

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION  
PROPOSED OREGON ADMINISTRATIVE RULES  
CHAPTER 436, DIVISION 010**

**MEDICAL SERVICES**

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

A Statement of Need and Fiscal Impact accompanies this form.

Dept of Consumer and Business Services, Workers' Compensation Division	OAR CHAPTER 436
Agency and Division	Administrative Rules Chapter Number
Fred Bruyns	(503) 947- 7717 Fax (503) 947-7581
Rules Coordinator	Telephone
PO Box 14480, Salem, OR 97309-0405; 350 Winter Street NE, Rm 27, Salem, OR 97301-3879	
Address	

	Room 260 (2 <sup>nd</sup> floor), Labor & Industries Building	
January 22, 2004	2:00 p.m.	350 Winter Street NE, Salem, Oregon Fred Bruyns
<b>Hearing date</b>	<b>Time</b>	<b>Location</b> <b>Hearings Officer</b>

**NOTE: The hearing will convene at 2:00 p.m. and end when all present who have indicated their intention to testify have been called to present testimony. Written testimony will be accepted until 5:00 p.m., January 27, 2004 (must be received by the Workers' Compensation Division).**

**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:** 436-001-0300, 436-030-0023

**AMEND:** OAR chapter 436, divisions 001, 009, 010, 030, 060, and 120

**REPEAL:** OAR ~~436-001-0025~~, 436-001-0025, 436-001-0045, 436-001-0055, 436-001-0065, 436-001-0090, 436-001-105, 436-001-120, 436-001-0135, 436-001-0140, 436-001-0171, 436-001-0175, 436-001-0191, 436-001-0195, 436-001-0205, S436-001-0231, 436-001-0255, 436-001-0285, 436-001-0295, 436-010-0350, 436-030-0581, 436-060-0210, 436-120-0920

**AMEND AND RENUMBER:** OAR 436-030-0045 to 436-060-0018

ORS 656.726(4), 656.704

Stat. Auth.

ORS 183.335; OAR 137-001; OAR 436-001

Other Authority

ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)

Stats. Implemented

**RULE SUMMARY**

The agency proposes to amend these rules and replace temporary rules issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature:

- Senate Bill 233 changed the time frame for appeal of a proposed order or proposed assessment of civil penalty from 60 days following the party's receipt of notice to 60 days from the date the order is mailed by the department. Related proposed rule changes affect OAR 436-010, 436-030, and 436-120.
- Senate Bill 285 allows an insurer or self-insured employer to contest its Notice of Closure if it disagrees with the findings used to rate impairment, and OAR 436-030 has been revised accordingly.
- Senate Bill 620 requires payment of fees to workers' attorneys when a claimant prevails at the administrative level in certain medical and vocational disputes or when the attorney is instrumental in obtaining a settlement. This fee provision affects OAR 436-001, 436-009, 436-010, and 436-120.
- Senate Bill 914 eliminates the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim, and the director proposes to amend OAR 436-060 to require reporting within 14 days after acceptance or denial of the claim. Senate Bill 914 also clarified the statute regarding the department's obligation both to administer and pay supplemental disability benefits if the

## **Oregon Administrative Rules, Chapter 436**

### **Notice of Proposed Rulemaking Hearing**

insurer or self-insured employer chooses to have the department do so, and related amendments are proposed to OAR 436-060.

- House Bill 2305 addresses how medical records may be released, consistent with the federal Health Insurance Portability and Accountability Act, and related changes are proposed to OAR 436-010 and 436-060.
- House Bill 3669 gives additional authority to nurse practitioners to treat injured workers and authorize temporary disability payments. Amendments are proposed to OAR 436-009, 436-010, 436-030, 436-060, and 436-120 to reflect this change. This bill was a result of legislative action after development of the legislative concepts by nurse practitioners and the Management Labor Advisory Committee.

#### **In addition, these proposed rules:**

##### **436-001**

- Update the rulemaking notice rule.
- Update the contested case rules to establish consistency with the Attorney General's Model Rules of Procedure applicable to hearings before the Office of Administrative Hearings, OAR 137-003. Because the model rules control, duplicative or inconsistent rules are proposed to be repealed. Remaining supplementary rules are updated. Significant changes include filing of hearing requests; delegation of authority to the ALJ; clarifications regarding scope of review; admissibility of reproductions of originals; attorney fee matrix to implement SB 620 (2003); and a new process for alternative dispute resolution.

##### **436-009**

- Adopt updated medical fee schedules.
- Incorporate data reporting requirements currently published in Bulletin 220.
- Add Group number nine to the fee schedule of Medicare ambulatory service center groups.
- Require insurers and self-insured employers to keep track of dates of receipt of medical bills.
- Provide that if a provider's usual and customary fee is excessive compared to similar providers, the director may determine a reasonable fee based on the usual and customary fee of similar providers.
- Increase the dollar amount of each conversion factor by 2.33%, based on the annual increase in the physicians' component of the consumer price index.
- Require electronic billings to include a "zz" modifier.
- Modify the definitions of first and second level physical capacity evaluations and of work capacity evaluation.
- Provide that pharmacy fees shall be paid at 85% of the Average Wholesale Price (AWP) – a reduction from 95% in the current rules -- with a \$10 dispensing fee – an increase from \$6.70 in the current rules.
- Provide that a brand name drug that has a generic equivalent will be reimbursed at the lesser of 85% of the AWP for the brand name or 85% of the average AWP for a generically equivalent drug, plus dispensing fee, unless the prescribing medical provider writes "Do not substitute" or similar phrase on the prescription.
- Provide that reimbursement for Oxycontin, Vioxx, Celebrex and Neurontin is limited to an initial 5-day supply unless the prescriber writes a clinical justification for the drug.

##### **436-010**

- Provide that a dispute may be resolved by agreement between the parties, and that the director may then issue a letter of agreement in lieu of an administrative order.
- Allow reimbursement to medical service providers such as physical therapists even if a physician fails to sign the required treatment plan within 30 days of starting treatment.
- Require that, except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are compensable for a maximum supply of 10 days.
- Require insurers to forward requested medical information to new attending physicians or authorized nurse practitioners within 14 days of a request.
- Require that the insurer forward a copy of the insurer medical examination report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt of the report.
- Require that the insurer notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim.
- Delete the provision that allows an insurer or the director to request an examination to determine the extent of impairment.

## Oregon Administrative Rules, Chapter 436

### Notice of Proposed Rulemaking Hearing

#### 436-030

- Prescribe the conditions under which a Notice of Closure may be corrected or rescinded by the insurer or self-insured employer.
- Move rule 0045, “Disabling/Nondisabling Reporting Requirements and Change in Status Determinations” to OAR 436-060.
- Clarify criteria for determination and periodic review of permanent total disability; define “withdrawn from the workforce”; require that preexisting disability be included in redetermination of permanent total disability status.
- Reorganize procedural requirements for reconsideration of the notice of closure.
- Require that medical arbiter panel requests be received within ten working days of the start of the reconsideration.
- Prescribe the conditions for submission of surveillance videotapes.
- Provide for a medical arbiter deselection process; if the claim qualifies for the process, each party may eliminate one physician from the list of arbiters provided by the director.
- Repeal the rule prescribing how the director issues penalty orders.

#### 436-060

- Revise the requirements and limitations for release of medical information by the insurer.
- Adopt rule 0018, “Nondisabling/Disabling Reclassification (amended and renumbered from 436-030-0045); Requires the insurer to reclassify a non-disabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in rule 0018; simplifies related notification requirements.
- Require that if permanent partial disability is paid monthly, it be paid at 4.35 times the weekly temporary disability rate.
- Require the insurer to send a lump-sum application (for payment of a permanent partial disability award) to the worker or his or her attorney within five business days of a request.
- Clarify actions required if the worker cooperates after the insurer has requested suspension of benefits or if the worker documents that the failure to cooperate was reasonable.
- Require that notices of claim acceptance be copied to the worker’s representative and attending physician.
- Require a claim denial notice to include one of three specific statements if the denial was based in whole or in part on an insurer medical examination.
- Require that if the insurer receives medical bills after claim denial, it send a copy of the denial to the medical provider and explain the status of the denial.
- Require the insurer to pay for a worker requested medical examination that the worker fails to attend, but not for a subsequent examination unless the worker failed to attend the first exam for reasons beyond the worker’s control.
- Require that if claim responsibility is at issue, insurers share claim information without charge.
- Provide time frames for monetary adjustments among insurers.
- Provide for civil penalties if an insurer intentionally or repeatedly fails to give notice as required by ORS 656.331 and OAR 436-060-0015.

#### 436-120

- Require the insurer to notify the worker in writing, within 14 days of a request for vocational assistance when the insurer is not required to determine eligibility.
- Refer vocational professionals to the *Oregon Wage Information* (OWI) publication in lieu of the *Oregon Automated Reporting System (OARS) Job Order Wage Report*, both published by the Oregon Employment Department. The OARS publication will no longer provide job/wage data effective 4/1/04. When using the OWI wage information data, the presumed standard shall be the 10<sup>th</sup> percentile unless there is sufficient evidence that a higher or lower wage is more appropriate.
- Eliminate the requirement that vocational counselors sign statements that their eligibility determinations were based on substantial handicap assessments.
- Specify the conditions under which training may be terminated for failure to attend.
- State additional circumstances that require vocational eligibility to be redetermined.
- Provide that for workers found to have an exceptional disability or exceptional loss of earning capacity, certain fee schedule spending limits are increased by 30%.

**Oregon Administrative Rules, Chapter 436  
Notice of Proposed Rulemaking Hearing**

- Increase the direct worker purchase training category fee schedule maximum by 10% due to state-wide tuition increases.
- Provide that to conduct only labor market research and/or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

**Request for public comment:**

The agency 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://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#proprules> or from WCD Publications at 503-947-7627 or fax 503-947-7630.**

January 27, 2004  
5 p.m.  
\_\_\_\_\_  
Last Day for Public Comment

\_\_\_\_\_  
*/s/ John L. Shilts* December 15, 2003  
Authorized Signer and Date

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

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

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Secretary of State  
**STATEMENT OF NEED AND FISCAL IMPACT**

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

Department of Consumer and Business Services,  
Workers' Compensation Division

\_\_\_\_\_  
OAR CHAPTER 436

Agency and Division

\_\_\_\_\_  
Administrative Rules Chapter Number

In the Matter of

The Amendment of:

OAR 436-001, Procedural Rules Governing Rulemaking and Hearings

OAR 436-009, Oregon Medical Fee and Payment Rules

OAR 436-010, Medical Services

OAR 436-030, Claims Evaluation, Determination, and Reconsideration

OAR 436-060, Claims Administration

OAR 436-120, Vocational Assistance to Injured Workers

) Statutory Authority,

)

) Statutes Implemented,

) Statement of Need,

)

) Principal Documents Relied Upon,

)

) Statement of Fiscal Impact

**Statutory Authority:** ORS 656.704, 656.726(4)

**Other Authority:** ORS 183.335; OAR 137-001; OAR 436-001

**Statutes Implemented:** ORS chapter 656; ch. 86, OL 2003 (HB 2305); §9, ch. 170, OL 2003 (SB 233); ch. 429, OL 2003 (SB 285); ch. 760, OL 2003 (SB 914); §2, ch. 756, OL 2003 (SB620); §3, ch. 811, OL 2003 (HB 3669)

**Need for the Rule(s):**

Rule revisions are needed to make permanent the changes implemented by temporary rules effective 1/1/04. The temporary rules were issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature: Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669. In addition, rule revisions are needed to effectively carry out existing workers' compensation laws: These changes were discussed with advisory committees comprised of people and organizations affected by the rules, and a number of the changes were made at the request of these committees, as well as other customers and stakeholders. Specific substantive changes are listed on the Notice of Proposed Rulemaking Hearing. A number of "housekeeping" changes are proposed. In general, substantive revisions are needed to:

- Carry out the director's duties to publish and update medical fee schedules under ORS 656.248.
- Establish time frames for certain actions required by statutes and rules.
- Require more thorough notification of medical providers and the injured worker regarding decisions and actions affecting the claim.
- Provide for a medical arbiter deselection process in reconsideration proceedings.
- Provide an alternative source of labor market information to be used in determining eligibility for vocational assistance.

**Documents Relied Upon:** Enrolled Senate Bills 233, 285, 620, and 914; and Enrolled House Bills 2305 and 3669; fiscal impact statement forms for SB 285, 620, and 914; advisory committee meeting minutes and audio tapes; issues documents, and medical cost analyses. These documents will be available for public inspection in the Administrator's Office, Workers' Compensation Division, 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) 947-7810.

**Fiscal and Economic Impact:**

SB 233 and HB 2305, in so far as they affect these rules, should have no fiscal impact on any party.

SB 285 is expected to increase the number of reconsideration requests by about 4%, based on historical data. Most of these requests will include a medical arbiter examination. However, a downward trend in reconsideration requests means the net effect will be approximately a 1.7% increase, which will be absorbed by existing division resources. The fiscal impact on insurers and self-insured employers cannot be determined at this time, but may be slightly positive, since appeal will generally only be made if a party thinks it is in the party's financial interest to do so.

## Oregon Administrative Rules, Chapter 436

### Statement of Need and Fiscal Impact

SB 620-related rule changes will have a fiscal impact on insurers and self-insured employers, estimated to be \$500,000 to \$700,000 annually. Currently, the Workers' Compensation Division receives approximately 1,000 disputes (administrative reviews) per year. Workers prevail in nearly 50% of these, for which we estimate a \$1,000 attorney fee per case. There is a potential for fees to slightly increase the number of disputes. These dollars will flow to Oregon attorneys, the majority of whom are self-employed or employed by small businesses. The overall cost increase to the workers' compensation system would be about 0.1 to 0.2%.

SB 914-related rule changes should result in savings for insurers, self-insured employers, and the Workers' Compensation Division. Elimination of the reporting of "deferred" claims will reduce the number of documents that must be completed and filed. However, the extent of savings cannot be quantified at this time.

HB 3669 increased the authority of nurse practitioners to provide medical services and authorize temporary disability. This change should positively impact nurse practitioners. Medical payments to nurse practitioners will therefore not go to medical providers who can be attending physicians under Oregon law. We do not know how many workers will choose to treat with nurse practitioners, but we estimate any impact on other provider types will be small, and there should be no fiscal impact to the workers' compensation system as a whole.

The proposed 2.33% increase to the medical conversion factors would increase overall medical payments by between 1.0 and 1.2%. Based on actuarial analysis, expected reductions in other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates.

The proposed change in the pharmacy reimbursement formula and increased dispensing fee is projected to reduce insurers' and self-insured employers' pharmacy costs by at least 6%. Pharmacies, wholesalers, and manufacturers would therefore have decreased revenues equal to insurers' savings.

The proposed incentive to dispense generic drugs should reduce insurers' and self-insurers' costs slightly. Use of generics is already quite common, so savings for insurers and reduced revenues to brand-name manufacturers is expected to be minor.

The proposal to limit Oxycontin, Vioxx, Celebrex and Neurontin to an initial 5-day supply unless the physician provides a clinical justification is expected to reduce costs for insurers and self-insured employers. While these drugs represent approximately 13% of total prescriptions, they account for about 34% of total prescription payments. We do not know how many physicians will write clinical justifications or prescribe a suitable alternative medication. This change would result in reduced revenues for the manufacturers of these brand-name drugs.

The proposed requirements to notify medical providers of certain actions taken regarding claims would slightly increase insurers' and self-insured employers' administrative costs. However, during advisory meetings, insurer representatives told us that certain notifications are already common practice.

The increase in the direct worker purchase training category fee schedule maximum by 10% is estimated to cost insurers and self-insured employers an additional \$250,000 to \$375,000 annually. The change is proposed because tuition costs have risen sharply, e.g. community college costs rose 12% in the past year. The 30% increase allowed for workers with exceptional disabilities is expected to have a minor effect on costs because very few workers meet the criteria for exceptional disability.

Additional changes to these rules are expected to have no significant fiscal impact on any party.

**Administrative Rule Advisory Committee consulted:** Yes

October 16, 2003, November 3, 2003, November 17, 2003, November 18, 2003, November 21, 2003

*/s/ John L. Shilts*

December 15, 2003

Signature and Date

John L. Shilts, Administrator, Workers' Compensation Division

Printed name

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

BEFORE THE DIRECTOR OF THE  
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
OF THE STATE OF OREGON

In the Matter of the Amendment of Oregon	)	
Administrative Rules, chapter 436, divisions:	)	
001, Procedural Rules Governing Rulemaking and Hearings	)	
009, Oregon Medical Fee and Payment Rules	)	SUMMARY OF
010, Medical Services	)	TESTIMONY AND
030, Claim Closure and Reconsideration	)	AGENCY RESPONSES
060, Claims Administration	)	
120, Vocational Assistance to Injured Workers	)	

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to provide the Director with a record of the agency conclusions about the major issues raised.

The amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated January 1, 2004. On January 22, 2004 a public rulemaking hearing was held as announced at 2:00 p.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, Rules Coordinator, acted as presiding officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through 5:00 p.m. January 27, 2004.

The following individuals gave oral testimony on these rules at the public hearing:

<b>Subject Division</b>	<b>Testimony received from:</b>
009	Dave Dery, P.T., Work Injury Management Association of Oregon
009	Mark Healy, O.T., Work Injury Management Association of Oregon
009	Cathy Zarosinski, Oregon Physical Therapy Association
009	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	Colleen Guido, Department of Consumer and Business Services, Workers’ Compensation Division
060	Jennifer Flood, Department of Consumer and Business Services, Workers’ Compensation Division

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 Summary of Public Testimony & Agency Responses

The following written testimony was received:

<b>Subject Division</b>	<b>Exhibit #</b>	<b>Testimony received from:</b>
NA	1	Testimony withdrawn at request of submitter
010	2	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009 & 010	3	Diana E. Godwin, Attorney, on behalf of client group, Oregon Physical Therapists in Independent Practice
009	4	David Silver, M.D.
030	5	Rodger M. Hepburn, Attorney, Reinisch Mackenzie Healey Wilson & Clark, PC
009	6	Karen Elton-Walz, PT, MA, OCS, COMT, Therapeutic Associates; Central Oregon Physical Therapy
060	7	Jennifer Flood, Department of Consumer and Business Services, Workers' Compensation Division
060	8	Bradford A. Vinson, Attorney, Starr & Vinson, P.C.
009	9	Colleen Guido, Department of Consumer and Business Services, Workers' Compensation Division
009	10	Pamela Lundsten, Department of Consumer and Business Services, Information Management Division
009	11	Dave Dery, P.T., and Mark Healy, O.T., Work Injury Management Association of Oregon
009	12	Michael Casey, M.D.
120	13	Nyla L. Jebousek, Attorney
120	14	Robert J. Malone, CPDM, Vocational Unit Supervisor, Liberty Northwest Insurance
009, 010, 030, 060	15	Linda Jefferson, Oregon Self-Insurers Association
010	16	Nancy Bieber, Department of Consumer and Business Services, Information Management Division

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Summary of Public Testimony & Agency Responses

009	17	Kevin C. Tribout, PMSI
009	18	Perry Lewis, Third Party Solutions
009	19	Tom Holt, Executive Director, Oregon State Pharmacists Association
001	20	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
030	21	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
060	22	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
120	23	Christopher J.T. Davie, CPCU, Government Affairs Coordinator, SAIF Corporation
009 & 010	24	Linda Olsen, Medical Audit Review Manager, SAIF Corporation
010	25	Morris D. Haney, DPDM, Operations Manager, WMCI Prime Evaluations
009	26	Gene Ogrod, M.D., CEO, Oregon Medical Association

The following is a summary of the testimony received and the agency’s responses to that testimony. If oral and written testimony were submitted by the same party, summarized oral testimony is listed separately only if and to the extent it differs from written testimony.

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**OAR 436-001-0155(1)**

**Testimony: Exhibit # 20**

The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers’ Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): “. . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law.”

**Response:** We agree. Under ORS 656.726(4)(a), “Mailing date” determines timeliness.

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**OAR 436-001-0240(8)**

**Testimony: Exhibit # 20**

Section (8) of this rule is superfluous. Although this matches the Workers' Compensation Board's requirements affecting document reproductions, it serves no purpose for the Workers' Compensation Division. At the board, all documents are submitted as a group. At the division, the insurer submits most documents as part of the initial review. This rule would require certification of the few additional documents submitted at hearing, and there is no reason for the distinction.

**Response:** We agree that this proposed requirement is unnecessary. The Workers' Compensation Division has not experienced problems with document reproductions. Section (8) will not be included the permanent rule.

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**OAR 436-001-0265(2)**

**Testimony: Exhibit # 20**

Two additional factors should be considered in determining attorney fees:

- ‘“Attorney time devoted” shall be limited to those hours that a reasonable attorney, well-trained in workers' compensation law, would expend on the matter at issue.’
- ‘Proof of “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.’

**Response:** SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of “extraordinary circumstances” the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of \$10,000.

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**OAR 436-009-0004**

**Testimony: (Exhibit #3)**

Widely used medical fee schedules take effect January 1<sup>st</sup> of each year. Medical providers and health insurers generally begin using them for services provided after that date. The Workers' Compensation Division has to adopt fee schedules via rule-making, and updated schedules become effective April 1<sup>st</sup>, causing a “gap” during which insurers and providers still use the “old” schedules only for injured workers. We propose that rule 0004 be permissive, allowing providers to bill and insurers to pay, using current codes and schedules. This change will not

Oregon Administrative Rules, Chapter 436  
Summary of Public Testimony & Agency Responses

have an effect until January 1, 2004, and any administrative or data collection issues can be addressed prior to that time.

**Response:** We agree this is a good idea, but believe there are logistical problems that we need to address before this can be done. By making it permissive, there can be disagreement about which codes to use, giving rise potentially to more disputes. In the event of a dispute, which set of standards apply? This is an issue we would like to explore with external advisors at more length prior to the next rule revisions, and leave as is for now.

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**OAR 436-009-0008**

**Testimony: (Exhibit #3)**

We support the incorporation of the provisions of Senate Bill 620 (Ch. 756, OL2003) and approach for calculating appropriate attorney fees. However, the proposed revisions fail to include attorney fees for represented medical providers who prevail in a medical treatment or fee dispute with an insurer. Section 2 of SB 620 amends ORS 656.385(1) to allow the award of attorney fees to a claimant who prevails, not just a worker. If the Legislature had intended to limit attorney fees to a worker's attorney, it would use the word "worker," as it did elsewhere in the bill. The injured worker benefits if a represented medical provider prevails in a medical dispute; e.g. if a medical provider doesn't challenge an insurer's denial of palliative care (even though it is appropriate and the provider would prevail in a dispute), OAR 436-009-0015(1)(c) allows the provider to bill the worker.

**Response:** ORS 656.385, as revised by SB 620 refers solely to attorney fees paid to the claimant or the claimant's attorney. We believe the reference uses "claimant" to mean the injured worker. We do not believe the intent was to provide insurer-paid attorney fees to medical providers.

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**OAR 436-009-0008(1)(b), (2)(a), (2)(b), & (5)**

**Testimony: Exhibit # 24**

All language regarding attorney fees associated with medical billing disputes must be stricken from the Division 009 rules. Senate Bill 620 does not provide authority to award attorney fees when medical fees are the subject in dispute. Division 009 is promulgated under the authority of ORS 656.248, and SB 620 does not refer to ORS 656.248, but only to ORS 656.245, 260, 327, and .340.

**Response:** We agree and will delete all references to attorney fees from this rule.

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**OAR 436-009-0008(2)(a)**

**Testimony: Exhibit #24**

Proposed subsection (2)(a) states: "If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director." We do not send fee disputes to MCOs even if they have a dispute resolution process in place. It is our understanding that MCOs do not want to become involved in

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fee disputes. Providers and workers are already informed of their appeal rights with the director through the explanation of benefits they receive with payment. The proposed language should be deleted as it adds a layer of bureaucracy to a process that already works well.

**Response:** This concept is not new, but moved from (1)(c) of this rule and simplified. The purpose of the rule is to clarify the process that is current practice. While in general the rules require a party to first go through the MCO process, that is not a reasonable requirement if there is no MCO process. Other timelines and procedures then apply. If an insurer is notifying parties with the bill of their entitlement to appeal to the director, that already complies with the new rule, and does not add a layer of bureaucracy.

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**OAR 436-009-0008(4)(c)(A), (B), & (C)**

**Testimony: Exhibit #24**

We appreciate the department's acknowledgement of the need to allow medical providers and insurers to resolve disputes without going through the formal dispute process. However, the rule states the director may revise the final agreement or reinstate the review under certain conditions. All issues should be addressed before the agreement becomes final. If the department's concern is that workers may not truly understand the process, limit the use of agreements to include insurers, providers, and workers who are represented. A final agreement is just that, final.

**Response:** We believe that the short list of conditions listed would require a reinstatement of the review except the provision that allows reinstatement if all parties agree. We believe that if all parties agree, the director should allow it. The others allow reinstatement if one or both parties fails to honor the agreement, the agreement becomes infeasible or it was based on a misrepresentation.

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**OAR 436-009-0010(3)(a)**

**Testimony: Exhibit #10**

The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend this subsection accordingly. Also, delete the language that requests the provider's social security number and instead refer to the option of providing a federal tax reporting identification number.

**Response:** We will make this change.

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**OAR 436-009-0010(7)**

**Testimony: Exhibit #24**

We recommend deletion of the second sentence of this section, that states in part that mere submission of the bill by the provider shall serve as warrant that the fee submitted is the provider's usual fee for the services provided. Inconsistent billing patterns may indicate unintentional mistakes or possibly fraud. The language of this rule would make a lack of knowledge defense by the provider difficult to make, when that may in fact be the case. If the

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department is concerned that insurers will not pay bills because they believe they don't represent the provider's usual fees, there is already a dispute process in place to address that concern. If the department is concerned insurers may misuse this rule, again, there is a process in place that can also result in penalties to insurers.

**Response:** We believe it is appropriate to expect medical providers to "warrant" that their bill is their usual and customary fee, and have had no complaints from medical providers that this is a potential problem for them.

**OAR 436-009-0020(3)(b)(C) & (3)(j)**

**Testimony: Exhibit #24**

This rule requires payment in full to out of state hospitals, and the wording of the rule even inhibits an insurer's ability to reimburse at the rate of that state. Out of state providers will not negotiate a lower fee when they know they must be reimbursed in full by the insurer. The rule should either be eliminated entirely or revised to say services will be paid as negotiated. If the concern is that the worker should not be billed for balances not paid by Oregon insurers, the rule should require a clause in the agreement stating that the worker will not be billed for the remaining balance for compensable services related to the workers' compensation claim.

**Response:** We are concerned about workers being burdened with balance billing if insurers are able to negotiate a lower price with the hospital, but also are concerned about making it difficult for insurers to control costs. This is a complex issue, and we will keep it on the issues document for the next rule revision process.

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**OAR 436-009-0030 Appendix A language:**

**Testimony: Exhibit #10**

The Provider Identification Number (PIN) has been replaced by the Unique Provider Identification Number (UPIN). Amend the Appendix accordingly. Delete references to the provider's social security number and instead refer to the federal tax reporting identification number. See the testimony regarding OAR 436-009-0010(3)(a) for this exhibit number.

**Response:** We will make this change.

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**OAR 436-009-0030(9)(b)(B)**

**Testimony: Exhibit #24**

The last sentence should end "ICD-9-CM diagnostic code" rather than procedure code.

**Response:** We will make this change.

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**OAR 436-009-0030(9)(d)**

**Testimony: Exhibit #10**

Revise the following sentence as shown: ~~Only~~ Insurers transmitting data for more than one insurer may batch multiple insurer data files in one file transmission . . . “

**Response:** We will make this change.

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**OAR 436-009-0040(3)**

**Testimony: (Exhibit #3)**

We support the revision to allow an insurer to dispute (under OAR 436-009-0008) a provider’s “usual and customary” fee as being unreasonably high; however, if the provider prevails, he or she should be able to recover reasonable attorney fees.

**Response:** Based on past experience, we believe there will be few cases where the provider’s usual and customary fee is found to be unreasonably high. Most fees are governed by the fee schedule, and this only applies for the relatively rare cases of “pay as billed,” and the insurer believes the provider’s charges are unreasonable compared to the industry as a whole. We do not believe the current statute has a provision for an award of attorney fees to medical providers.

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**OAR 436-009-0040(4)**

**Testimony: Exhibit #24**

We are still concerned about the impact of much higher workers’ compensation conversion factors, when compared to healthcare factors, on employer medical and insurance costs. The consumer price index (CPI) relates to what consumers pay, not to what it costs to provide services. It appears you want to automatically apply the medical component of the CPI to the fee schedule each year. The statute requires more rigorous review prior to adjusting fees than to merely apply the CPI automatically without hearing or due process. Consider alternatives to the CPI; at least it should not be the sole determinant to changing the fee schedule each year.

The annualized average rate of increase in the CPI over the last 56 years is 5.3%. Since 1990 it is 3.9%. In only four of the last 56 years has the increase been less than the current 2.3%. Between 65% and 72% of medical dollars paid are subject to the conversion factors. We estimate the 2.3% increase will increase our medical costs by \$1.6 million dollars. If over the next four years the rate increase is at the average since 1990 (3.9%), at the end of 5 years, just due to the increase in the conversion factors, we will have an increase of \$13.45 per year.

The department’s fiscal impact statement said other system cost drivers should offset this increase sufficiently to negate an impact on pure premium rates. Our calculations don’t come close to offsetting payment of an additional \$1.6 million. The 6%+ savings projected based on proposed pharmacy changes appear to be based on the assumption that we reimburse pharmacies at the current rate of AWP minus 5% plus a \$6.70 dispensing fee. The assumption is incorrect. SAIF and the other major workers’ compensation carrier in Oregon use a Pharmacy Benefits

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Manager (PBM), and the rates we have negotiated with our pharmacies through the PBM are much more in line with the proposed reimbursement rates than the current rates.

**Response:** By this current rule revision, we are simply increasing the conversion factor for this year only, for the first time in several years. Each year we will consider an adjustment based on an array of relevant factors. We do believe the increase will be offset by other cost drivers.

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**OAR 436-009-0040(4)**

**Testimony: (Exhibit #3)**

We support the 2.33% increase in the conversion factors.

**Response:** We will include this provision in the permanent rules.

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**OAR 436-009-0070(2) & (3)**

**Testimony: Exhibit #9**

“. . . by the attending physician” and “attending physician’s” were inadvertently deleted in the proposed rules. The deleted wording should be reinserted, as well as “or authorized nurse practitioner,” and thus make the wording match the temporary rule.

**Response:** We agree and will make the appropriate revisions.

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**OAR 436-009-0070(4) and (12)**

**Testimony: Exhibit # 6**

See amended testimony submitted as Exhibit #11.

**Response: NA**

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**OAR 436-009-0070(4)(a) & (b)**

**Testimony: Exhibit #24**

This rule should make it clear that additional time components should be billed only when multiple or additional body parts are reviewed. Some providers are confused on this issue.

**Response:** We agree, but believe the proposed language makes this clear.

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**OAR 436-009-0070(4)(a)**

**Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski**

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.]  
“**This [first level PCE] is a limited evaluation to measure the musculoskeletal components of**

**a specific body part as required for claim closure which are: AROM, motor power using 5/5, and 2 point discrimination.**

**Response:** The proposed rules incorporate these recommended changes, and the changes will be included in the permanent rules.

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**OAR 436-009-0070(4)(b)**

**Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski**

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “Additional 15 minute increments ~~(per additional body part) may be necessary to establish endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion)~~ **may be necessary to measure additional body parts, and/or establish endurance, and/or to project tolerances.**”

**Response:** This change was incorporated in the proposed rule and will be incorporated in the permanent rule.

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**OAR 436-009-0070(4)(c) & (d)**

**Testimony: Exhibit #11 and oral testimony at the public hearing by Dave Dery, Mark Healy, and Cathy Zarosinski**

The descriptions of physical capacity evaluations (PCEs) should be revised to reflect how PCEs are being used by carriers and the medical community. [Extract from proposed wording follows.] “**This [work capacity evaluation] is a PCE . . . with special emphasis on 1) the ability to perform essential physical function of the job, based on a specific job analysis as related to the accepted condition, 2) the ability to sustain activity over time and 3) the reliability of the evaluation findings. Other general evaluation information . . . may be included in accordance with requirements for claim closure. This level requires not less than 4 hours of actual claimant contact** [current rule wording requires not less than 6 hours]. **A record review is required before the evaluation begins.**”

Delete subsection (4)(d).

**Response:** Most of the concepts in this suggestion were incorporated in the proposed rules and will be incorporated in the permanent rules.

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**OAR 436-009-0070(12)**

**Testimony: Exhibit #9**

The division inadvertently deleted “attending physician” from the table in this section (next to N0001/brief narrative). The deleted wording should be reinserted, as well as “or authorized nurse

practitioner.” To be consistent, add to “complex narrative” (Code N0002), “by the attending physician or authorized nurse practitioner.”

**Response:** We will make the change.

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**OAR 436-009-0070(12)**

**Testimony: Exhibit #11**

We propose a price increase for physical capacity evaluations (PCEs). Clinics routinely have labor expenses above and beyond the identified evaluation contact time: 10 to 30 minutes authorization process, 15 minutes clerical support, 15-30 minutes of record review by therapist(s), 15-30 minutes of report time by therapist(s), and 15-30 minutes for clerical support to transcribe and mail the report. Under the current fee schedule, therapists perform PCEs for less money than a standard procedure when breaking it down into 15-minute billable units. We request the following fee increases:

Code 99196	First Level PCE	Increase Relative Value to 2.77
Code 99197	Second Level PCE	Increase Relative Value to 5.54
Code 99193	Additional 15 minutes	Increase Relative Value to 0.94

**Response:** The relative value units for these services were developed by a broad group of stakeholders, and reimbursement for these procedures will be increased by the across-the-board increase in the conversion factors. Any specific change to the relative value units or a particular conversion factor would need to be developed through a thorough interchange between various stakeholders.

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**OAR 436-009-0090**

**Testimony: Exhibit #4**

Regarding the proposal to limit reimbursement for four drugs – Oxycontin, Vioxx, Celebrex, and Neurontin – to an initial 5-day supply unless the physician writes a clinical justification, this will create more paperwork for providers – in contrast to the goals of the Paperwork Reduction Taskforce, which was formed by the Workers’ Compensation Division a few years ago, in recognition of providers’ paperwork burdens.

“Clinical justification” is not defined. Who reviews it, the claims examiner? IMEs or file reviews about whether a patient should take a prescribed drug or a less expensive drug will result in more paperwork and expense to “justify the justification.”

Only changes in U.S. law can slow the increases in drug prices – pressuring providers to use less desirable drugs is not the answer. The four drugs listed represent improvements over alternatives in many situations. Before Neurontin was available, physicians prescribed carbamazepine, which can cause bone marrow failure, and now use of carbamazepine requires a complete baseline blood screening test and follow-up white blood counts. Celebrex and Vioxx are superior to alternatives in pre-operative patients, as they do not interfere with the effect of platelets on blood clotting. If we keep the list, Bextra, another cox-inhibitor, should be added to the list or it will likely be prescribed in place of Vioxx and Celebrex at no savings to the system (from addendum

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to Exhibit 4). The cost of Oxycontin is exorbitant. Its value is that it need only be taken twice per day. Some alternatives are less easily controlled, such as methadone, though long acting forms of morphine may be less expensive. It would be useful to provide cost information to providers.

I recommend that the Department consider creating a program that would address the problem of drug costs that relies on clinical studies of comparative effectiveness of drugs and the education of practitioners. I suggest a Pharmacy Review Program, in which the cost and usage information from insurers is shared with a group of physicians, pharmacists, and workers. Publish cost summaries of frequently prescribed medications, along with the costs and suggested dose schedules for alternatives. I respectfully request that this rule not be enacted, and that a program which shares information about drug costs and alternatives be created.

*See response to testimony below.*

**Testimony: Exhibit #12**

The division does have an obligation to be concerned about the cost of medications. However, the proposed rule making reimbursement for (more than a five-day supply of) Oxycontin, Vioxx, Celebrex, and Neurontin contingent on the physician's clinical justification, implies that, unless there is a watchdog, physicians routinely prescribe medications that are not "clinically indicated." The only thing these drugs have in common is their cost. It would be more honest to use the term "unless economically indicated."

*See response to testimony below.*

**Testimony: Exhibit #15**

The proposed rule does not reflect the consensus of the Pharmacy Fee Advisory Task Force. The minutes from the final meeting show the group favored a dispensing fee somewhere between \$6.70 and \$8.70. Also, the meeting summary noted general support for limiting certain brand name, cost-driver medications to a three business day supply on the initial prescription, unless clinical justification is provided. We recommend in section (1): an \$8.70 dispensing fee; in section (2), a limit of a three-day supply of the named drugs (or a clinical justification) with the qualification "on the initial prescription," and, also in section (2), insertion of the word "generic" as follows: ". . . clinical justification for prescribing that drug [Oxycontin, Vioxx, Celebrex, or Neurontin] rather than a less costly generic drug with a similar therapeutic effect.

*See response to testimony below.*

**Testimony: Exhibit #17**

We oppose the reduction in the pharmacy reimbursement rate. We feel that the division did not examine the financial impact on the pharmacy provider who may be forced to fill prescriptions at a reimbursement rate below the provider's cost, or the cost savings role proper pharmacy care can provide, in the form of early return to work and fewer surgeries. Finally, we feel the division failed to fully examine the most detrimental impact, reduced worker access to quality pharmacy care, because workers' compensation pharmacy is purely voluntary for the pharmacy provider.

Workers' compensation pharmacy claims require more of a pharmacist's professional time and carry far greater risks than State Medicaid or Group Health prescriptions. In fact, most states today provide a higher reimbursement rate for workers' compensation prescriptions than are paid through Medicaid or Group Health.

Our data shows that once a drug or drug ingredient exceeds \$33, the pharmacy begins to lose money on each prescription. Regardless of the proposed increase in the dispensing fee, the reduced reimbursement for the drug ingredient cost will cause pharmacists to lose money on many workers' compensation prescriptions. Pharmacy providers will be unwilling to lose money on high priced prescriptions and begin to withdraw from serving injured workers. California provides an example for Oregon. Effective 1/1/04, reimbursement for workers' compensation prescriptions was reduced to the MediCal rate (AWP – 10%). Several large pharmacy chains have stated that they no longer fill workers' compensation prescriptions. A recent study by the California Pharmacy Association Educational Foundation found that 65 percent of its members said that they would no longer fill workers' compensation prescriptions at the MediCal rate. Oregon has proposed an even more drastic cut that would cause greater access issues for Oregon. An NCCI October 2003 study found reducing fee schedule reimbursements to dangerously low levels would cause pharmacy access issues for injured workers.

Oregon already has one of the lowest reimbursement rates to pharmacists. Reducing reimbursement to the pharmacy does not control the underlying problem: the rising costs of prescription drugs. We suggest that the division look to other health care models and engage in practices that will help control the root problem of rising drug prices by: 1. Creating tighter controls on physician prescribing patterns, 2. Utilizing step therapy programs at the physician and pharmacist level, and 3. Creating non-restrictive formularies or preauthorization controls.

Our data show that nearly 57% of Oregon workers' compensation pharmacy transactions are already generic. This number is very close to what Group Health or State Medicaid programs can achieve with generic mandates, so the intent of the proposed rule to drive more generic utilization will not reduce system costs. Further, our data shows that 83% of brand drug fills have no generic substitute. Pharmacy providers will lose money on nearly all of these transactions because the proposed reimbursement level is below pharmacies' cost of doing business.

We request that the division rescind the proposed rule and that the division postpone any final decision on the proposed rule until more testimony and input from pharmacy providers and other stakeholders can be provided.

*See response to testimony below.*

**Testimony: Exhibit #18**

Within our program, generics average around 60% or above of prescriptions dispensed. We expect little increase in generic volume, as the percentages are already relatively high. If proposed rates are implemented, brand fills with no generic available will be dispensed at under cost. We recommend either leaving current reimbursement levels for brand drugs as is, or if need

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be AWP minus 10% + \$10.00. Consider payment for generics at a higher level to support their use. We suggest an AWP plus option: AWP + 5% plus \$8.50.

Regarding limitations affecting Oxycontin, Vioxx, Celebrex, and Neurontin, the rules need to address if the justification covers just the initial fill or multiple refills. If repeat justifications are needed, who is responsible to obtain or provide them, the patient, pharmacist, doctor? Any delay in obtaining pain medication needs to be avoided if at all possible.

Within current rules payment will be based upon the lower of either the provider's usual and customary charge or the fee established by this rule. This provision gives the director authority to determine if a submitted U&C is excessive when compared to other providers. This provision is ambiguous and provides interpretation on a case-by-case basis as to what is reasonable for payment if not paid at established rates. In many states disputes have arisen over what constitutes usual & customary. We recommend deletion of the reference to usual & customary and make the rule reflect a true fee based system. Proposed amended language: "Payment will be ~~the lower of either the provider's usual and customary charge or the~~ **fee established by this rule.**"

*See response to testimony below.*

**Testimony: Exhibit #19**

We participated in the Workers' Compensation Pharmacy Fee Advisory Task force, and the proposed rule appears to be consistent with the recommendations of the Task Force. By increasing the dispensing fee to a level that more appropriately reflects pharmacy dispensing costs, lowering the AWP rate, and requiring clinical justification for the use of certain drugs, the proposed rule provides appropriate incentives for pharmacists and pharmacies to encourage use of cost-effective drug therapies. We recommend you clarify the clinical justification process such that once submitted, the justification carries over to any refills authorized the prescribing practitioner.

*See response to testimony below.*

**OAR 436-009-0090(1)**

**Testimony: Exhibit #24**

The Pharmacy Fee Advisory Taskforce made its final recommendation to the Department of Consumer and Business Services to modify the rules as follows: 1) If a brand medication has a generic equivalent, the pharmacist will dispense the generic; 2) If a brand drug has a therapeutic equivalent, the pharmacist would contact the physician to see if the therapeutic substitution could be made, and that a higher dispensing fee -- \$10.00 -- would be appropriate in these instances, but not across the board; all other fills and refills of the therapeutic equivalent should remain at \$6.70; and 3) See OAR 436-010-0230(6) for Exhibit #24.

*See response to testimony below.*

**OAR 436-009-0090**

**Testimony: Exhibit #26**

Regarding the proposal to limit reimbursement of OxyContin, Vioxx, Celebrex, and Neurontin to an initial five-day supply unless the medical provider writes a “clinical justification” for the drug: The Oregon Medical Association (OMA) recently polled a sample of its members who treat workers’ compensation patients. The results suggest that adoption of the proposed rule would discourage physicians from seeing workers’ compensation patients and that it would affect patients’ access to timely care.

“Clinical justification” is not defined in the proposed rules, and the absence of clear definition will erect paperwork barriers, adding unnecessary costs and jeopardizing timely access to care. What criteria will be used to determine what is clinically justified and what is not? Will a physician need to repeat the justification every time he or she writes a script for the same patient?

These drugs are not first line drugs, so other drugs will have been tried first. What is the need for requiring additional documentation? The prescription itself should stand as “clinical justification” by the prescribing physician. The OMA would be interested in exploring other possibilities, such as the Pharmacy Review Program, which was recommended by Dr. David Silver. We request that the proposed rules not be implemented and that other alternatives be discussed.

**Response:** Revamping the pharmacy fee schedule has indeed required a careful balance between many competing forces. Last year, WCD convened a Pharmacy Fee Advisory Task Force which met four times over several months to review concerns and make recommendations about pharmacy fees. The recommendations were then reviewed by the medical rules External Advisory Committee and the Medical Advisory Committee. Finally, we received a great deal of public comment, much of it directly in contrast to other comment. Some comments have contended the dispensing fee is higher than recommended by the Pharmacy Task Force. Others have expressed concern that the reduction in the percentage of AWP will drive many pharmacies from participation in workers’ compensation. We note that the Oregon system already tended to have a lower percentage of AWP than other states’ workers’ compensation schedules, but also higher dispensing fees. We believe this combination favors and encourages dispensing lower cost alternatives wherever allowable. We have made some adjustments to the rule based on the public comment. We have increased the percentage of AWP from 85% to 88%, while decreasing the dispensing fee from \$10 per prescription filled to \$8.70 per prescription filled. This will create a somewhat smaller impact on payment to pharmacies. For the less expensive drugs, the new payment will be a little lower than proposed. For example, a drug with an AWP of \$20.00 will be paid at \$26.30 instead of \$27.00. Under the current schedule, it would be paid at \$25.70. Higher cost drugs will be cut less than under the proposed rules. For example, a drug with an AWP of \$100 will be paid at \$96.70 instead of \$95.00. Under current rules, it would be paid at \$101.70. These changes will still provide incentive to dispense lower cost drugs over higher cost drugs.

Another change made as the result of the testimony received was to eliminate Neurontin from the list of drugs requiring clinical justification. Unlike the other drugs on the list, this drug was not

part of the studies completed by the Oregon Health Plan, and is not covered by the Oregon Health Plan drug formularies. We added Bextra to the list because it is another cox inhibitor like Celebrex and Vioxx which are on the list. We are also sensitive to the concerns raised by the OMA and medical providers. We not only clarified the language to make it clear that the clinical justification need only be a simple statement explaining why the prescribed drug is the best drug for this patient, but also that the justification is not subject to review and approval by the insurer. The intent, as expressed by the Pharmacy Fee Task Force, is to create a “pause” to let the doctor consider if a therapeutically similar, less expensive drug might be as effective in treating the patient. Oxycontin alone accounts for over 10% of every dollar spent for drugs in Oregon’s workers’ compensation system, and over 1/5th of every dollar is spent on Oxycontin and the cox inhibitors. It was suggested that rather than create this paperwork “hassle,” WCD appoint an advisory council to advise medical providers on the options to prescribing the identified “cost-driver” drugs. We will look into that as an alternative with the OMA and the workers’ compensation Medical Advisory Committee during the upcoming year.

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**OAR 436-010-0008**

**Testimony: Exhibit #3**

See recommendations regarding OAR 436-009-0008 for Exhibit #3.

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**OAR 436-010-0008(13)**

**Testimony: Exhibit #24**

“Professional Hours Devoted” should contain the statement about the hours that a reasonable attorney, well trained in workers’ compensation law, would expend on the matter at issue. The rule should also provide that “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix. The attorney fee provisions in Senate Bill 620 do not include ORS 656.247 or 656.248 and therefore do not apply to medical fee disputes.

**Response:** It was the intent in creating and adopting a matrix system to keep the attorney fee procedure as simple and non-contentious as possible. We believe that qualifiers such as these suggestions will complicate rather than simplify the process and give rise to more disputes.

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**OAR 436-010-0210(7)**

**Testimony: Exhibit #24**

Nurse practitioners should be required to complete a self-test on the key elements of workers’ compensation law and their responsibilities to treat Oregon injured workers, a concept supported at a recent Nurse Practitioner sub-committee meeting.

**Response:** A voluntary self-test is included in the packet of materials provided to the nurse practitioners. We do not believe the statute supports a rule requiring it.

**OAR 436-010-0220(3)(f)**

**Testimony: Exhibit #24**

Should the referral to an attending physician for completion of the closing examination count as a worker choice? The language in subsection (f) does not cover this scenario.

**Response:** We agree this referral does not count as a choice and have revised the language.

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**OAR 436-010-0230(4)(a)**

**Testimony: (Exhibits #2 and #3)**

We support the intent of the proposed change. The current rule provides a basis for insurer denial of payment to a physical therapist if the attending physician fails to sign the treatment plan within 30 days of the beginning of treatment. The attending physician's timeliness is outside the control of the physical therapist, yet it is the therapist who has suffered the financial consequences of the current rule – not the worker or the physician.

However, the rule remains ambiguous. The third sentence in subsection 0230(4)(a) still requires the physician to sign within 30 days. Some insurers will likely deny payment and the therapist will be required to go through a fee dispute resolution process. We propose the alternative of making reimbursement contingent on having the ancillary care provider send the treatment plan to the physician and to the insurer within seven days of beginning treatment. This gives the physician and the insurer an early opportunity to review the plan and raise any concerns or questions. We also propose requiring the physician to sign a copy of the treatment plan within 30 days after treatment begins and send the plan to the insurer.

**Response:** We have revised the language to add clarity about what is due, when it is due, and what the appropriate consequences are.

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**OAR 436-010-0230(4)(a)**

**Testimony: Exhibit #24**

The requirement for a signed treatment plan by the attending physician should not be deleted. The current requirement that an attending physician sign the plan within 30 days of the start of ancillary services allows for checks and balances between the ancillary provider and the attending physician. Without a signed plan and a connection to payment for the ancillary services, treatment could continue indefinitely – even if the worker stops treating with his or her attending physician.

**Response:** The requirement for the attending physician is not deleted, but the rule is changed to make it clear that the attending physician, not the ancillary care provider, is held accountable.

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**OAR 436-010-0230(6)**

**Testimony: Exhibit #15**

The Pharmacy Fee Advisory Task Force also addressed dispensing of drugs by a physician's office. We believe the group's intent was to limit the amount dispensed to a five-day supply. We recommend this section be revised to include a five-day limit.

**Response:** There was a lot of discussion about this issue, and 10 days was selected because of the need to dispense an adequate amount of antibiotics to complete a course of therapy.

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**OAR 436-010-0230(6)**

**Testimony: Exhibit #24**

This section should not be modified but remain as is allowing for medications to be dispensed from physician offices only in the case of an emergency. The Pharmacy Fee Advisory Taskforce unanimously, and all but two members of the Division 009 & 010 Advisory Committee, recommended that this rule not be changed (current wording: "Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable."). The proposed rule allows for a maximum supply of 10 days. If the rule was intended to allow patients access to first script medications, the rule doesn't limit fills to first scripts. The rule may promote additional office visits for additional medication, increasing costs for both office visits and dispensing fees. If the physician provides an initial supply and writes a prescription for the longer term, the insurer will pay two dispensing fees instead of one..

**Response:** The rule allowing a 10-day supply is a compromise between competing interests on this issue. We agree with the physicians who support this concept that there are times when it is medically in the best interests of the patient to assure the patient receives the prescribed drugs. We also understand the concerns about quality control expressed by others. A 10-day supply will allow the doctor to dispense a reasonable starter course of medication or a complete course of antibiotics (in most cases.)

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**OAR 436-010-0240(12)**

**Testimony: Exhibit #16**

I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

**Response:** We agree and have modified the language to clarify this requirement.

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**OAR 436-010-0240(12)**

**Testimony: Exhibit #24**

This rule requires a nurse practitioner to refer a worker to an attending physician for a closing examination, and does not limit the requirement to disabling claims. If closing examinations are required on non-disabling claims, this will add a cost to the system that is unwarranted and unnecessary. In addition, if the nurse practitioner believes the worker has no permanent

impairment, the nurse practitioner should be able to state this and not refer to an attending physician. For each referral, the insurer will have to pay a new patient level office visit fee in addition to a closing examination fee.

**Response:** As noted above, we have clarified that this rule applies only to disabling claims. The provision that exempts certain claims from the requirement to complete a closing exam when an attending physician finds “no impairment” cannot be applied to claims managed by an authorized nurse practitioner because “no” or “zero” impairment are findings of impairment and cannot legally be made by the nurse practitioner.

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**OAR 436-010-0240(18)(b)&(c)**

**Testimony: Exhibit #15**

For clarity and consistency, we recommend the following wording change to these subsections: “For the purpose of this rule, ‘protected health information in the medical record’ means any oral or written information . . . (c) . . . Upon request, the entire health information record, including any protected health information, in the possession of the medical provider . . .

**Response:** We have modified the rule to add clarity.

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**OAR 436-010-0250(13)**

**Testimony: Exhibit #24**

Regarding elective surgery notifications, we would like the opportunity to state that more information is needed before deciding if a second surgical opinion is warranted. The current form doesn’t allow for any objection, other than to notify the physician a second surgical opinion is being obtained. Also, insurers should have 14 rather than 7 days to respond to an elective surgery request, as seven days does not allow sufficient time to assess the need for a second surgical opinion.

**Response:** We believe this recommendation is a significant departure from the current process and should be reviewed by a broader group of external advisors. We can include a review of the elective surgery procedure during the next revision of these rules if external parties wish to do so.

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**OAR 436-010-0265(11)**

**Testimony: Exhibit #24**

We object to the proposed requirement that the insurer send a copy of the insurer medical examination (IME) report to the attending physician within 72 hours of receipt. IME providers can forward the report to the attending physician sooner; by transferring the responsibility to the insurer, the rule adds unnecessary delay to delivery of the report. We also propose the language about the IME should refer to “examining physician or IME company” to more accurately describe whose responsibility it is to send the report to the attending physician.

**Response:** We revised this requirement in the proposed rules because it is an administrative requirement more properly imposed on the insurer managing the claim than on a doctor providing an examination. The change is in response to considerable evidence that examining physicians are not fulfilling this requirement, which then interferes with a workers' ability to obtain a Worker Requested Medical Examination. We have modified the language to add "(s)" to physicians to clarify that the responsibility to send a report to the insurer is a collective responsibility of physicians completing the examination and report.

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**OAR 436-010-0265(11)**

**Testimony: Exhibit #25**

Regarding the proposed requirement that the insurer forward a copy of the insurer medical examination (IME) report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt: I am not opposed to the rule, but note that this rule section already requires the IME physician to send a copy of the report to the attending physician within seven days. Is it really necessary for the treating physician to receive a copy from two sources? This duplicates effort and expense. The insurer usually includes a concurrence request along with the report, whereas the IME physician provides no explanation as to why it has been sent. I propose that the responsibility for sending a copy of the IME report to the treating physician be with the insurer and that OAR 436-010-0265(11) be removed from the medical rules.

**Response:** We have deleted the requirement for the IME doctor to submit a copy to the attending physician.

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**OAR 435-010-0270(3)**

**Testimony: Exhibit #3**

This issue was presented to the Medical Advisory Committee as Primary Issue #8 under Division 010. The stated option was to "require the insurer to provide simultaneous notice to the medical providers [Emphasis added] on denials, partial denials or changes in status, whether or not a denial is on appeal." The proposed section only requires notice to the attending physician or authorized nurse practitioner, and not any other medical service providers, such as a physical therapist, who may be the only provider actively treating the worker. Therapists suffer financial losses when they are not informed that a claim has been denied. If notified, the therapist can contact the worker's private health insurer, if any, or discuss payment terms with the worker if treatment is to continue. The insurer should contact any medical service provider known to the insurer when it denies or partially denies a previously accepted claim.

**Response:** In the Oregon workers' compensation system, the attending physician has a gate-keeper function that makes it imperative for the attending physician to know what the status of the claim is. The AP makes referrals to other providers and has oversight responsibility for care provided. The insurer may not even be aware of everyone who might be providing care until it receives bills for payment. This provision is a compromise to assure the gate-keeper has adequate information to make decisions about a workers' care, while maintaining a reasonable administrative burden on the insurer.

**OAR 436-010-0270(4)**

**Testimony: Exhibit #24**

Regarding the addition of a time frame for insurer responses to requests for prior medical records, the rule section should specify that the request be in writing, so insurers can comply with the specific needs of requesters.

**Response:** To require the request be in writing is not necessary and may be overly prescriptive.

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**OAR 436-010-0270(7)(a)**

**Testimony: Exhibit #24**

We object to the specificity of this proposed language. Nurse practitioners are probably not as prevalent as other medical practitioners that would also qualify as suitable attending physicians in certain geographic areas. We anticipate this would add additional mileage expense to the claim. We propose you change the language in the first sentence to “Reimbursement . . . for transportation costs . . . may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician or nurse practitioner who is in a geographically closer medical community in relationship to the worker’s home.”

**Response:** The intent of SB 3669 was to allow workers access to nurse practitioners in all cases, but was not intended to require a worker to select a nurse practitioner instead of a physician only because the nurse practitioner was closer geographically to the worker. We needed to make this distinction clear in the rule that a worker is entitled to full reimbursement for transportation costs so long as they are receiving care from the closest type of practitioner of their choice.

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**OAR 436-010-0280(1)**

**Testimony: Exhibit #16**

I recommend we make it clear that authorized nurse practitioners need to refer injured workers to an attending physician for a closing examination only when the underlying claim is disabling.

**Response:** We have made this clarification.

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**OAR 436-030-0165(3)(c)**

**Testimony: Exhibit #5**

The three-day response time for the deselection process is not long enough. A longer period, perhaps ten days, would seem more appropriate. In order to respond, the file must be pulled and reviewed to see what conditions are at issue, and arbiter options must be discussed with the client. In the rare occasion where the parties may want to stipulate on an arbiter, there is insufficient time to contact the opposing counsel and come to an agreement.

**Response:** The medical arbiter deselection process represents a way whereby the parties retain some control over the selection of the arbiter physician. But in implementing this process, a

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price has been paid, that being in terms of timeliness. The new timelines associated with deselection can be challenging. However, over the past year most attorneys have adjusted to the demands of this new process by restructuring their intake process for referrals from their clients.

Historically, the department did look at various aspects of the deselection process, including timeliness, during the pilot study of 2001. An eleven member advisory committee from the workers' compensation industry provided input at that time, followed by in-depth questioning of the actual participants in the pilot (claims handlers, attorneys, etc.). By consensus, it was decided that a three-day turn around for response to the deselection notification letter was adequate.

Part of the consensus process was the fact that the statute allows the department a period of 60 days within which to process, schedule and obtain a medical arbiter evaluation. While this may seem generous, the reality is that the Appellate Review Unit needs all the time it can garner to ensure the medical arbiter's report is received and they secure any clarification of arbiter findings that may be required in time to be used in the order on reconsideration. The medical arbiter scheduling process diminishes the time rapidly because of numerous steps involved, plus the department's obligation to schedule the exam at least two weeks out from the date of the medical arbiter appointment letter, which is triggered only after the deselection response period has expired. This coupled with the time lag often associated with obtaining the arbiter's written report, makes it impractical to lengthen the period of response as suggested by this testimony.

The rule will remain as proposed.

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**OAR 436-030-0055(1)(h)**

**Testimony: Exhibit #15**

The proposed definition for "withdrawn from the workforce" needs additional clarification of what constitutes a withdrawal from the workforce by adding "Such withdrawal is considered to be complete and permanent."

**Response:** Adding the suggested language would not be accurate unless it was applicable to the period in question, which is already addressed in OAR 436-030-0055(3)(d) and (4)(a). The proposed rule will be modified but based on Exhibit #21 testimony.

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**OAR 436-030-0003(3)(a)**

**Testimony: Exhibit #21**

A verb is required in the second sentence of this rule.

**Response:** Agreed. The rule will be modified to include a verb.

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**OAR 436-030-0007(1)(b)**

**Testimony: Exhibit #21**

The proposed change could be construed to give the director authority to abate or amend an Order on Reconsideration at any time even after the case has gone to the Board for a hearing. There is no reason for the director to maintain jurisdiction once a hearing has been requested. We suggest that the current language remain.

**Response:** The intent of the rule change is to clarify that the director does have and has had the authority to withdraw an order on reconsideration up to the time the order becomes final. The director has been given by the Legislature the plenary authority to decide matters committed to DCBS, unless clearly limited by statute. There is no legislatively imposed limitation on the director's authority to withdraw an order on reconsideration prior to that order becoming final. The rule will remain as proposed.

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**OAR 436-030-0007(3)(a)**

**Testimony: Exhibit #21**

This rule illustrates the inconsistency in appeal procedures that will exist if all of the rule divisions are adopted as proposed. In other divisions, it is proposed that appeals are timely if received by the due date, rather than mailed by that date. This is a different standard than contained in this rule and a different standard than that used by the Worker's Compensation Board. Stakeholders are best served by a consistent regulatory standard. All rules should use the mailing date, for reasons expressed in Division 001 testimony.

Division 001 (OAR 436-001-0155(1), testimony stated that under the existing rule the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. Recent weather-related problems caused many Oregon Post Offices to suspend service and to add a Sunday delivery to clear a backlog. The new rule would cause filings to be deemed untimely for reasons beyond the control of the party making the filing.

The division 001 proposed rule would create different standards for WCD and WCB. The Board uses mailing date, not date of receipt. DCBS should use consistent procedures, so that it is easier for the public to do business with the department.

Furthermore, ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law". The proposed rule is an impermissible deviation from statute.

**Response:** We agree. Under ORS 656.726(4)(a), "Mailing date" determines timeliness.

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**OAR 436-030-0023**

**Testimony: Exhibit #21**

“Rescinding Notice of Closure” is a title understood by regular system participants, but its legalese is likely to confuse an unrepresented worker who receives such a document through the mail. “Withdrawal of Notice of Closure” would be a better title.

**Response:** The word “rescinding” in the form “Rescinding Notice of Closure” does appear to be legalese but once the worker reads further down the form the intent becomes very clear. The first sentence states, “This is to advise you that your workers’ compensation claim closure has been reversed and your claim returned to open status.” In addition, the insurer has an area on the form to specifically explain why the worker’s closure has been withdrawn and the claim has been reopened. Together, these statements clearly inform the worker what has happened with their claim.

Additionally, the department does not have any evidence that would suggest that “withdrawal” would be a better understood word to use than “rescind”. What is known is that the word “rescind” is the common term within workers’ compensation and what is used on forms and in brochures. To change these terms would require additional costs and time, which cannot be justified and spent without significant supporting evidence. The rule will remain as proposed.

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**OAR 436-030-0023(3)**

**Testimony: Exhibit #21**

The term “current date” as used in this rule is confusing. We suggest “the date of the correction or withdrawal.”

**Response:** The director agrees, but with the more general perspective that some modifications are needed to clarify that the “current date” must be the date the document is mailed.

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**OAR 436-030-0034(1)**

**Testimony: Exhibit #21**

The rule should not require claim closure if there has been no treatment for 30 days. There may be extenuating circumstances, when the best interests of the parties would be served by allowing the claim to remain open. Insurers should have the discretion to make the best judgment in the individual case. We request that the word “may” be left in this rule.

**Response:** The testimony presents a reasonable argument, but the change in wording from “may” to “must” is required because “may” is in direct conflict with OAR 436-030-0020(1) and ORS 656.268(1). The rule will remain as proposed.

**OAR 436-030-0034(6)**

**Testimony: Exhibit #21**

Copies are routinely sent to medical providers. In the infrequent case where the notice is not sent, this should not be grounds to nullify a closure. We suggest adding the following sentence:

“Failure to send a notice required by this rule may subject an insurer to civil penalties, but will not invalidate the closure”.

**Response:** The attending physician’s and/or nurse practitioner’s input on their patient’s claim closure has been and will continue to be a critical part of the workers’ compensation system. If the medical providers are not sent the required copies, then the claim closure may be rescinded. How critical the information (on the notification and denial letters) is to claim closure will determine if the closure will be rescinded or not. This is not a new procedure, nor is this a new rule. The rule has just been moved, and nurse practitioner has been added as mandated by House Bill 3669.

The recommendation is not an effective remedy when considering the importance of the medical provider’s participation in the claim closure process. Rather than rewrite the rule, review or revision of internal procedures may be necessary to ensure that all necessary documentation is copied to the medical provider. The rule will remain as proposed.

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**OAR 436-030-0055(1)(h)**

**Testimony: Exhibit #21**

The last sentence of this rule is redundant, but if the rule is to be retained, “retirement” should be defined. Otherwise, it could be interpreted to mean collecting Social Security, collecting a company pension, collecting IRA or 401(k) distributions, ceasing employment without intent to seek new employment, etc.

**Response:** The director agrees that the term “retirement” is not clearly defined. The intent of the proposed language was to (1) establish the fact that a worker who is receiving retirement benefits (e.g. Social Security, company pension payments, etc.) is not necessarily withdrawn from the workforce, and (2) require an insurer or self-insured employer to use more than the fact a worker is receiving ‘retirement benefits’ to establish that the worker has withdrawn from the workforce. There are numerous examples of workers who receive such benefits and still are working in the workforce. Individuals may retire from the military, state, or federal government and then get another job in the private sector or return to government work. Individuals may receive Social Security but continue to work. Employees may collect company pensions and return to the workforce to supplement that income. The proposed language will be modified to better reflect such circumstances.

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**OAR 436-030-0065(1)**

**Testimony: Exhibit #21**

Two changes in the proposed rule seriously undermine the management of Permanent Total Disability claims.

First, the revised rule suggests that an insurer can only re-examine a PTD claim at two-year intervals, despite intervening events that may make the worker employable. The insurer is responsible for monitoring the worker's condition and, if the insurer determines that the worker's physical condition has improved or the vocational situation has changed, should be able to act on the information as soon as it has been developed, and not wait for an arbitrary schedule of reviews.

Second, the revised rule appears to remove the incentive for a worker to cooperate with any reexamination of a PTD award. Currently, a worker who refuses to attend a medical examination may be subject to benefit suspension. The new rule would allow the worker to ignore a reexamination with impunity. As medical evidence is an essential component in any PTD reexamination, this proposed rule would effectively prevent reversal of PTD awards. This rule violates ORS 656.325(1)(a) which clearly states that benefits will be suspended for failure to submit to an examination. The proposed changes also appear to conflict with ORS 656.325(3), which requires the worker to cooperate in the reduction of disability.

Implementation of these rules would not only affect the system cost to employers and insurers, but would also increase cost to the Worker Benefit Fund. Retroactive Reserve payments are the largest single draw on that Fund.

**Response:** The director agrees with the first position that the insurer is responsible for monitoring their PTD claims and should be able to act on any information that will change the PTD status as soon as possible. It was not the director's intent to limit the insurer in this respect and the changes that have been proposed have not done so. Statute and rule do not prohibit the insurer from reviewing a PTD claim more frequently than every two years. The purpose of removing this language was to eliminate duplication and reduce rules. Since it appears to have created confusion, the director will modify the language to clarify the insurer's existing right to review a PTD claim more frequently than every two years.

The director does not agree with the second position that the deletion of the suspension rule will remove the incentive for the worker to cooperate with any reexamination of a PTD award. The statutes cited in the testimony have given the insurer the right to suspend a worker who does not cooperate with a reexamination. That right cannot be taken away by rule.

The director's intent was not to eliminate the insurer's right to suspend a worker who has not cooperated with the reexamination, but to eliminate redundancy of rule and statute. The reason that the suspension part of this rule was taken out is because it is addressed in OAR 436-060-0095, OAR 436-030-0055, and statute. But to ensure clarity, the deleted suspension portion will be restored and a reference to OAR 436-060-0095 will be inserted.

**OAR 436-030-0135(6)**

**Testimony: Exhibit #21**

The word “accepted” as used in this rule is undefined and ambiguous. It would be more appropriate to use “requested and received.”

**Response:** The director agrees, but with the suggestion for some modifications to clarify that the fiscal instrument not only has to be received, but also negotiated by the worker. The reason for this terminology is because a worker may receive the money from the insurer but return it after deciding to request reconsideration. The language has been modified to more clearly reflect the intent of the change.

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**OAR 436-030-0155(3)**

**Testimony: Exhibit #21**

The proposed rule needs to be restructured to more clearly convey the intent. The proposed rule appears to require that the attending physician has viewed the recordings, but the insurer cannot know with certainty whether anything sent to a physician has actually been reviewed. Written reports are routinely sent, but the insurer has no way of knowing whether they have been read. Surveillance material should be treated the same way as any other information. Suggested language:

“The insurer must submit to the director for arbiter review all surveillance documentation (including any materials supplied by the insurer to the physician(s), such as videotape, investigator field notes, summary or narrative reports regarding the worker’s observed activities, cover letters or other forms of recorded documentation) of the injured worker’s activities, that were obtained prior to the closure and that were submitted to the attending physician. Surveillance tapes, compact discs or other forms of electronic storage that reflect the worker’s activities will be accompanied by documentation indicating the dates the information was obtained and the total time of the recording. This information will be supplied to the arbiter to view and consider in conjunction with the arbiter’s medical assessment of the worker’s accepted condition and level of disability.”

**Response:** The director agrees that the proposed language does need to be clarified because the insurer cannot be sure if material sent to a medical provider has been reviewed by that provider. The director’s intent is to require that the insurer submit to the director any surveillance videotape both obtained prior to claim closure and submitted to any physician(s) involved in the treatment of the injured worker. The proposed language will be modified to clarify the intent.

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**OAR 436-060-0008(3)(a)**

**Testimony: Exhibit #22**

The proposed change may be more convenient for the Division, but works to the disadvantage of the stakeholders. Under the existing rule, the party filing a document can be sure that the deadline has been met if the document is transmitted or mailed on the due date. The Division can verify

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timely filing by looking at the post mark. The proposed rule leaves the party at the mercy of the Post Office or other mail delivery service. The proposed rule would create different standards for WCD and the Workers' Compensation Board. DCBS should use consistent procedures, so that it is easier for the public to do business with the Department. ORS 656.726(4)(a) requires that "documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law." The proposed rule is an impermissible deviation from statute.

**Response:** The Department of Justice has advised the division that ORS 656.726 controls. The current language will be retained.

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**OAR 436-060-0010(3)**

**Testimony: Exhibit #15**

The proposed language is extremely vague and too subjective to make it a standard for notice or knowledge of a claim. The worker must retain the responsibility of filing the claim. Suggest modifying the sentence to read, "The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a worker's intent to file a claim, either through written communication from the worker, the worker's representative, or the worker's attending physician. [or of when enough facts exist to lead a reasonable employer to conclude that workers' compensation liability is a possibility.] (Emphasis in original)

**Response:** This language is not new. It has been moved from 436-060-0010(10) to (3) in connection with the change from reporting claims to the division within 21 days of the employer's knowledge date to 14 days from the decision to accept or deny the claim. When read in conjunction with 436-060-0010(4), it is clear that the worker retains the responsibility of filing a claim. ORS 656.262(3)(a) reads, in relevant part, "Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer." Emphasis added. The possibility exists that a worker would choose not to file a claim for an accident that may result in a compensable injury claim, but according to the statute the employer should still report the incident to the insurer. However, as a result of this testimony we will add clarification to the rule that it is the employer who must know the facts.

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**OAR 436-060-0010(12) and (13)**

**Testimony: Exhibit #7**

Senate Bill 914 eliminated the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim. Proposed OAR 436-060-0010(10) clearly indicates that all disabling claims shall now be reported within 14 days of the insurer's decision to either accept or deny the claim.

To be consistent, it is recommended that the reporting timeframe in OAR 436-060-0010(12) & (13) be changed from 21 days to 14 days. This will eliminate any confusion as to how many days an insurer has to file a form 1502.

**Response:** Consistency is a valid reason to change all 21-day reporting timeframes to 14 days. In addition to the cites referenced in this testimony, there are also 21 day reporting timeframes in OAR 436-060-0010(14), (15), (16), and 436-060-0018(1). Also, it is not clear in 436-060-0018(1) that this applies only to accepted claims. The language in the proposed rules will be changed to require reporting to the director within 14-days of the action and the language in 436-060-0018(1) will be clarified to apply only to accepted claims.

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**OAR 436-060-0018(11)**

**Testimony: Exhibit #22**

The rule should be prefaced with the phrase: “Subject to the provisions of subsection (12),...” Exhibit 22. In a follow-up call regarding this testimony, the author stated that (11) implies an insurer can change the classification of the claim anytime. It should be limited to the one year mentioned in (12).

**Response:** This testimony caused us to look closely at the proposed language and recognize there could be better direction for claim processing in these situations. There have been instances when a claim has been classified as disabling, then closed with a Notice of Closure. When the claim is reopened on aggravation or a new or omitted condition is accepted, the claim status remains disabling even though the aggravation or the new or omitted condition may be non-disabling. We recognize there are times when the original decision to classify the claim as disabling was incorrect because the criteria were never met. Case law (*DeGrauw v. Columbia Knit*) does not clearly establish a process for such circumstances other than the requirement that the worker have access to recourse if they are dissatisfied. The proposed language will be modified.

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**OAR 436-060-0035(8)**

**Testimony: Exhibit #22**

The proposed revision to this rule is incorrect. The current version of (8) correctly states that TPD for supplemental temporary disability must be calculated on the combined pre- and post-injury earnings, not calculated independently. The proposed rule does not work whenever maximum or minimum TTD rates are involved. You cannot calculate primary and secondary benefits separately to get the correct amount to pay the worker. The benefit has to be figured based on combined earnings. You figure the benefits from the primary job and the difference is the secondary benefit that is reimbursable from WBF.

**Response:** This change was made to limit the required involvement of insurers who elect not to process and pay supplemental disability. However, this testimony has pointed out the problems this change would create. With some modification to incorporate the assigned processing agent, the previous language will be restored.

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**OAR 436-060-0035(18)**

**Testimony: Exhibit #22**

Disputes concerning the rate of disability should be raised before the first closure of the claim. Allowing them “at any time” means that the issue could be raised many years after the initial rate calculation, when evidence of earnings may no longer be available.

**Response:** There is no statutory limitation on when an injured worker can raise a wage dispute. Similarly, OAR 436-060-0025 does not limit when a wage dispute may be raised. Regardless of when the wage dispute is raised, it is the worker who must supply the wage records for secondary employment. The proposed language will be retained.

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**OAR 436-060-0060(2)**

**Testimony: Exhibit 22**

We agree that an insurer should respond promptly to a lump sum request. However, we believe the insurer should be allowed ten business days. This would allow the request to be processed within the regular two-week file review cycle. This would allow an average turnaround of five business days, without disrupting the normal review schedule.

**Response:** When this issue was discussed in the Internal and External Advisory Committees there was general consensus to add a “reasonable timeframe” to the rules. However, what is reasonable was not specifically discussed. Requiring the insurer to send the form within 10 days to coincide with the regular two-week file review cycle seems reasonable. The rule will be modified accordingly.

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**OAR 436-060-0095**

**Testimony: Exhibit #22**

A proposed revision of OAR 436-030-0065(1) appears to remove the ability to suspend compensation when a worker with a PTD award refuses to attend a medical examination. For the reasons stated in our Division 030 testimony, we oppose that change. It would be logical to move that rule to Division 060, where all other benefit suspension issues are covered.

**Response:** Suspension of benefits for any worker who refuses to attend a reasonable requested medical examination is currently contained in OAR 436-060-0095. However, the last sentence of OAR 436-030-0065(1) will be added back with a cross-reference to OAR 436-060-0095. This will make it clear that if a worker with a PTD award refuses to attend a medical examination, the process for requesting suspension is under OAR 436-060-0095.

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**OAR 436-060-0140(9)**

**Testimony: Exhibit #22**

Since claims that have been resolved by a claim disposition agreement are not subject to reopening under any circumstances, the rule should be prefaced with the phrase: “Except for claims resolved by claim disposition agreement under ORS 656.236,…”

**Response:** Claims that have been resolved by a claim disposition agreement are subject to reopening if a new or omitted condition is later accepted. The rule will remain as proposed.

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**OAR 436-060-0155(2)**

**Testimony: Exhibit 8**

The right to the penalty is in ORS 656.262(11). The rule terminates claimant's rights after 180 days of the alleged violation. The rule is in direct conflict with ORS 656.319(6), which provides claimant a right to a hearing on this issue for a period of two years after the alleged action or inaction. There is adequate case law that explains when the two-year period begins and ends. There is also adequate case law to support the position that the Director cannot promulgate a rule that takes away a right or limits a statutory right.

**Response:** This language has existed in these rules for many years. In *Kathryn R. Cook v. Liberty Northwest Insurance Corporation*, 150 Or App 597 (1997), the Court of Appeals held this rule is reasonably required for the director to carry out the performance of his duties. The case also considered the issue the testimony presented concerning ORS 656.319(6). The current language will remain.

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**OAR 436-060-0180(8)**

**Testimony: Exhibit #22**

The requirement that an insurer's response to WCD be "adequate" is reasonable, but the insurer cannot know what WCD may perceive to be adequate. We suggest rewording to say that the insurer must respond "in good faith".

**Response:** This language was patterned after OAR 436-060-0155(4) where it's clear that inadequate means failing to answer specific questions or provide requested documents. The language in this rule will be modified to make it clear what the director considers inadequate by more closely mirroring the language in OAR 436-060-0155(4).

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**OAR 436-120-0004(2)(d)**

**Testimony: Exhibit # 13**

Regarding the statement in the notice text in (d), "If you disagree with this decision, you should contact (person's name and insurer) within five days of receiving this letter to discuss your concerns," if the injured worker is required to contact the insurer to remain eligible, the time allowed should be longer.

Regarding the remaining notice text, add a reference to the worker's attorney, as in "If you are still dissatisfied, you **or your attorney** must contact . . ."

**Response:** The changes recommended were not included in the proposed rules. The division can not take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

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**OAR 436-120-0008(2)**

**Testimony: Exhibit # 13**

Regarding statements of services for attorney fees, in addition to the hours spent on the case, consideration should be given to the difficulty involved as well as the likelihood of prevailing, because attorneys are only paid if they win.

The rule should be consistent with awards made by the Workers' Compensation Board, and not start a trend of requiring a statement of services.

**Response:** SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

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**OAR 436-120-0008(2)**

**Testimony: Exhibit # 23**

Two additional factors should be considered in determining attorney fees:

- ‘“Professional hours devoted” shall be limited to those hours that a reasonable attorney, well-trained in workers’ compensation law, would expend on the matter at issue.’
- ‘Proof of “extraordinary circumstances” cannot merely be a showing that the attorney spent more time and/or achieved estimated results beyond the values set forth in the attorney fee matrix.’

**Response:** SB 620 defined attorney fees that are assessed by the director to be based on the proportionate benefit to the injured worker, while also giving primary consideration to the results achieved and time devoted to the case. The external advisory committee agreed upon a matrix format that would operate with a minimal amount of paperwork and would not invite disputes based upon attorney fees assessed.

The division believes the proposed rule accomplishes those goals.

With regard to the proof of “extraordinary circumstances” the division would agree that the proof on such circumstances existing would have to involve more than an attorney simply billing more time than the matrix allows or having a benefit in excess of \$10,000.

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**OAR 436-120-0008(4)(b)**

**Testimony: Exhibit #23**

The filing deadline should continue to be determined by the mailing date – not to the received date as in the proposed rule. The proposed rule leaves the sender at the mercy of the Post Office or other delivery service. Mailing date is easy to verify and is consistent with Workers' Compensation Board practices. The proposed rule conflicts with ORS 656.726(4)(a): “. . . documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law.”

**Response:** The division agrees that the standard should be the one described in ORS 656.726(4)(a). The proposed rule will be changes to reflect agreement with ORS 656.726 (45)(a).

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**OAR 436-120-0340(2)(g)**

**Testimony: Exhibit #23**

Regarding the Oregon Wage Information publication [of the Oregon Employment Department], the rules should require reference to the fifth percentile rather than the 10<sup>th</sup> percentile as proposed. The 5<sup>th</sup> percentile is better aligned with the standard now in use.

**Response:** The division compared the Oregon Wage Information (OWI) 5<sup>th</sup> and 10<sup>th</sup> percentile to the current use of the Oregon Automated Reporting System (OARS) median wage (Q2). A review by the Information Management Division of DCBS found the 10<sup>th</sup> percentile to be the closest to the Q2 statistic. In addition, the Oregon Department of Employment which publishes the OWI will only publish for general circulation statistics starting with the 10<sup>th</sup> percentile.

Given the divisions analysis of the 5<sup>th</sup> and 10<sup>th</sup> percentiles and in order to make the statistics as readily available as possible, the 10<sup>th</sup> percentile will be the standard.

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**OAR 436-120-0360(7)**

**Testimony: Exhibit # 14**

Regarding proposed language for this section, “The worker returned to work prior to the worker becoming medically stationary, and the physician **later** [emphasis added] rescinded the release.” This section should include a time limit for rescission; otherwise, insurers could be compelled to complete an eligibility evaluation 12 months after the return to work if a physician later rescinds a release – even if the worker has not perfected a claim for aggravation. Recommended replacement language: “The worker returned to work prior to becoming medically stationary, and the physician *rescinds the release within 60 days of the date of the Notice of Closure.*”

**Response:** This rule is being moved from its present location as 436-120-0360 (9) to 436-120-0360(7). The only other change was change the word rescinds to rescinded. Time frames were not recommended for this rule and no discussions on the effect of adding time frames was part of the internal or external advisory committees. The present wording of this rule has not generated requests for reconsideration under the scenario presented in the testimony. While the

recommendation may have merit, the division could not consider implementation of the recommended wording without further public input. The division will file the proposed wording for consideration future rule changes.

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**OAR 436-120-0710(7)**

**Testimony: Exhibit #23**

This section should not provide for prepayment of the last month's rent, as this is not generally required in today's market and is inconsistent with OAR 436-110.

**Response:** This rule was not proposed for any changes and as such has not had any public comment or advisory committee discussion. The division cannot take action on this recommendation at this time, but will file the suggested changes for consideration for future rule changes.

The current wording does not require the payment of last months rent but does state it is only payable . . ." if required prior to moving in."

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**OAR 436-120-0720**

**Testimony: Exhibit # 13**

The advisory committee discussed increasing the dollar amount for direct worker purchases for training programs. The need was acknowledged by some of the insurer representative's. The proposed rules do not address this need.

**Response:** The division is proposing an increase in OAR 436-120-0720(3) for direct worker purchases in training programs. The increase in from \$14,256 to \$16,157, which is a 10% increase.

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**OAR 436-120-0720(2)**

**Testimony: Exhibit # 23**

As proposed, this section, a worker may qualify as having an exceptional loss of earning capacity if additional services would yield just a 10% greater wage than a shorter program. For a 21-month training program, the TTD benefit alone may exceed \$80,000. The analysis to authorize extended benefits should include whether the program will result in significantly improved earning capacity over the likely period of post-training employment.

**Response:** The proposed rule recommends changes to the fee schedule for workers found to have an exceptional disability or exceptional loss of earning capacity and the percentage increase to be applied. The change recommended in the testimony proposes a change in how exceptional loss of wage earning capacity is determined, which is in OAR 436-120-0440(2)(b).

No changes were proposed for OAR 436-120-0440 and as such there has not been any public comment or advisory committee discussion. The division cannot take action on this

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recommendation at this time, but will file the suggested changes for consideration for future rule changes.

Having reviewed and considered all data, views and arguments presented, I hereby submit this report as a summary of statements given and exhibits received. I recommend the adoption of the amendments to the rules consistent with the above responses.

Dated this 12<sup>th</sup> day of March, 2004.

WORKERS' COMPENSATION DIVISION

*/s/ Fred Bruyns*

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Fred Bruyns, Rules Coordinator

Policy Section

Workers' Compensation Division

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

**436-010-0001 Authority For Rules**

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.

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

**Stats. Implemented:** ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

**Hist:** Filed 1/14/72 as Admin. Order 1-1972, eff 1/1/72  
Amended 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 4/29/85 as Admin. Order 2-1985, eff 6/3/85;  
Renumbered from OAR 436-69-003, 5/1/85  
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)  
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90  
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92  
Amended 5/3/96 as Admin. Order 96-060, eff 6/1/96  
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99  
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

**436-010-0002 Purpose**

The purpose of these rules is to establish uniform guidelines for administering the delivery of and payment for medical services to injured workers within the workers' compensation system.

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

**Stats. Implemented:** ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

**Hist:** Filed 1/5/90 as Admin. Order 1-1990, eff 2/1/90  
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90

**436-010-0003 Applicability Of Rules**

(1) These rules shall be applicable on or after the effective date to carry out the provisions of ORS 656.245, **656.247**, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service pursuant to ORS chapter 656

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

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

**Stats. Implemented:** ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

**Hist:** Filed 10/20/76, as Admin. Order 4-1976, eff 11/1/76  
Filed 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;

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Renumbered from OAR 436-69-004, 5/1/85  
Amended 12/10/85, as Admin. Order 6-1985, eff 1/1/86  
Amended 1/20/88 as Admin. Order 1-1988, eff 2/1/88  
Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90  
(formerly OAR 436-010-0004)  
Amended 1/24/90 as Admin. Order 3-1990, eff 2/1/90 (Temp)  
Amended 4/29/90 as Admin. Order 4-1990, eff 5/1/90 (Temp)  
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)  
Amended 8/7/90 as Admin. Order 16-1990, eff 8/7/90  
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90  
Amended 6/11/92 as Admin. Order 13-1992, eff 7/1/92  
Amended 12/20/94 as Admin. Order 94-064, eff 2/1/95  
Amended 12/4/95 as Admin. Order 95-071, eff 12/4/95 (Temp)  
Amended 5/3/96 as Admin. Order 96-060, eff 6/1/96  
Amended 12/16/98 as Admin. Order 98-060, eff 1/1/99  
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

**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 pursuant to these rules except the contested case process described in OAR 436-001.

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

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

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

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

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

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

(3) **“Authorized nurse practitioner” means a nurse practitioner authorized pursuant to ORS 656.245 (§3, ch. 811, OL 2003) to 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, during that 90 day period. The authorized nurse practitioner may also authorize temporary disability benefits for a period of up to 60 days from the first nurse practitioner visit on the initial claim. Effective October 1, 2004, to be an authorized nurse practitioner, the nurse practitioner must certify to the director that the nurse practitioner**

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**has reviewed informational materials about the workers' compensation system provided by the director.**

**(4)** "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.

**(4)** **(5)** "Contested Case" means a proceeding as defined in ORS 183.310(2) pursuant to OAR 436-001.

**(5)** **(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.

**(6)** **(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.

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

**(8)** **(9)** "Days" means calendar days.

**(9)** **(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.

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

**(11)** **(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.

**(12)** **(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.

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

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

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

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[(16)] **(17)** "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

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

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

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

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

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

[(22)] **(23)** "Interim Medical Benefits" means those services provided pursuant to 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.

[(23)] **(24)** "Mailed or Mailing Date," for the purposes of determining timeliness pursuant to these rules, means the date a document is postmarked [or, pursuant to ORS 84.043, the date an electronic record is sent]. **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 shall 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, shall be considered mailed as of the date of the request.**

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

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

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[(26)] **(27)** "Medical Service" means 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.

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

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

[(29)] **(30)** "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

[(30)] **(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 pursuant to ORS 656.005 and subsections (2)(c) and (2)(d) of this rule.

[(31)] **(32)** "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also outpatient services.

[(32)] **(33)** "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

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

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

[(35)] **(36)** "Report" means medical information transmitted in written form containing relevant subjective and/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.

[(36)] **(37)** "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing,

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balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

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

[(38)] **(39)** "Usual Fee" means the fee charged the general public for a given service.

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

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

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

**Stats. Implemented:** ORS 656.000 et seq.; 656.005

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

#### **436-010-0006 Administration of Rules**

Any orders issued by the division in carrying out the director's authority to administer, regulate, and enforce ORS chapter 656 and the rules adopted pursuant thereto, are considered orders of the director.

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

**Stats. Implemented:** ORS 656.726

**Hist:** Filed 1/5/90 as Admin. Order 1-1990, eff 2/1/90

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Amended 5/3/96 as Admin. Order 96-060, eff 6/1/96  
Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

**436-010-0008 Administrative Review**[ and Contested Cases]

(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 arising under ORS 656.245, 656.247, 656.260, and 656.327.

(b) A party need not be represented to participate in the administrative review before the director except as provided in ORS chapter 183 and OAR chapter 436, division 001.

(c) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and 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, a director's order shall be issued.

(2) Administrative review and contested case processes for change of attending physician **or authorized nurse practitioner** issues are in OAR 436-010-0220; additional insurer 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, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. After the compensability of the underlying claim is finally decided, any party may request director's review of appropriate medical issues within 30 days after the date the decision becomes final by operation of law.

(4) When there is a denial of the causal relationship between the medical service and the accepted condition or the underlying condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.

(5) 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.

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

(a)[For all MCO enrolled claims,] **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

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final decision [under the MCO's internal dispute resolution process]. 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 of dispute, the insurer shall 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, whichever 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 shall be processed in accordance with OAR 436-010-0250.

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

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

(7) Parties shall submit requests for administrative review to the director in the form and format provided in Bulletin 293. **Unrepresented workers may seek help from the director in meeting the filing requirements.** The requesting party shall simultaneously notify 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.

(8) In addition to medical evidence relating to the medical services 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.

(9) When a request for administrative review is filed pursuant to ORS 656.247, 656.260, or 656.327, the insurer shall 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 shall 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 shall include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical service in 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 shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages, and date of the document. The packet shall 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 which 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 shall 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.

(10) 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 shall be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

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

(c) When such an examination of the worker is required, the director shall notify the appropriate parties of the date, time, and location of the examination. The physician or panel shall 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

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or panel, these questions must be submitted to the director for screening as to the appropriateness 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.

(11) The director shall 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 10<sup>th</sup> 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) One or both parties fail 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.**

[a] **(b) If the dispute is not resolved by agreement and i** if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order pursuant to ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical services dispute exists, the party may appeal the order to the Workers' Compensation 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.

[b] **(c)** When a bona fide dispute exists, the director will issue an administrative order and provide notice of the record used in the review.

(A) [The parties will have] **A request for contested case hearing must be received by the director within** 30 days from the issuance of an order pursuant to ORS 656.245, 656.260, or 656.327, or 60 days from the issuance of an order pursuant to [section 14, chapter 865, Oregon Laws 2001] **ORS 656.247**, to request a contested case hearing before the director].

(B) 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

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reconsideration at the director's sole discretion. A request [for reconsideration] must be mailed before the administrative order becomes final[, or if appealed, before the contested case order is issued].

(C) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this subsection and may respond to such evidence submitted by others.

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

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

**(13) In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director shall award an attorney fee to be paid by the insurer or self-insured employer, as provided in ORS 656.385 (§2, ch. 756, OL 2003). The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration shall 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:**

<u>Estimated Benefit Achieved</u>	<u>Professional Hours Devoted</u>				
	<u>1-2 hours</u>	<u>2.1-4 hours</u>	<u>4.1-6 hours</u>	<u>6.1-8 hours</u>	<u>8.1-12 hours</u>
<u>\$1-\$2000</u>	<u>\$100-400</u>	<u>\$200-700</u>	<u>\$300-750</u>	<u>\$600-1000</u>	<u>\$800-1250</u>
<u>\$2001-\$4000</u>	<u>\$200-500</u>	<u>\$400-800</u>	<u>\$600-900</u>	<u>\$800-1300</u>	<u>\$1050-1500</u>
<u>\$4001-\$6000</u>	<u>\$300-700</u>	<u>\$600-1000</u>	<u>\$800-1250</u>	<u>\$1000-1450</u>	<u>\$1300-1750</u>
<u>\$6001-\$10000</u>	<u>\$400-900</u>	<u>\$800-1300</u>	<u>\$1050-1600</u>	<u>\$1350-1800</u>	<u>\$1550-2000</u>

**(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 case if greater than two hours. In the absence of such a statement, the director shall assume the time spent on the case 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**

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**(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.**

**(c) Where the dispute is between the insurer and medical provider over a medical fee, the presumed benefit to the worker is zero unless the fee could be billed to the worker under ORS chapter 656 and these rules if the insurer were found not liable to pay the medical provider.**

**(d) 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 statement of the extraordinary circumstances to the director.**

**(e) In order to provide parties an opportunity to inform the director of agreements regarding attorney fee amounts or value of services, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any statements provided to the director must simultaneously be provided to all other parties to the dispute.**

**(f) An assessed attorney fee shall be paid within 30 days of the date the order authorizing the fee becomes final.**

**(14)** Contested cases before the director: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested, and include a copy of the administrative order being appealed.

(b) The appeal must be [made] **received** within 30 days of the mailing date of the order or notice of action being appealed.

(c) The hearing shall be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(d) In the review of orders issued pursuant to ORS 656.327(2), ORS 656.260(14) and (16), and [section 14, chapter 865, Oregon Laws 2001] **ORS 656.247**, no new medical evidence or issues shall be admitted at the contested case 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.

(e) 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 contested case hearing is not subject to the "no new medical evidence or issues rule" in subsection (13)(d) of this rule. However, if the disputed medical service 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

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the performance of medical services are subject to the substantial evidence rule at contested case hearing.

[(14)] **(15)** Contested case hearings of sanction and civil penalties: Under ORS 656.740 (**§9, ch. 170, OL 2003**), any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation 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 filed with the division within 60 days after [service]**the mailing date** of the order or notice of assessment.

(c) The [D]**division** shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

[(d) An administrative law judge from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS chapter 183.

(15) **(16)** 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)] **(15)** of this rule, pursuant to 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 ninety (90) days of the disputed action and must specify the grounds upon which the action is contested.

(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)] **(14)** 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

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**436-010-0200      Advisory Committee on Medical Care**

The Advisory Committee on Medical Care shall be appointed by the director. The committee shall include one representative of insurers, one representative of employers, one representative of workers, one representative of managed care organizations, a diverse group of health care providers representative of those providing medical care to injured workers, and other persons as the director may determine are necessary to carry out the purpose of the committee. Health care providers shall comprise a majority of the committee at all times. The selection of health care providers shall consider the perspective of specialty care, primary care, and ancillary care providers, and the ability of members to represent the interests of the community at large.

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

**Stats. Implemented:** ORS 656.794

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**436-010-0210      Who May Provide Medical Services and Authorize Time-loss**

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

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

(3) Attending physicians **and authorized nurse practitioners** may prescribe treatment to be carried out by persons licensed to provide a medical service. **Attending physicians may prescribe treatment to be carried out** [or] by persons not licensed to provide a medical service **or treat independently** [ Those persons not licensed to treat independently or not licensed to provide a medical service, may only provide treatment prescribed by the attending physician which is] **only when such 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) [Nurse practitioners and p] **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 [nurse practitioners and] physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are contained in ORS 442.470.

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(5) 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 physician assistant is approved for practice by the Board of Medical Examiners.

(7) **Effective October 1, 2004, in order to qualify as an authorized nurse practitioner, a nurse practitioner 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 to any nurse practitioner after April 1, 2004.**

**(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 shall 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 shall 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 shall 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 shall 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 services to Oregon injured workers; and

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

**[8](9)** After giving prior approval, if the out-of-state physician does not comply with these rules, the insurer may object to the worker's choice of physician and shall notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by that physician after notification shall not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

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

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

**Stats. Implemented:** ORS 656.005(12), 656.245 [ (§3, ch. 811, OL 2003) ], 656.260

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**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, shall 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 shall 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. Fees for treatment by more than one physician at the same time are payable only when treatment is sufficiently different that separate medical skills are needed for proper treatment.

(3) The worker is allowed to change **his or her** attending physician[s] **or authorized nurse practitioner** by choice two times after the initial choice. Referral by the attending physician **or authorized nurse practitioner** to another attending physician **or authorized nurse practitioner**, initiated by the worker, shall count in this calculation. The limitations of the worker's right to choose physicians **or authorized nurse practitioners** pursuant to 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 [of physician] by choice of the worker:

- (a) Emergency services by a physician;
- (b) Examinations at the request of the insurer;

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(c) Consultations or referrals for specialized treatment 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 [physicians] **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, when the physician terminates practice or leaves the area, when a physician is no longer willing to treat an injured worker, when the worker moves out of the area requiring more than a 50 mile commute to the physician, **when the 90 day period for treatment by an authorized nurse practitioner has expired, or the nurse practitioner is required to refer the worker to an attending physician because of a possible worsening of the worker's condition following claim closure**, and when a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A Worker Requested Medical Examination; [or]

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

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

(4) When a worker has made an initial choice of attending physician **or authorized nurse practitioner** and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer shall inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician **or authorized nurse practitioner**, the insurer shall 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 shall pay for appropriate services rendered prior to the time the insurer notifies the [physician] **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[s] **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 [attending physician] **medical service provider** or a Form 827 indicating the worker is choosing to change **his or her** attending physician[s] **or authorized nurse practitioner**, the insurer shall notify the worker in writing whether the change is approved. If the insurer objects to

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the change, the insurer shall 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 Physicians **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[s] **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 [change of attending physician] request, the insurer shall notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer shall 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 shall 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** shall 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 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 and/or lost time from work.

(8) Any party that disagrees with the director's order may request a contested case hearing before the director, pursuant to ORS 183.310(2) and OAR 436-001, as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested and must include a copy of the order appealed.

(b) The appeal must be [made] **received** within 30 days of the mailing date of the order.

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

**Stats. Implemented:** ORS 656.245[(§3, ch. 811, OL 2003)], 656.252, 656.260

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**436-010-0230 Medical Services And Treatment Guidelines**

(1) Medical services provided to the injured worker shall 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 consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present. The worker has the right to refuse such attendance. The insurer shall 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. Unless otherwise provided for by statute, or within utilization and treatment standards [established by the director or] **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 the 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 shall 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 signed by the attending physician or specialist physician within 30 days of beginning treatment]. The medical service provider shall provide an initial copy of the treatment plan to the attending physician, **authorized nurse practitioner**, or specialist physician and the insurer within seven days of beginning treatment. A copy of the treatment plan signed by the attending physician, **authorized nurse practitioner**, or specialist physician shall be provided to the insurer by the medical service provider within 30 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 pursuant to ORS 656.245(2)(b)(A).

(b) Medical services prescribed by an attending physician, **specialist physician, or authorized nurse practitioner** and provided by a chiropractor, naturopath, acupuncturist, or

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podiatrist shall be subject to the treatment plan requirements set forth in subsection (4)(a) of this rule.

(c) Unless otherwise provided for within utilization and treatment standards [prescribed by the director or] **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. The attending physician **or authorized nurse practitioner** shall document the need for 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, shall complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician **or authorized nurse practitioner** shall 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, [or] dispensing physician, **or authorized nurse practitioner** shall dispense generic drugs to injured workers in accordance with and pursuant to ORS 689.515. For the purposes of this rule, the worker shall 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 office are [not] compensable **only for a maximum supply of 10 days, subject to the provisions of this rule and OAR 436-009-0090. Compensation for certain drugs are limited as provided in OAR 436-009-0090.**

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

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

(9) Upon request of either the director or the insurer, original [X-ray films] **diagnostic studies** shall be forwarded to the director or the insurer. Films shall be returned to the medical provider. A reasonable charge may be made for the costs of delivery of films. If a medical provider refuses to forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

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(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** shall 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 eye glasses.

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

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#### **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**. 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

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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, shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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** shall, 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 shall use Form 3245.

(6) Medical providers shall maintain records necessary to document the extent of 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

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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 shall 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 shall 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 shall respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, and any or all necessary records needed to review the efficacy of treatment, frequency, and necessity of care. The medical provider shall 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** shall 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 shall 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** shall notify the worker, the insurer, and all other medical providers who are providing services to the worker. **If the worker has been under the care of an authorized nurse practitioner, the authorized nurse practitioner must refer the worker to a qualified attending physician to complete a closing examination.** The attending physician shall send a closing report to the insurer within 14 days of the examination in which the worker is declared medically stationary, except where a consulting physician examines the worker. The procedures and time frames for a consulting physician to perform the closing exam are provided in OAR 436-010-0280.

(13) The attending physician **or authorized nurse practitioner** shall 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** shall not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

(14) An injured worker's claim for aggravation must be filed on Form 827 and must be accompanied by a medical report from the attending physician supported by objective findings that can be used to determine whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273. The attending physician, on the worker's behalf, shall submit within five days the claim for aggravation and the medical report directly to the insurer

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(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 shall 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 shall provide the consultant with all relevant clinical information. The consultant shall 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, shall be considered insurer medical examinations subject to the provisions of 436-010-0265.

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

(17) [When] **Any time** an injured worker [elects to] changes **his or her** attending physician[s] **or authorized nurse practitioner, 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.**

**(c) The requirements of (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.**

**(d) 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**[or is referred to a new physician who is qualified to be an attending physician and who becomes primarily responsible for the worker's care, the new attending physician shall notify the insurer, using Form 827, not later than five days after the change or the date of first treatment. The new attending physician shall request all available medical information, including information concerning previous temporary disability periods, from the previous attending physician or from the insurer. A previous attending physician who fails to forward requested information within 14 days to the new attending physician will be subject to penalties as provided by OAR 436-010-0340].

(18) Injured workers, or their representatives, are entitled to copies of all [relevant] **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:** [upon the payment of an appropriate charge for copies in accordance with OAR 436-009-0070 (1) However, records that contain medical and psychological information relevant to the claim, which in the judgment of the writer of the report should not be shown to the worker because it would not be in the worker's best interest, need not be supplied to the worker, but must be supplied to the worker's representative. Upon request by the insurer, the director, or the worker, records containing the relevant information shall be provided, subject to the above exception.]

**(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.**

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

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

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

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

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

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

**(B) Psychotherapy notes;**

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

**(D) Other reasons specified by federal regulation.**

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245 [ (§3, ch. 811, OL 2003) ], 656.252, 656.254, 656.273, [ (ch. 86, OL 2003) ]

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#### **436-010-0250 Elective Surgery**

(1) "Elective Surgery" is 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.

(2) Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician **or authorized nurse practitioner**, believes elective surgery is needed to treat a compensable injury or illness, the attending physician, **authorized nurse practitioner**, or the surgeon shall give the insurer actual notice at least seven days prior to

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the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, and the approximate surgical date and place if known.

(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the recommending physician, the worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician. When requested, the consultation shall be completed within 28 days after notice to the [attending ] physician.

(4)(a) Within seven days of the consultation, the insurer shall notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer shall endeavor to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, shall obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

(c) The recommending physician shall provide written notice to the insurer, the worker and the worker's representative when further attempts to resolve the matter would be futile by signing Form 440-3228.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in subsection(4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request **by submitting Form 440-3228**, or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery **is or** was excessive, inappropriate, or ineffectual.

(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.

(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-0340.

(8) Surgery which must be performed promptly, i.e., before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases the attending physician **or authorized nurse practitioner** should endeavor to notify the insurer of the need for emergency surgery.

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

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**436-010-0260      Monitoring and Auditing Medical Providers**

(1) The department will monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and these rules.

(2) All records maintained or required to be maintained shall be disclosed upon request of the director.

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

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

(1) The insurer may obtain three medical examinations of the worker by physicians of their choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. 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 pursuant to ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "insurer 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. The examination may be conducted by one or more medical providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the medical providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer shall 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 shall be as follows:

(a) The insurer shall 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

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information requested by the director. A copy of the request shall 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 shall 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) and/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 treatment, 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 the condition has been included in the compensable claim.

(4) Any party aggrieved by the director's order may request a hearing by the Hearings Division of the Workers' Compensation Board pursuant to ORS 656.283 and OAR chapter 438.

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

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

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

(c) A 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); and

(e) An examination by a consulting physician that has been arranged by the worker's attending physician **or authorized nurse practitioner** in accordance with OAR 436-010-0280.

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

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

(8) When scheduling an IME, the insurer shall provide Form 440-3227 (Invasive Medical Procedure Authorization) to the medical service provider.

(9) If a medical service provider intends to perform an invasive procedure as part of an IME, the worker shall sign Form 440-3227 and may refuse the procedure. 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.

(10) The person conducting the examination shall determine the conditions under which the examination will be conducted. Subject to the physician's approval, the worker may use a video camera or tape recorder to record the examination. Also subject to the physician's approval, the worker may be accompanied by a family member or friend during the examination. If the physician does not approve a worker's request to record an examination or allow the worker to be so accompanied, the physician must document the reasons.

(11) Upon completion of the examination, the examining physician shall send a copy of the report to the insurer [and attending physician] within seven days. **The insurer shall forward a copy of the report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.**

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

**Stat. Implemented:** ORS 656.252, 656.325, 656.245 [(§3, ch. 811, OL 2003)], 656.248, 656.260, 656.264

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#### **436-010-0270 Insurer's Rights and Duties**

(1) Insurers shall notify the injured worker in writing, immediately following receipt of notice or knowledge of a claim, of the manner in which they may receive medical services for compensable injuries.

(2) Insurers may obtain relevant medical records, using a computer-generated equivalent of Form 2476 (Release of Information), with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(3) **The insurer shall notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim.** In claims which have been denied [and are on appeal], the insurer shall notify the medical **service** provider and MCO, if any, within ten days of any change of status of the claim.

(4) Upon request, the insurer shall forward all relevant medical information to return-to-work specialists, [or] vocational rehabilitation organizations, **or new attending physician or authorized nurse practitioner within 14 days.**

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(5) In disabling and non-disabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers shall notify the injured worker and the attending physician **or authorized nurse practitioner** in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(6) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician **or authorized nurse practitioner**, the insurer shall notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer shall be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician **or authorized nurse practitioner**.

(7) Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(e), 656.325, and 656.327.

(a) Reimbursement by the insurer to the worker for transportation costs to visit [their] **his or her** attending physician may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician of the same specialty who is in a geographically closer medical community in relationship to the worker's home. **If a worker seeks treatment from an authorized nurse practitioner, reimbursement by the insurer to the worker for transportation costs to visit his or her authorized nurse practitioner may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate nurse practitioner of the same specialty who is in a geographically closer medical community in relationship to the worker's home.** All medical practitioners within a metropolitan area are considered part of the same medical community and therefore are not considered geographically closer than any other physician in that metropolitan medical community for purposes of travel reimbursement.

(b) A worker who relocates within the State of Oregon may continue treating with the established attending physician **or authorized nurse practitioner** and be reimbursed transportation costs.

(c) Prior to limiting reimbursement under subsection (7)(a) of this rule, the insurer shall provide the worker a written explanation and a list of providers who can timely provide similar services within a reasonable traveling distance for the worker. The insurer shall inform the worker that treatment may continue with the established attending physician **or authorized nurse practitioner**; however, reimbursement of transportation costs may be limited as described.

(d) When the director decides travel reimbursement disputes at administrative review or contested case level, the determination will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

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

**Stat. Implemented:** ORS 656.252, 656.325, 656.245 [(§3, ch. 811, OL 2003)], 656.248, 656.260, 656.264

**Hist:** Filed 2/23/82 as Admin. Order 5-1982, eff 3/1/82  
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Amended 12/10/85 as Admin. Order 6-1985, eff 1/1/86  
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Amended 1/5/90 as Admin. Order 1-1990, eff 2/1/90  
Amended 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)  
Amended 12/10/90 as Admin. Order 32-1990, eff 12/26/90  
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Amended xx/xx/xx as Admin. Order 03-069, eff 1/1/04 (Temp)  
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**436-010-0275 Insurer's Duties under MCO Contracts**

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

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

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

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

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

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

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

(4) When the insurer is enrolling a worker in an MCO, the insurer shall simultaneously provide written notice to the worker, all medical service providers, and the MCO of enrollment.

[Any notification to the MCO or medical service provider required by this subsection may be given via electronic mail subject to the requirements for electronic transmissions described in OAR 436-010-0005(23).] The notice shall:

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

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

(c) Describe how the worker can receive compensable medical treatment from a primary care physician **or authorized nurse practitioner qualified to provide services as described in**

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**OAR 436-015-0070**, who is not a member of the MCO, including how to request qualification of their primary care physician **or authorized nurse practitioner**;

(d) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(5);

(e) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

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

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

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

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

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

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

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

(b) If the MCO does not have a dispute resolution process for that issue, the insurer shall notify the parties in writing to seek administrative review before the director.

(9) The insurer must also notify the MCO of the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, and must keep the MCO informed of any changes.

(10) Insurers under contract with MCOs shall maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer

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numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

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

**Stat. Implemented:** ORS 656.252, 656.325, 656.245 [(§3, ch. 811, OL 2003)], 656.248, 656.260, 656.264

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**436-010-0280 Determination of Impairment**

(1) The attending physician **or authorized nurse practitioner** shall 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. **Upon finding or notification that the worker is medically stationary, an authorized nurse practitioner shall refer the worker to a qualified attending physician to complete a closing examination.**

(2) The attending physician shall perform a closing examination pursuant to OAR 436-030-0020 (2) and submit the closing report within 14 days of the examination in which the worker was determined medically stationary, or shall arrange or request the insurer to arrange for the worker to be examined by a consulting physician for all or any part of the closing examination within five days of the examination in which the worker is declared medically stationary.

(3) A closing examination shall be performed when the attending physician 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. The attending physician shall 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 shall be scheduled within five days of the denial notification. **Upon notification that the worker's accepted condition is no longer the major contributing cause of the worker's condition, an authorized nurse practitioner shall refer the worker to a qualified attending physician to complete a closing examination.**

(4) Closing reports for examinations performed by a [consulting] **specialist** physician pursuant to this rule shall be submitted to the attending physician within seven days of the examination. The attending physician must review the report and, within seven days of receipt of the report, concur in writing or provide a report to the insurer describing any finding/conclusion with which the attending physician disagrees.

(5) [The insurer or the director may request an examination to determine the extent of impairment. The physician conducting the examination shall provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007.

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

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[(7)]**(6)** 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)]**(7)** The attending physician shall 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)]**(8)** 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 shall estimate the worker's future impairment and residual functional capacity pursuant to OAR 436-035-0007(5).

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

**Stats. Implemented:** ORS 656.245 [ (§3, ch. 811, OL 2003) ], 656.252

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Amended xx/xx/xx as Admin. Order xx-xxx, eff. 4/1/04

#### **436-010-0290 Palliative Care**

(1) When the worker's attending physician believes that palliative care is appropriate to enable the worker to continue current employment or a current vocational training program, the attending physician must first submit a written request for approval to the insurer. The request shall:

- (a) Describe any objective findings;
- (b) Identify by ICD-9-CM diagnosis, the medical condition for which palliative care is requested;
- (c) Detail a treatment plan which includes the name of the provider who will render the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;
- (d) Explain how the requested care is related to the compensable condition; and

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(e) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(2) Insurers shall date stamp all palliative care requests upon receipt. Within 30 days of receipt, the insurer shall send written notification to the attending physician, worker, and worker's attorney approving or disapproving the request as prescribed.

(a) Palliative treatment may begin following submission of the request to the insurer. If approved, services shall be payable from the date the approved treatment begins. If the requested care is ultimately disapproved, the insurer is not liable for payment of the treatment.

(b) If the insurer disapproves the requested care, the insurer shall explain, in writing:

(A) Any disagreement with the medical condition for which the care is requested;

(B) Why the requested care is not acceptable; and/or

(C) Why the requested care will not enable the worker to continue current employment or a current vocational training program.

(3) If the insurer fails to respond in writing within 30 days, the attending physician or injured worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. If the request is from a physician, it shall include a copy of the original request and may include any other supporting information.

(4) When the attending physician or the injured worker disagrees with the insurer's disapproval, the attending physician or the injured worker may request administrative review by the director in accordance with OAR 436-010-0008, within 90 days from the date of insurer's notice of disapproval. In addition to information required by OAR 436-010-0008(6), if the request is from a physician, it shall include:

(a) A copy of the original request to the insurer; and

(b) A copy of the insurer's response.

(5) When the worker, insurer, or director believes palliative care, compensable under ORS 656.245(1)(c)(J), is excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services, the dispute shall be resolved in accordance with ORS 656.327 and OAR 436-010-0008.

(6) Subsequent requests for palliative care shall be subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

**Stat. Auth:** ORS 656.726

**Stats. Implemented:** ORS 656.245

**Hist:** Filed 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)  
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Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

**436-010-0300 Process for Requesting Exclusion of Medical Treatment from Compensability**

(1) If an injured worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability pursuant to ORS 656.245 (3). The request shall include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process.

(2) The investigation shall include a request for advice from the licensing boards of practitioners who might be affected and the Medical Advisory Committee.

(3) The director shall issue an order and may adopt a rule declaring the treatment to be non-compensable. The decision of the director is appealable to the director for a contested case hearing.

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

**Stats. Implemented:** ORS 656.245

**Hist:** Filed 1/20/88 as Admin. Order 1-1988, eff 2/1/88  
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Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

**436-010-0330 Medical Arbiters and Panels of Physician**

(1) In consultation with the Workers' Compensation Management-Labor Advisory Committee pursuant to ORS 656.790, the director shall establish and maintain a list of physicians to be used as follows:

(a) To appoint a medical arbiter or a panel of medical arbiters in accordance with ORS 656.268 and to select a physician in accordance with ORS 656.325 (1)(b).

(b) To appoint an appropriate physician or a panel of physicians to review medical treatment or medical services disputes pursuant to ORS 656.245 and ORS 656.327.

(2) Arbiters, panels of arbiters, physicians, and panels of physicians will be selected by the director.

(3) When a worker is required to attend an examination pursuant to this rule the director shall provide notice of the examination to the worker and all affected parties. The notice shall inform all parties of the time, date, location and purpose of the examination. Such examinations shall be at a place reasonably convenient to the worker.

(4) The arbiters, the panels of arbiters, the physicians and the panels of physicians selected pursuant to this rule shall be paid by the insurer in accordance with OAR 436-009-0070 (9) to (11).

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(5) The insurer shall pay the worker for all necessary related services pursuant to ORS 656.325(1).

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

**Stats. Implemented:** ORS 656.268, 656.325, 656.327

**Hist:** Filed 6/20/90 as Admin. Order 6-1990, eff 7/1/90 (Temp)  
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Amended 12/17/01 as Admin. Order 01-065, eff 1/1/02

**436-010-0340 Sanctions and Civil Penalties**

(1) If the director finds any medical provider in violation of the medical reporting requirements established pursuant to ORS 656.245, 656.252, and 656.254(1), as found in OAR 436-009 and 436-010, the director may impose one or more of the following sanctions:

- (a) Reprimand by the director;
- (b) Non-payment, reduction or recovery of fees in part, or whole, for services rendered;
- (c) Referral to the appropriate licensing board; or
- (d) Civil penalty not to exceed \$1,000 for each occurrence. In determining the amount of penalty to be assessed, the director shall consider:
  - (A) The degree of harm inflicted on the worker or the insurer;
  - (B) Whether there have been previous violations; and
  - (C) Whether there is evidence of willful violations.

(2) The director may impose a penalty of forfeiture of fees and a fine not to exceed \$1,000 for each occurrence on any health care practitioner who, pursuant to ORS 656.254 and 656.327, has been found to:

- (a) Fail to comply with the medical rules;
- (b) Provide medical treatment that is excessive, inappropriate or ineffectual; or
- (c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(3) If the conduct as described in section (2) is found to be repeated and willful, the director may declare the practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(4) A health care practitioner whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years. A certified copy of the revocation or suspension order shall be prima facie justification for the director's order.

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(5) If a financial penalty is imposed on the attending physician **or authorized nurse practitioner** for violation of these rules, no recovery of penalty fees may be sought from the worker.

(6) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are appropriate, either may submit a complaint in writing to the director.

(7) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical treatment, the director may order the insurer to reimburse any affected medical service providers for services rendered until the insurer complies with the notification requirement. Any penalty shall be limited to the amounts listed in section (8) of this rule.

(8) If the director finds any insurer in violation of OAR 436-009 or OAR 436-010, or an order of the director, the insurer [shall] **may** be subject to penalties pursuant to ORS 656.745 of not more than \$2000 for each violation or \$10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation.

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

**Stat. Implemented:** ORS 656.245 [(§3, ch. 811, OL 2003)], 656.254, 656.745

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### **436-010-0350 Service of Orders**

[(1) When the director imposes a sanction or assesses a penalty under the provisions of 436-010-0340, the order, including a notice of the party's appeal rights, shall be served on the party.

(2) The director shall serve the order by delivering a copy to the party in the manner provided by Oregon Rules of Civil Procedure 7 D, or by sending a copy to the party by certified mail with return receipt requested.]

**Stat Auth:** ORS 656.740

**Stat. Implemented:** ORS 656.740

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