



Oregon

John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter Street NE
P.O. Box 14480
Salem, Oregon 97309-0405
1-800-452-0288, 503-947-7810
www.wcd.oregon.gov

Jan. 14, 2011

Regarding Proposed Changes to Workers' Compensation Rules

Comment Period Extended

The last day for written comments is now Jan. 27, 2011.

The Workers' Compensation Division proposes changes to OAR chapter 436, mainly affecting the Oregon Medical Fee and Payment Rules, OAR 436-009, plus several additional rules related to medical services in OAR 436-010 and 436-060.

In order to allow additional time for the public to submit written testimony, the division has extended the comment period through and including Jan. 27, 2011 (formerly Jan. 20).

Otherwise, the *Notice of Proposed Rulemaking Hearing* and *Statement of Need and Fiscal Impact* filed with the Secretary of State on Dec. 15, 2010 remain the same. Copies of these forms and complete text of the proposed rules with marked revisions are available on the division's website: www.wcd.oregon.gov/policy/rules/rules.html#proprules

- When is the hearing?** Jan. 18, 2011, 1:30 p.m.
- Where is the hearing?** Labor & Industries Building
350 Winter Street NE, Room F, Salem, Oregon 97301
- How can I make a comment?** Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone – 503-947-7717; Fax – 503-947-7514

The closing date for written comments is Jan. 27, 2011.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –
www.wcd.oregon.gov/policy/rules/rules.html#proprules

Or call 503-947-7717 to get free paper copies

Questions?

Contact Fred Bruyns, 503-947-7717.



Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
PO Box 14480
Salem, OR 97309-0405
1-800-452-0288 or 503-947-7810
www.wcd.oregon.gov

Dec. 20, 2010

Proposed Changes to Workers' Compensation Rules

The Workers' Compensation Division proposes changes to OAR chapter 436, mainly affecting the Oregon Medical Fee and Payment Rules, OAR 436-009, plus several additional rules related to medical services in OAR 436-010 and 436-060.

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

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

When is the hearing?

Jan. 18, 2011, 1:30 p.m.

Where is the hearing?

Labor & Industries Building
350 Winter Street NE, Room F (basement),
Salem, Oregon 97301

How can I make a comment?

Come to the hearing and speak, send written comments, or do both. Send written comments to:
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Email - fred.h.bruyns@state.or.us
Phone – 503-947-7717; Fax – 503-947-7514

The closing date for written comments is Jan. 20 27, 2011.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's Web site –
www.wcd.oregon.gov/policy/rules/rules.html#proprules

Or call 503-947-7717 to get free paper copies

Questions?

Contact Fred Bruyns, 503-947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING
A Statement of Need and Fiscal Impact accompanies this form.

Department of Consumer and Business Services,
Workers' Compensation Division

OAD CHAPTER 436

Agency and Division

Administrative Rules Chapter Number

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

(503) 947- 7717
Fax (503) 947-7514

Rules Coordinator

Address

Telephone

RULE CAPTION

Amendments to rules affecting workers' compensation medical fee schedules and medical services

Hearing date	Time	Location	Hearings Officer
Jan. 18, 2011	1:30 p.m.*	Room F (basement), Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns

*NOTE: The hearing will begin at 1:30 p.m. and end when all present who wish to testify have done so. Written testimony will be accepted through **Jan. 20, 2011**.

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:

AMEND: OAR 436-009; 436-010-0230, 436-010-0265, 436-010-0290; 436-060-0095

REPEAL:

ORS 656.726(4); 656.248; 656.325

Stat. Auth.

Other Authority

ORS chapter 656, primarily ORS 656.248, 656.252, 656.254, and 656.325

Stats. Implemented

RULE SUMMARY

Unless stated otherwise, references to "insurers" mean workers' compensation insurers and self-insured employers.

The agency proposes to amend OAR chapter 436, division 009. These proposed rules address:

- Adoption of updated medical fee schedules and resources for the payment of health care providers
- Data that must be included on hospital inpatient and outpatient bills
- Billing requirements and payment criteria for ambulatory surgery centers
- Health care provider and payer communication regarding medical bills, including explanations of benefits that accompany payments or denials of payment
- Inclusion of certain Healthcare Common Procedure Coding System (HCPCS) level II codes in the maximum allowable payment table (Appendix B)
- Maximum allowable payment when OAR 436-009 does not set a maximum
- Documentation of time spent with a patient when constant attendance is required, affecting physical medicine codes
- Payment for independent medical examinations
- Maximum allowable payment for drugs based on wholesale acquisition cost or average wholesale price
- Procedures and forms required for clinical justifications when health care providers prescribe certain drugs; results of failure by provider to submit timely justification
- Prescription pricing guides to be used by insurers in calculating payment for drugs

- Payment of interpreters when a worker fails to attend a medical appointment required by the insurer or the director

The agency proposes to amend OAR chapter 436, division 010. These proposed rules address:

- Progress reporting by a physical therapist to the worker's attending physician and the insurer
- The type and form of information the insurer must make available to the health care provider to give to the patient at a scheduled independent medical examination
- Procedures for a worker to provide comments to the director about an independent medical examination or to file a complaint
- Training requirements for health care providers to be included on the list of authorized independent medical examination providers

The agency proposes to amend OAR chapter 436, division 060. These proposed rules address:

- The information an insurer must include with the independent medical examination appointment notice it sends to the worker

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

Address questions or requests for paper copies of the rules to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7514; e-mail fred.h.bruyns@state.or.us. Proposed rules are available on the Workers' Compensation Division's Web site: <http://wcd.oregon.gov/policy/rules/rules.html#proprules>

Jan. 20, 2011
Last Day for Public Comment
(Last day to submit written comments to the
Rules Coordinator)

/s/ John L. Shilts Dec. 15, 2010
Authorized Signer and Date
John L. Shilts, Administrator, Workers' Compensation Division
Printed name

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Distribution: WCD-ID, S0, S1, S4, S7, S, U, AT, CE, EG, LU, NM, MR, TT, DC, DO, GR, MD, ND, OT, PY, M1, M2, CI; E-mail lists; and legislators under ORS 183.335(15)

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
Agency and Division

436

Administrative Rules Chapter Number

Amendments to rules affecting workers' compensation medical fee schedules and medical services

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of
OAR 436-009, Oregon Medical Fee and Payment Rules
OAR 436-010, Medical Services
OAR 436-060, Claims Administration

Statutory Authority: ORS 656.726(4); 656.248; 656.325

Other Authority:

Stats. Implemented: ORS chapter 656, primarily ORS 656.248, 656.252, 656.254, and 656.325

Need for the Rule(s): The agency is proposing changes to update the medical fee schedules as required by ORS 656.248, and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

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

Fiscal and Economic Impact: Unless stated otherwise, references to "insurers" (below) mean workers' compensation insurers and self-insured employers. The following is a list of significant estimated economic impacts on persons and organizations affected by these proposed rule changes.

Statement of Cost of Compliance:

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

- a. The agency projects proposed rule changes would have no direct effect on state agencies, with the exception of this agency, as described below, and also with the exception of the State Accident Insurance Fund (SAIF) Corporation, and no effect on units of local government. The fiscal effect on SAIF Corporation is included with the impacts on workers' compensation insurers.
- b. Proposed changes to OAR 436-009 affecting maximum allowable payments by CPT® code are based on the relative value units published by the Centers for Medicare & Medicaid Services (CMS). CMS has substantially increased the relative value units overall. CMS also decreased its conversion factor to offset the increased relative value units. The agency has adjusted its maximum allowable payments to reinstate current payment levels, which were substantially increased in July 2010. The agency's objective is to keep overall payments under the Physician Service Categories equivalent to payments under the existing schedule. However, the changes to individual CPT® codes may result in some changes in reimbursements according to the types of services provided by the individual providers.
- c. Proposed changes to OAR 436-009 should promote communication between health care providers and payers. Insurers would have some initial costs to modify their explanations of benefits that accompany payments or denials of payment. While the changes proposed make it clear that the insurer cannot refer bill inquiries to other companies to answer, the requirement to answer physician questions relating to medical payments has not changed. There should not be any fiscal impact due to the clarification unless the insurer has not complied with the existing law. The agency projects, however, that the overall economic effect of the changes would be slightly positive by expediting appropriate payment and reducing payment disputes.

- d. Proposed changes to OAR 436-009 would set maximum allowable payments for certain CPT® codes and two HCPCS codes relating to drug testing. The agency projects that this would have no overall positive or negative fiscal impact on providers, because the agency set the price at levels commonly paid; however, providers that have been paid more than the proposed maximum allowable payment for drug testing procedures would experience a decrease in reimbursement for these services.
- e. Proposed changes to OAR 436-009 would limit payment to 80% of a health care provider's usual fee when the rules don't set a maximum allowable payment for a specific service. This change would decrease reimbursements for those services that are currently paid at the amount charged by the provider. The paid-as-billed codes are extensive (e.g., approximately 10,000 HCPCS codes), and charged regularly by nearly all providers working within the workers' compensation system. The agency projects this change would reduce payments to providers by approximately \$4 million per year, and reduce insurers' costs by a corresponding amount.
- f. Proposed changes to OAR 436-009 would limit reimbursement for drugs to 110% of wholesale acquisition cost (WAC) or, if the drug has no WAC, to 80% of the average wholesale price. Proposed changes also include procedures and forms required for clinical justifications when health care providers prescribe certain drugs, to promote dispensing of generic and therapeutically equivalent drugs. The agency projects these changes would reduce reimbursements to pharmacies by approximately \$1.9 million per year, and reduce insurers' costs by a corresponding amount. If a health care provider fails to provide the clinical justification, the insurer may reduce the provider's future payments on the claim by the amount the insurer paid for the drug. The agency projects a small administrative cost for providers to complete the clinical justification forms.
- g. Proposed changes to OAR 436-009 would require insurers to pay interpreters if a worker fails to attend a scheduled appointment that has been ordered by the insurer or the director. The agency projects that this change would have a positive economic impact on interpreters at a corresponding cost to insurers.
- h. Proposed changes to OAR 436-009 include a fee schedule for ambulatory surgery centers (ASCs) that is more consistent with schedules used by the Centers for Medicare & Medicaid Services (CMS). The agency's objective is to keep overall payments to ASCs equivalent to payments under the existing schedule. However, the CMS model may result in some changes in reimbursements according to the types of services provided by the ASC.
- i. Proposed changes to OAR 436-010 would require physical therapists to send progress reports to the worker's attending physician and the insurer. The objective is to promote effective treatment and to expedite return to work. The agency projects that this change could reduce or increase payments to therapists to the extent improved communication affects the frequency or duration of care.
- j. Proposed changes to OAR 436-010 and 436-060 would eliminate the requirement that independent medical examination (IME) providers give workers a survey form, though workers would still receive a brochure explaining procedures to provide comments to the director about an IME and to file a complaint, either by using the agency's website or by telephone. The agency projects that this change would slightly reduce agency costs to process IME data. Insurers and providers will be required to print the brochure from a web-based document, which will add some administrative costs to insurers and providers.
- k. The agency projects that additional proposed rule changes should not have significant economic impacts on any persons or businesses, including small businesses.

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

- a. **Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:** Small businesses affected by these rules are primarily medical providers, including suppliers of prosthetics and orthotics, and independent community pharmacies (according to the Oregon Board of Pharmacy, Oregon has approximately 210 independent community pharmacies). Many language interpreters are also small businesses. We estimate approximately 12,000 Oregon health care providers are small businesses, as defined in ORS 183.310(10). We do not have data showing how many small interpreter firms operate in Oregon, but estimate there are at least two hundred firms meeting the "small business" definition.
- b. **Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:** Health care providers would assume a small administrative cost to complete

clinical justification forms when prescribing certain drugs. Independent medical examination providers would assume a small administrative cost to print certain informational materials from the agency's website. Please review additional potential impacts above, especially 1. e. and f.

- c. Equipment, supplies, labor and increased administration required for compliance:**
None anticipated.

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

Representatives of small businesses participated in the stakeholder advisory committee or provided written advice.

Administrative Rule Advisory Committee consulted? Yes

If not, why?

The agency asked the committees for advice on the economic impacts of the discussed changes, including impacts on small businesses.

/s/ John L. Shilts

John L. Shilts

Dec. 15, 2010

Signature

Printed name

Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 925-2007



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

Proposed

TABLE OF CONTENTS

Rule		Page
436-010-0230	Medical Services and Treatment Guidelines	1
436-010-0265	Independent Medical Examinations (IME)	6
436-010-0290	Medical Care After Medically Stationary	11
Appendix B	IME Training Curriculum Requirements	14
Appendix C	IME Standards.....	17

NOTE: Revisions are marked as follows:

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

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

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

436-010-0230 Medical Services and Treatment Guidelines

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

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

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

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

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

(3) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services.

(4)(a) Except as otherwise provided by an MCO, ancillary services including but not

ORDER NO. 11-XXX

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

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

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

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

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

(e) Unless otherwise provided for within utilization and treatment standards under an MCO contract, a physical therapist must simultaneously submit a progress report to the attending physician and the insurer each 30 days or 10 visits of physical therapy, whichever occurs first. The progress report may be included in the provider's chart notes. The progress report must include whether the worker's condition is improving. If the workers' condition is improving, the improvements must be demonstrated by objective and measurable findings. The progress report must also provide any change in the worker's physical restrictions.

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

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care

ORDER NO. 11-XXX

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

provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker will be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090.

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

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

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

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

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

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

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

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

ORDER NO. 11-XXX

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

workers.

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

(13) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(g) is always inappropriate for injured workers with the following conditions (absolute contraindications):

- (a) Metabolic bone disease – for example, osteoporosis;
- (b) Known spondyloarthropathy (seropositive and seronegative);
- (c) Posttraumatic vertebral body deformity at the level of the proposed surgery;
- (d) Malignancy of the spine;
- (e) Implant allergy to the materials involved in the artificial disc;
- (f) Pregnancy – currently;
- (g) Active infection, local or systemic;
- (h) Lumbar spondylolisthesis or lumbar spondylosis;
- (i) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or
- (j) Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

(14) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(g) may be inappropriate for injured workers with the following conditions, depending on severity, location, etc. (relative contraindications):

- (a) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;
- (b) Arachnoiditis;
- (c) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);
- (d) Facet arthropathy – lumbar – moderate to severe, as shown radiographically;
- (e) Morbid obesity – BMI greater than 40;
- (f) Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;
- (g) Osteopenia – based on bone density test;
- (h) Prior lumbar fusion at a different level than the proposed artificial disc replacement;

or

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

(i) Psychosocial disorders – diagnosed as significant to severe.

(15) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(h) is always inappropriate for injured workers with any of the following conditions (absolute contraindications):

- (a) Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;
- (b) Significantly abnormal facets;
- (c) Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g. -2.7);
- (d) Allergy to metal implant;
- (e) Bone disorders (any disease that affects the density of the bone);
- (f) Uncontrolled diabetes mellitus;
- (g) Active infection, local or systemic;
- (h) Active malignancy, primary or metastatic;
- (i) Bridging osteophytes (severe degenerative disease);
- (j) A loss of disc height greater than 75 percent relative to the normal disc above;
- (k) Chronic indefinite corticosteroid use;
- (l) Prior cervical fusion at two or more levels; or
- (m) Pseudo-arthritis at the level of the proposed artificial disc replacement.

(16) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0015(6)(h) may be inappropriate for injured workers with any of the following conditions, depending on severity, location, etc. (relative contraindications):

(a) A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

(b) Multilevel degenerative disc disease – cervical – moderate to severe, as shown radiographically;

(c) Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;

(d) Prior cervical fusion at one level;

(e) A loss of disc height of 50 percent to 75 percent relative to the normal disc above; or

(f) Psychosocial disorders – diagnosed as significant to severe.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252

Hist: Amended 6/12/08 as WCD Admin. Order 08-052, eff. 6/30/08
 Amended 5/21/09 as Admin. Order 09-051, eff. 7/1/09

ORDER NO. 11-XXX

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

436-010-0265 Independent Medical Examinations (IME)

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

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

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

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

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

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

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

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

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

ORDER NO. 11-XXX

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

processing/benefits.

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

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

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

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

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

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

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

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

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

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

(f) A consultation requested by the Managed Care Organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under its contract.

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

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

(8) A medical provider who unreasonably fails to timely provide diagnostic records required for an IME in accordance with OAR 436-010-0230(9) and 436-010-0240(11) may be assessed a penalty under ORS 656.325.

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

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

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

(c) If necessary, the director will conduct an expedited review and issue an order

ORDER NO. 11-XXX

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

regarding the reasonableness of the location.

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

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

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

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

(11) When scheduling an IME, the insurer must ensure the medical service provider has:

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

(b) ~~A Worker IME Survey~~ **The Form 440-3923, "Important Information about Independent Medical Exams"** (Form 440-0858), ~~with instructions to give the form(s) to the worker at the time of the IME.~~ **available to the injured worker before the exam.**

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

(13) Any medical service provider wishing to perform an IME or a Worker Requested Medical Exam (WRME) under ORS 656.325(1)(e) and OAR 436-060-0147 for a workers' compensation claim must meet the director's criteria and be included on the list of authorized providers maintained by the Director of the Department of Consumer and Business Services under ORS 656.328.

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

~~(A) Hold~~ **hold** a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon Medical Board, **and must:-**

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

(B) Review IME training materials provided or approved by the director. The material can be found at www.oregonwcdoc.info.

ORDER NO. 11-XXX

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

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

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

~~(c)~~ **(b) To be included on the list of authorized IME providers, the provider must complete the online certification form. Providers may access the certification form at www.oregonwcdoc.info. Submit the Application for Independent Medical Exam Medical Service Provider Authorization (Form 440-3930) to the director. On the application, the provider must supply his or her license number, the name of the training vendor, and certify to the director that the provider completed at least one of the training requirements under OAR 436-010-0265(13)(a) and the date the provider completed a director-approved initial training course regarding IMEs. By signing and submitting the application form, the provider agrees to abide by: Any provider that completes the certification agrees to abide by the following:**

~~(i)~~ **(A)** The standards of professional conduct for performing IMEs adopted by the provider's regulatory board, or the independent medical examination standards published in Appendix C, which apply if the provider's regulatory board does not adopt standards of conduct for IMEs. Providers on the director's list of authorized IME providers as of June 7, 2007, remain authorized to perform IMEs and do not need to reapply; and

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

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

(c) Providers on the director's list of authorized IME providers as of March 31, 2011, remain authorized to perform IMEs and do not need to reapply.

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

(A) Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C, whichever applies;

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

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

(D) Has entered into a voluntary agreement with his or her regulatory board which the

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

director determines is detrimental to performing IMEs;

- (E) Violated workers' compensation laws or rules; or
- (F) Has failed to attend training required by the director.

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

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

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

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

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

(b) The worker must submit a signed observer form (440-3923A) to the examining provider acknowledging that the worker understands the worker may be asked sensitive questions during the examination in the presence of the observer. If the worker does not sign form 440-3923A, the provider may exclude the observer.

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

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

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

(17) The IME provider must make Form 440-3923, "Important Information about Independent Medical Exams," available to the worker before the exam.

~~(17)~~**(18)** Upon completion of the examination, the examining medical service provider must:

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

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

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

ORDER NO. 11-XXX

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

~~(18)~~**(19)** The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

~~(19)~~**(20)** ~~A complaint about an IME may be sent to the director for investigation. The director will determine the appropriate action to take in a given case, which may include consultation with or referral to the appropriate regulatory board.~~ **The worker may complete an online survey or make a complaint about the IME at www.wcd.oregon.gov. The worker may call the Workers' Compensation Division for assistance if the worker does not have access to the internet.**

~~(20)~~**(21)** Training must be approved by the director before it is given. Any party may submit medical service provider IME training curriculum to the director for approval. The curriculum must include training outline, goals, objectives, specify the method of training and the number of training hours, and must include all topics addressed in Appendix B.

~~(21)~~**(22)** Within 21 days of the IME training, the training supplier must send the director the date of the training and a list of all medical providers who completed the training, including names, license numbers, and addresses.

~~(22)~~**(23)** Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

Stat. Auth: ORS 656.726(4)

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

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

Amended 12-1-2009 as Admin. Order 09-055, eff. 1-1-2010

436-010-0290 Medical Care After Medically Stationary

(1) Palliative care means medical services rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when it is prescribed by the attending physician and is necessary to enable the worker to continue current employment or a vocational training program. 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.

(a) The request must:

(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

(E) Describe how the requested care will enable the worker to continue current

ORDER NO. 11-XXX

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

employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

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

(A) Palliative care may begin following submission of the request to the insurer. If approved, services are payable from the date the approved medical service begins. If the requested care is ultimately disapproved, the insurer is not liable for payment of the medical service.

(B) If the insurer disapproves the requested care, the insurer must explain, in writing:

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

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

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

(c) 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 must include a copy of the original request and may include any other supporting information.

(d) 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 must include:

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

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

(e) 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 will be resolved in accordance with ORS 656.327 and OAR 436-010-0008.

(f) Subsequent requests for palliative care are 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.

(2) Curative medical care is compensable when the care is to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(a) The director must approve curative care arising from a generally recognized, non-experimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must

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

submit a written request for approval to the director. The request must:

- (A) Describe any objective findings.
 - (B) Identify by ICD-9-CM diagnosis, the medical condition for which the care is requested.
 - (C) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition.
 - (D) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition.
 - (E) Describe why the care is otherwise justified by the circumstances of the claim.
- (3) In addition to sections (1) and (2) of this rule, medical services after a worker's condition is medically stationary are compensable when they are:
- (a) Provided to a worker who has been determined permanently and totally disabled.
 - (b) Prescription medications.
 - (c) Services necessary to administer or monitor administration of prescription medications.
 - (d) Prosthetic devices, braces, and supports.
 - (e) Services to monitor the status, replacement or repair of prosthetic devices, braces, and supports.
 - (f) Services provided under an accepted claim for aggravation.
 - (g) Services provided under Board's Own Motion.
 - (h) Services necessary to diagnose the worker's condition.
 - (i) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

Stat. Auth: ORS 656.726

Stats. Implemented: ORS 656.245

Hist: Amended 12/5/05 as Admin. Order 05-071, eff. 1/1/06

Appendix B

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

A. Overview

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

1. Why the IME training is required.

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

2. Workers' Compensation system:

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

Additional items to discuss:

- Exclusive remedy.
 - The Legislature found that common law is expensive without proportionate benefit.
 - No fault versus tort.
 - The economy and the costs of injuries.
- b) Causation of work related injuries.
 - Is the injury work related?
 - What are pre-existing conditions?
 - What is major contributing cause?
 - What is material contributing cause?

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

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

B. Provider Code of Professional Conduct

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

1. the guidelines adopted by the appropriate health professional regulatory board, OR
2. the “Guidelines of Conduct” published in Appendix C, if the appropriate regulatory board hasn't adopted standards for professional conduct regarding IMEs.

C. Report writing

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

D. Communication

What is appropriate communication between claims examiners and medical providers?

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

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

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

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

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

H. Workers' Compensation Division's complaint process:

1. use of injured workers surveys about IMEs
2. complaints received by the Workers' Compensation Division.

I. Impairment findings: the purpose of measuring impairment.

It is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job-at-injury being performed, etc.

J. Other necessary information as determined by the director.

Appendix C
INDEPENDENT MEDICAL EXAMINATION STANDARDS
As developed by the Independent Medical Examination Association

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