information to the director begin with the mailing date of the agency's letter or order; implement HB 2707 by prescribing notice requirements when the insurer learns that the worker was employed in more than one job at the time of injury; exclude secondary employment by Oregon subject volunteers from the calculation of supplemental disability; require notice to the worker, as part of the notice of claim acceptance, about criteria for reimbursement of claim-related expenses; describe timeliness criteria, notice requirements, and consent requirements related to the electronic payment of benefits to workers and beneficiaries; implement HB 3345 by setting conditions for the payment of penalty assessments to workers and fees to attorneys related to late payment of disputed claim settlement amounts.

The agency proposes to amend OAR 436-075, "Retroactive Program," OAR 436-140, "Construction Carve-Out Programs," and OAR 436-150, "Workers' Benefit Fund Claims Program." These proposed rules: Eliminate references to "guaranty contract," because Senate Bill 559 (2007 Session) replaced the guaranty contract with policy-based proof of coverage and reporting.

The agency proposes to amend OAR 436-105, "Employer-at-Injury Program (EAIP)." These proposed rules: Define "consumables," as purchases required to support the functioning of newly purchased tools or equipment, and allow purchase of consumables under the EAIP; clarify that a worksite modification must be related to limitations that resulted in the worker's EAIP eligibility or prevent the worsening of an accepted condition; clarify minimum reimbursement thresholds and when administrative costs are reimbursable.

The agency proposes to amend OAR 436-110, "Preferred Worker Program (PWP)." These proposed rules: Clarify the definition of "date of hire"; revise definitions of "premium" and "reimbursable wages" to be consistent with the definitions in OAR 436-105; implement HB 2197 by clarifying procedures for use of premium exemption under ORS 656.622; provide a more specific time limit for requesting claims cost reimbursement; create a new employment purchase type – placement assistance provided by a certified vocational counselor or any public or private agency that provides placement services, reimbursable if the assistance results in employment that the preferred worker retains for at least 90 days; provides that placement assistance may not be combined with vocational assistance under OAR 436-120.

The agency proposes to amend OAR 436-120, "Vocational Assistance to Injured Workers." These proposed rules: Define several terms used in division 120 – "delivered," "director," "filed," "likely eligible," and "mailed"; defer to OAR 436-001 for awarding attorney fees under ORS 656.385; provide that modified or new employment that results from an employer-at-injury-activated use of the PWP is considered "suitable" 12 months after the department determines a worksite modification is complete; implement HB 2705 by eliminating the requirement to complete a vocational eligibility evaluation if the worker is released to regular or other suitable work with the

employer at injury or aggravation; specify that the insurer is not required to do an eligibility evaluation if the worker is deceased or has a permanent total disability award; implement HB 2195 by allowing an insurer, without approval by the director, to extend time loss up to 21 months; allow further training to a worker who has completed one training plan if there is a reasonable cause to do so; publish vocational fee schedule maximums as percentages of Oregon's state average weekly wage rather than fixed dollar amounts; to implement HB 2195, provide for "registration" rather than "authorization" of vocational assistance providers; require certified counselors who are subject to continuing education requirements under these rules to take at least eight hours (currently 7 ½ hours) of training in ethical practices and at least six hours of training on the vocational assistance and reemployment assistance rules during the five years before certification renewal.

The agency proposes to amend OAR 436-160, "Electronic Data Interchange." These proposed rules: Specify whether certain proof-of-coverage data elements should be mandatory or optional.

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 or written testimony to: Fred Bruyns, rules coordinator; phone 503-947-7717; fax 503-947-7514; e-mail fred.h.bruyns@state.or.us. Proposed rules are available on the Workers' Compensation Division's Web site: <http://wcd.oregon.gov/policy/rules/rules.html#proprules> or at no charge from WCD Publications, 503-947-7627.

Oct. 29, 2009

(Last day to submit written comments
to the rules coordinator)

/s/ Jerry R. Managhan, for

Authorized Signer and Date

9/15/2009

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday.

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Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

Department of Consumer and Business Services,
Workers' Compensation Division

OAR CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

Workers' compensation claims administration, medical services and billing, reemployment assistance, and attorney fees

Rule Caption

In the Matter of: The Amendment of:

- 436-001, Procedural Rules for Rulemaking and Hearings
- 436-009, Oregon Medical Fee and Payment Rules
- 436-010, Medical Services
- 436-030, Claim Closure and Reconsideration
- 436-060, Claims Administration
- 436-075, Retroactive Program
- 436-105, Employer-at-Injury Program
- 436-110, Preferred Worker Program
- 436-120, Vocational Assistance to Injured Workers
- 436-140, Construction Carve-Out Programs
- 436-150, Workers' Benefit Fund Claims Program
- 436-160, Electronic Data Interchange

Statutory Authority: ORS 656.726(4)

Other Authority:

Stats. Implemented: ORS chapter 656, as amended by Oregon Laws (OL) 2009: House Bill (HB) 2045 – OL 2009, ch. 32; HB 2195 – OL 2009, ch. 35; HB 2197 – OL 2009, ch. 36; HB 2705 – OL 2009, ch. 312; HB 2707 – OL 2009, ch. 313; HB 3345 – OL 2009, ch. 526; & ORS chapter 656, as amended by OL 2007, Senate Bill 559, ch. 241

Need for the Rules: To implement legislation passed by the 2007 and 2009 Legislatures; to improve the effectiveness of claims administration, regulatory and dispute resolution functions of the agency, vocational assistance, and reemployment assistance programs under ORS 656.622.

Documents Relied Upon, and where they are available: Enrolled House Bills 2045, 2195, 2197, 2705, 2707 and 3345; Enrolled Senate Bill 559 (2007); fiscal impact data; "Issues" document presented to stakeholder advisory committees; other advisory committee meeting records; and written advice. These records are available for public inspection in the 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: The agency projects fiscal/economic impacts as follows:

NOTE: "Insurer" in this document includes self-insured employers.

The proposed rules will implement HB 3345, which provides for new or increased attorney fees payable by insurers to workers' attorneys and new or increased penalties payable to workers by insurers.

ORS 656.262(12) will require payment of penalty assessments to workers and fees to attorneys related to late payment of disputed claim settlement (DCS) amounts. Assessments and fees are only triggered if payment of the DCS is late and the insurer fails to pay the DCS within five days of notice by the worker or the worker's attorney. Therefore, the agency estimates that the overall fiscal impact will be minor.

In 2008, the agency ordered payment of approximately \$189,000 by insurers to worker's attorneys who prevailed in medical and vocational disputes. HB 3345 raised the maximum payable under ORS 656.385 in these cases from \$2000 to \$3000, and the proposed attorney fee matrix increases all amounts payable by 50% - for equivalent results achieved and time devoted by the attorney. The agency projects the maximum fiscal

impact of this change is 50% above current costs or less than \$100,000 per year, payable by insurers to workers' attorneys.

Proposed rules explain that the matrix may be used as a guide for awarding attorney fees for prevailing in disputes under ORS 656.262(11), which would add slightly to insurers' costs.

The agency estimates that the overall fiscal and economic impact of proposed rule changes related to attorney fees will be substantially under \$150,000 per year, representing increased costs to insurers and increased payments to workers' attorneys.

The proposed rules will implement HB 2045 by including chiropractors among those health care providers who may make findings of impairment (when serving as the worker's attending physician). The agency estimates that this change will have a small positive fiscal impact on chiropractors and also a positive impact on insurers, because chiropractors will not have to refer workers to other physicians to perform closing medical examinations, which can increase medical costs and delay claim closure.

The proposed rules require that evidence stored by the parties on audio media may be submitted to the director (for the purpose of reconsideration of claim closure) only in transcribed form. Insurers have advised the agency that this will increase their costs substantially. The agency agrees that transcription will entail significant costs, though most insurers do not submit audio files as evidence, so costs will vary according to insurers' business practices.

The proposed rules lengthen the time period that an ongoing request by the claimant's attorney for future claim-related documents remains in effect. At the rulemaking advisory committee meeting, insurer representatives present explained that it has been common practice to continue providing documents longer than the 90 days currently required. The agency projects that this change may slightly increase insurers' costs. However, attorneys and insurers should save some time and money by not having to make and process multiple requests for records.

The proposed rules facilitate the electronic payment of benefits to workers and beneficiaries. For those workers/beneficiaries and insurers that choose to participate, the agency projects that electronic payment will result in faster payment of benefits, as well as cost savings for insurers.

The proposed rules allow purchase of "consumables" under the Employer-at-Injury Program (EAIP). The agency estimates that this will slightly increase costs to the Workers' Benefit Fund, with a corresponding benefit to employers and workers who participate in the EAIP.

The proposed rules create a new employment purchase type for job-placement assistance and will increase costs to the Workers' Benefit Fund. The agency cannot project how much placement assistance will be provided, but does project a significant cost to the Workers' Benefit Fund, with a corresponding positive impact on vocational rehabilitation providers and to the workers who are successfully returned to work.

The proposed rules will implement HB 2705, which eliminates the requirement to complete a vocational eligibility evaluation if the worker is released to regular or other suitable work with the employer at injury or aggravation, thus reducing the number of evaluations required. The agency estimates that this change will have a small positive fiscal impact on Oregon insurers, and a small negative impact on vocational rehabilitation organizations that have conducted the evaluations.

The proposed rules will implement HB 2195 by allowing an insurer, without approval by the director, to extend time loss to 21 months – for a worker engaged in training. The agency estimates this change will streamline the extension process and slightly reduce costs to insurers and the agency.

The proposed rules allow further training to a worker who has completed one training plan if there is a reasonable cause to do so. Although the agency expects this to occur infrequently, this change may slightly increase insurers' costs for vocational assistance, and increase payments to vocational assistance providers and training facilities. Affected worker would benefit from increased wage earning capacity.

Additional proposed rule changes should either have no significant fiscal impact on any party or be slightly positive in effect to the extent the agency achieves its objectives of improved clarity of its rules and general streamlining of requirements affecting claims administration. However, the agency welcomes public input on potential fiscal impacts of any of the proposed rule changes.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

Proposed rule changes will increase demand on the Workers' Benefit Fund. The agency projects that the fund

has sufficient reserves to meet the demand. Otherwise, proposed changes should not have any significant effect on other state agencies or local governments, and should not affect the general public at all except as described under "Fiscal and Economic Impact" above.

2. Cost of compliance effect on small business (ORS 183.336):

- a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:** Primarily, 1) workers' compensation attorneys retained by injured workers; and 2) vocational rehabilitation organizations (registered under OAR 436-120). 190 attorneys from 147 firms represented injured workers in cases before the Workers' Compensation Board during the past year. Bulletin 151 lists 106 vocational rehabilitation providers that have been registered by the Department of Consumer and Business Services. Not all of these providers are small businesses as defined in ORS 183.310, but approximately 100 vocational assistance providers are small businesses.
- b. Projected reporting, record-keeping and other administrative activities required for compliance, including costs of professional services:** None. The agency projects overall positive economic effects of the proposed rule changes on both attorneys and vocational assistance providers.
- c. Equipment, supplies, labor, and increased administration required for compliance:** None. The agency projects overall positive economic effects of the proposed rule changes on both attorneys and vocational assistance providers.

How were small businesses involved in the development of this rule? Attorneys who represent injured workers and vocational rehabilitation professionals participated on rulemaking advisory committees and submitted written advice to the agency.

Administrative Rule Advisory Committee consulted? Yes, the agency consulted with rulemaking advisory committees on August 7, 10, 11, 25, and 27, 2009.

<i>/s/ Jerry R. Managhan, for</i>	John L. Shilts, Administrator	9/15/2009
Signature	Printed name	Date

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Proposed Rules

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NOTE: Amendments are marked as follows:

Deleted text has a "strike-through" style, as in
Added text is bold and underlined, as in

~~Deleted~~
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>

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

436-010-0008 Administrative Review

(1) Administrative review before the director:

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services disputes arising under ORS 656.245, 656.247, 656.260, 656.325 and 656.327.

(b) A party need not be represented to participate in the administrative review before the director.

(c) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement must be in writing and be approved by the director. Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the ~~claimant~~ or claimant's attorney. If the dispute does not resolve through mediation or alternative dispute resolution, a director's order will be issued.

(2) Administrative review and hearing processes for change of attending physician or authorized nurse practitioner issues are in OAR 436-010-0220; additional independent medical examination (IMEs) matters are in OAR 436-010-0265; and fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

(3) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

(4) All issues pertaining to disagreement about medical services within a Managed Care Organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the injured worker, are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter by the director.

(5) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all disputes subject to dispute resolution within a Managed Care Organization, upon completion of the MCO process, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision. If a party has been denied access to an MCO internal dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving the particular type

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of dispute, the insurer must advise the medical provider or worker that they may request review by the director.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, which ever occurs last. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438 chapter, division 005.

(c) Disputes regarding elective surgery must be processed in accordance with OAR 436-010-0250.

(d) The director may, on the director's own motion, initiate a medical services or medical treatment review at any time.

(e) Medical provider bills for treatment or services which are subject to director's review will not be deemed payable pending the outcome of the review.

(6) Parties must submit requests for administrative review to the director in the form and format provided in Bulletins 293. When an insurer or the worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the information is submitted. Unrepresented workers may seek help from the director to meet the filing requirements. The requesting party must notify at the same time all other interested parties of the dispute, and their representatives, if known, as follows:

- (a) Identify the worker's name, date of injury, insurer, and claim number;
- (b) Specify what issues are in dispute and specify with particularity the relief sought;
- (c) Provide the specific dates of the unpaid disputed treatment or services.

(7) In addition to medical evidence relating to the medical dispute, all parties may submit other relevant information, including but not limited to, written factual information, sworn affidavits, and legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute.

(8) When a request for administrative review is filed under ORS 656.247, 656.260, or 656.327, the insurer must provide a record packet, without cost, to the director and all other parties or their representatives as follows:

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(a) Except for disputes regarding interim medical benefits, the packet must include certification that there is no issue of compensability of the underlying claim or condition. If there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document ten must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

As required by OAR 436-010-0008, we hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(c) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request in the form and format described in this rule.

(e) If the insurer fails to submit the record in the time and format specified in this rule, the director may penalize or sanction the insurer under OAR 436-010-0340.

(9) If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(b) When a panel of physicians is selected, at least one panel member must be a practitioner of the healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

(c) When such an examination of the worker is required, the director will notify the appropriate parties of the date, time, and location of the examination. The physician or panel must not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted to the director for screening as to the appropriateness

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of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination may include, but is not limited to:

- (A) a review of all medical records and diagnostic tests submitted,
- (B) an examination of the worker, and
- (C) any necessary and reasonable medical tests.

(10) The director will review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

(a) A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

- (A) A party fails to honor the agreement;
- (B) The agreement was based on misrepresentation;
- (C) Implementation of the agreement is not feasible because of unforeseen circumstances;

or

- (D) All parties request revision or reinstatement of the dispute.

(b) If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(c) If the director issues an administrative order resolving a bona fide dispute:

(A) For disputes arising under ORS 656.245, 656.260, or 656.327, a party may file a request for hearing within 30 days of the mailing date of the order.

(B) For disputes arising under ORS 656.247, a party may file a request for hearing within 60 days of the mailing date of the order.

(C) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed before the administrative order becomes final.

(D) During any reconsideration of the administrative review order, the parties may submit

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new material evidence consistent with this subsection and may respond to such evidence submitted by others.

(E) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(11) If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.

(12) **Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.** ~~In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director will award an attorney fee to be paid by the insurer or self-insured employer, as provided in ORS 656.385. The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration will be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed \$2000, nor fall outside the ranges for fees as provided in the following matrix:~~

Estimated Benefit Achieved	Professional Hours Devoted				
	1-2 hours	2-4 hours	4-6 hours	6-8 hours	over 8 hours
\$1-\$2000	\$100-400	\$200-700	\$300-750	\$600-1000	\$800-1250
\$2001-\$4000	\$200-500	\$400-800	\$600-900	\$800-1300	\$1050-1500
\$4001-\$6000	\$300-700	\$600-1000	\$800-1250	\$1000-1450	\$1300-1750
Over \$6000	\$400-900	\$800-1300	\$1050-1600	\$1350-1800	\$1550-2000

~~(a) An attorney must submit the following to the director in order to be awarded an attorney fee:~~

~~(A) A current, valid retainer agreement, and~~

~~(B) A statement of hours spent on the issue before the director if greater than two hours. In the absence of such a statement, the director will assume the time spent was 1-2 hours.~~

~~(b) In determining the value of the results achieved, the director may consider, but is not limited to, the following:~~

~~(A) The fee allowed by the fee schedule provided in OAR 436-009;~~

~~(B) The overall cost of the medical treatment or service; or~~

~~(C) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.~~

~~(e) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above \$2000, they may submit a written or faxed~~

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~~statement of the extraordinary circumstances to the director. Extraordinary circumstances are not established by merely exceeding eight hours or exceeding a benefit of \$6000.~~

~~(d) An assessed attorney fee must be paid within 30 days of the date the order authorizing the fee becomes final.~~

(13) Any party who disagrees with an action or administrative order under these rules 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 an order under ORS 656.245, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(a) In the review of orders issued under ORS 656.327(2), ORS 656.260(14) and (16), and ORS 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(b) For claims not enrolled in an MCO, disputes about whether a medical service after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c) and whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review by the director. If appealed, review at hearing is subject to the "no new medical evidence or issues rule" in subsection (13)(a) of this rule. However, if the disputed medical service or medical treatment is determined compensable under ORS 656.245(1)(c) or 656.245(3) all disputes and assertions about whether the compensable medical services are excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services are subject to the substantial evidence rule at hearing.

(14) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the board as follows:

(a) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.

(c) The division will forward the request and other pertinent information to the board.

(15) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (14) of this rule, under these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

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(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (13) of this rule.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704

Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

Amended xx-xx-xx as WCD Admin. Order xx-xxx, eff. xx-xx-xx

436-010-0240 Reporting Requirements for Medical Providers

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records under ORS 656.252 and diagnostic records required under ORS 656.325. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, ~~this separate authorization does not~~ **is required for** 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~~ **HIV**-related information otherwise protected by ORS 433.045(3). ~~HIV related information should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition(s).~~

(2) Any physician, hospital, clinic, or other medical service provider, must provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, or 2476 (Release of Information). "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the director, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule ~~will prevents~~ 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 "Worker's and ~~Physician's~~ **Health Care Provider's** Report for Workers' Compensation Claims" (Form 827). **Information that must be provided on the form includes, but is not limited to** ~~in every detail, to include~~ the worker's name, address, and **Social Security number if available** ~~information required by ORS 656.252 and 656.254.~~ **For an initial claim, The** ~~the~~ medical service provider must ~~mail~~ **send** Form 827 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.

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~~(b)~~ The worker's SSN will be used by the director to carry out the director's 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~~ **Providers must also notify workers** 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 **medical record**.

(5) All medical service providers must give a copy of "A Guide for Workers Recently Hurt on the Job" (Form 3283) to the worker when they give the worker a copy of Form 827.

~~(5)~~**(6)** 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)~~**(7)** Medical providers must maintain records necessary to document the extent of medical services provided to injured workers.

~~(7)~~**(8)** 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)~~**(9)** Reports may be handwritten and **must** include all relevant or requested information.

~~(9)~~**(10)** 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)~~**(11)** The medical provider must respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, original diagnostic studies, including, but not limited to, actual films, and any or all necessary records needed to review the efficacy of medical treatment or medical services, frequency, and necessity of care. The medical provider must be reimbursed for copying documents in accordance with OAR 436-009-0070 (1). If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

~~(11)~~**(12)** 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

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progress report. The insurer must not consider the anticipated date of becoming medically stationary as a release to return to work.

~~(12)~~**(13)** 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)~~**(14)** 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)~~**(15)** When an injured worker files a claim for aggravation, the claim must be filed on Form 827 and must be signed by the worker or the worker's representative and the attending physician. The attending physician, on the worker's behalf, must submit the aggravation form to the insurer within five days of the examination where aggravation is identified. When an insurer or self-insured employer receives a completed aggravation form, it must process the claim. Within 14 days of the examination the attending physician must also send a written report to the insurer that includes objective findings that document:

- (a) Whether the worker is unable to work as a result of the compensable worsening; and
- (b) Whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273.

(16) A worker may use the Form 827 to request the insurer to accept a new or omitted medical condition. The health care provider may write the claimed condition or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code for the worker in the space provided on the form. The health care provider, on the worker's behalf, must submit the form to the insurer within five days of the day the worker signs the form. The insurer must process the request for acceptance of a new or omitted condition, regardless of whether the health care provider sent the form within 5 days.

~~(15)~~**(17)** 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

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the insurer, which include examination of the worker, must be considered independent medical examinations subject to the provisions of OAR 436-010-0265.

~~(16)~~**(18)** 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)~~**(19)** 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)~~**(20)** Injured workers, or their representatives, are entitled to copies of all protected health information in the medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers under the following conditions:

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

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

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

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

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

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

(A) Information ~~which~~ **that** was obtained from someone other than a health care provider **when the health care provider** ~~under a promised~~ of confidentiality, and access to **release of** the

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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 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

Amended xx-xx-xx as WCD Admin. Order xx-xxx, eff. xx-xx-xx

436-010-0265 Independent Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by 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 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.

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(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 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.

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(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)~~ **(11)** 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.

(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 656.328.

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

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must:

(A) Hold a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon 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 independent medical examination standards published 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.

(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 standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards 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;

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(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 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

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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 11/1/07 as Admin. Order 07-057, eff. 1/2/08

Amended xx-xx-xx as WCD Admin. Order xx-xxx, eff. xx-xx-xx

436-010-0280 Determination of Impairment

(1) On disabling claims, when the worker becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. For workers under the care of **an authorized nurse practitioner or a type B attending physician other than a chiropractor** ~~or an authorized nurse 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) 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) 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) The attending physician must specify the worker's residual functional capacity or refer the worker for completion of a second level physical capacities exam or work capacities exam (as described in OAR 436-009-0070(4)) pursuant to the following:

(a) A physical capacities exam 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 capacities exam 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

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perform specific job tasks.

(5) If the insurer issues a major contributing cause denial on the accepted claim and the worker is not medically stationary, the ~~health care provider~~ **attending physician** must do a closing exam, ~~or in the case of~~ **An authorized nurse practitioner or** a type B attending physician **other than a chiropractor** ~~or authorized nurse practitioner,~~ **must** 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.

Stat. Auth: ORS 656.726(4), 656.245(2)(b)(B)

Stats. Implemented: ORS 656.245, 656.252

Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08

Amended xx-xx-xx as WCD Admin. Order xx-xxx, eff. xx-xx-xx

Appendix A - Matrix for health care provider types *

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

* This matrix does not apply to Managed Care Organizations

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?

- 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 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.

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.