

**WORKERS' COMPENSATION DEPARTMENT
MEDICAL SERVICE**

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

EFFECTIVE JULY 1, 1986

436-10-005 Definitions

Unless the context otherwise requires:

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

(2) "Board" means the Workers' Compensation Board of the Workers' Compensation Department.

(3) "Claim" means a written request for compensation from a worker or worker's agent, or any compensable injury or illness of which an employer has notice or knowledge.

(4) "Claimant" means the worker making a claim.

(5) "Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in diagnosis and/or treatment, and who may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness.

(6) "Current Procedural Terminology" means the Current Procedural Terminology, fourth edition, 1985, published by the American Medical Association.

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

(8) "Department" means the Oregon Workers' Compensation Department, consisting of the Board, the Director and all their assistants and employees.

(9) "Director" is the Director of the Workers' Compensation Department.

(10) "Disability Prevention Services" means services provided to an injured worker to prevent the injury from causing continuing disability. Such services include physical restoration and psychologic, psychiatric, and vocational evaluation and counseling.

(11) "Elective Surgery" means surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

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

(13) "Insurer" means the State Accident Insurance Fund Corporation, a guaranty contract carrier, or a self-insured employer.

(14) "Major Orthopedic or Neurologic Surgery" means operations on the spine, shoulder, elbow, hip, knee or ankle joints; replacement of any joint; surgery for thoracic outlet syndrome. Surgery for carpal tunnel syndrome is not major neurologic surgery.

**WORKERS' COMPENSATION DEPARTMENT
MEDICAL SERVICE**

(15) "Medical Director" means the physician in the office of the director of the Workers' Compensation Department.

(16) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device.

(17) "Medically Stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(18) "Peer Review" means the evaluation of the care provided to a worker by review of the pertinent records and/or personal interview with the attending physician or consultant. Such review may be conducted by a committee of the provider's peers and/or any other appropriate body selected by the director.

(19) "Physical Capacity Evaluation" means an objective, directly observed, measurement of worker's ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, Functional Capacity Assessment, and Work Tolerance Screening shall be considered to have the same meaning as Physical capacity evaluation.

(20) "Physician" or "Doctor" means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate.

(21) "Promptly" means without delay.

(22) "Report" means transmittal of medical information in a narrative letter, on a form or in progress notes from the worker's medical file. Reports may be handwritten but all shall be legible and include all relevant or requested information.

(23) "Treating Physician" means attending physician.

(24) "Usual Fee" means the fee charged the general public for a given service.

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

(26) "Worker" means a subject worker as defined in ORS 656.005.

(27) "Work Hardening" means an individualized, medically ordered and monitored, work oriented treatment process. Involves the worker in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance and productivity to return to work goals.

Hist: Filed 10/20/76 as Admin. Order 4-1976, eff. 11/1/76
Amended 6/5/78 as Admin. Order 7-1978, eff. 6/5/78
Amended 1/28/80 as Admin. Order 2-1980, eff. 2/1/80
Amended 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Amended 4/29/85 as Admin. Order 2-1985, eff. 6/3/85
Renumbered from OAR 436-69-005, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 6/26/86 as Admin. Order 4-1986, eff. 7/1/86

**WORKERS' COMPENSATION DEPARTMENT
MEDICAL SERVICE**

436-10-105 Disability Prevention Services

(1) Whenever a worker's file indicates the worker's compensable injury disability would improve, or worker's return to work would be expedited by disability prevention services, the insurer shall immediately schedule the worker into such services. The insurer may first schedule the worker for an evaluation to determine if/what services are required.

(2) When a worker is scheduled into disability prevention services, the insurer shall keep a record showing the provider, the services to be provided, the goal of the services, and the anticipated time of completion.

(3) One hundred and twenty days after the worker has suffered a disabling compensable injury, or has made a claim for aggravation for such an injury, the insurer shall ascertain whether the worker has returned to work and is still working, and shall report as prescribed in (4) and (7) of these rules to the Department unless:

(a) A report has already been made to the Department that the worker is being provided vocational assistance services (OAR 436-120-170); or

(b) A determination order has been requested or issued, or

(c) A notice of claim closure has been issued.

(4) The report shall be submitted to the Department no later than the 135th calendar day after the date of injury or date the claim is made for aggravation, and shall include, but not be limited to:

(a) A description of the worker's disability prevention program and anticipated date of completion of the program;

(b) Whether the worker has returned to work and is still working;

(c) Whether the worker is medically stationary;

(d) Whether the attending physician believes the worker is capable of participating in a disability prevention services program.

(5) A worker not receiving disability prevention services at the time of the report shall be immediately scheduled for such services, including an evaluation if necessary. An evaluation, if performed, shall not be considered an independent medical examination under ORS 656-325.

(6) The form and format of the report shall be prescribed by department bulletin.

(7) The insurer shall submit a report to the Department within 5 days of the date a workers vocational assistance plan is closed, or has been interrupted 120 calendar days, for medical reasons.

(8)(a) Reports submitted pursuant to ORS 656.335 shall be reviewed to determine if appropriate disability prevention services are being provided the worker.

(b) If service being provided is determined by a medical review not to be preparing the worker for return to gainful employment, the director may order the insurer to provide appropriate disability prevention services.

(9) The insurer may be required to submit monitoring reports regarding a worker's progress in a disability prevention service program.

**WORKERS' COMPENSATION DEPARTMENT
MEDICAL SERVICE**

(10) If a worker, insurer, or attending physician disagrees with the determination of the Department, an appeal to the director may be made. The director shall review the matter and issue a written decision.

(11) Any party aggrieved by an action taken under the rules which affects the worker's claim may request a hearing in accordance with ORS Chapter 656 and the Workers' Compensation Board Rules of Practice and Procedure for Contested Cases.

(12) An insurer who fails to report as required by ORS 656.335 may be subject to penalties as provided by OAR 436-10-110(6).

Hist: Filed 6/26/86 as Admin. Order 4-1986, eff. 7/1/86