



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

Sept. 21, 2011

Proposed Changes to Workers' Compensation Rules

The Workers' Compensation Division proposes changes to the Oregon Administrative Rules (OAR):

- 436-009, Oregon Medical Fee and Payment Rules
- 436-010, Medical Services
- 436-015, Managed Care Organizations
- 436-030, Claim Closure and Reconsideration

The purpose of the proposed changes is primarily to implement legislation passed by the 2011 Oregon Legislature. Please review the attached documents for more information about proposed rule changes and projected fiscal impacts.

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

When is the hearing? Oct. 24, 2011, 10:00 a.m.

Where is the hearing? Labor & Industries Building, Room 260
350 Winter Street NE, Salem, Oregon 97301

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

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

How can I get copies of the proposed rules?

On the Workers' Compensation Division's website –
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		436
Agency and Division		Administrative Rules Chapter Number
Fred Bruyns	350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405	503-947-7717
Rules Coordinator	Address	Telephone

RULE CAPTION

Medical fee schedule; managing care; attending physicians; delay of reconsideration of claim closure pending settlement
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Oct. 24, 2011	10:00 a.m.*	Room 260 Labor & Industries Building 350 Winter Street NE, Salem, Oregon	Fred Bruyns
Hearing Date	Time	Location	Hearings Officer

*NOTE: The hearing will begin at 10:00 a.m. and end when all present who wish to testify have done so. Written testimony will be accepted through **Oct. 27, 2011**.

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

AMEND: OAR 436-009-0080, 436-010-0210, 436-010-0230, 436-010-0280, 436-015-0008, 436-030-0003, 436-030-0036, 436-030-0145, 436-030-0165

Stat. Auth.: ORS 656.726(4), 656.248, 656.260, 656.268

Other Auth.:

Stats. Implemented: ORS chapter 656, primarily 656.005(12) [OL 2011, ch. 117, HB 2743], 656.245, 656.248, 656.260 [OL 2011, ch. 98, HB 2093], 656.268 [OL 2011, ch. 99, HB 2094]

RULE SUMMARY

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

The agency proposes to amend OAR chapter 436, division 009, "Oregon Medical Fee and Payment Rules," limited to rule 0080, affecting payment for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). These proposed rules: Establish maximum payments for DMEPOS Healthcare Common Procedure Coding System (HCPCS) codes published by the Centers for Medicare and Medicaid Services. These codes are commonly used by health care providers and payers. The rule also lists maximum percentages for services and items that have no HCPCS codes, and for equipment that is used or rented.

The agency proposes to amend OAR chapter 436, division 010, "Medical Services." These proposed rules: Implement House Bill 2743 by including podiatric physicians and surgeons among those health care providers who may serve as attending physicians, without limitation, in the workers' compensation system. In addition, the agency proposes to correct the term, "lumbar spondylosis," to "lumbar spondylolysis" (upon advice from the Medical Advisory Committee).

The agency proposes to amend OAR chapter 436, division 015, "Managed Care Organizations." These proposed rules: Implement House Bill 2093 by referring to civil penalties and to cease and desist orders that may be issued under ORS 656.260(20).

The agency proposes to amend OAR chapter 436, division 030, "Claim Closure and Reconsideration." These proposed rules: Implement House Bill 2094 by describing the process for the director to delay the reconsideration proceeding and toll the reconsideration timeline for up to 45 days when both parties request the delay for settlement negotiations. The proposed rules also more fully describe the arbiter selection process, including options for participation by the parties in the selection, and align rule with statute regarding the effective suspension date if a worker fails to attend or cooperate with a medical arbiter examination.

Notice of Proposed Rulemaking Hearing

Page 2

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule 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 website:

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

Oct. 27, 2011

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

/s/ John L. Shilts

John L. Shilts

Sept. 15, 2011

Signature

Printed name

Date

*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-S0, S1, S3, S4, S, U, AT, CE, EG, LU, NM, CI, MR, TT, DC, DO, GR, MD, ND, OT, PY, M1, M2, 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

436

Agency and Division

Administrative Rules Chapter Number

Medical fee schedule; managing care; attending physicians; delay of reconsideration of claim closure pending settlement

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

In the Matter of: Amendment of OAR:

- 436-009, Oregon Medical Fee and Payment Rules
- 436-010, Medical Services
- 436-015, Managed Care Organizations
- 436-030, Claim Closure and Reconsideration

Statutory Authority: ORS 656.726(4), 656.248, 656.260, 656.268

Other Authority:

Stats. Implemented: ORS chapter 656, primarily 656.005(12) [OL 2011, ch. 117, HB 2743], 656.245, 656.248, 656.260 [OL 2011, ch. 98, HB 2093], 656.268 [OL 2011, ch. 99, HB 2094]

Need for the Rule(s): Rule amendments are needed: to implement legislation passed by the 2011 Legislature; to provide a fee schedule with commonly used billing codes for durable medical equipment, prosthetics, orthotics, and supplies; to remove obsolete information; and to align rules with standard practices and Oregon statutes.

Documents Relied Upon, and where they are available: The agency relied on advisory committee meeting records and written advice from stakeholders and customers, as well as Enrolled House Bills 2093, 2094, and 2743. These records are available for public inspection in the Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call 503-947-7717 to request copies.

Fiscal and Economic Impact: The agency projects the following impacts:

Proposed changes to OAR 436-009 will establish a fee schedule for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The agency projects that adoption of the DMEPOS schedule should not have a large impact on any of the affected service providers, and overall payments for these services should remain approximately the same as under the current rule. However, with adoption of a standard code set and a payment rate at 110% of the rate currently paid by the Centers for Medicare and Medicaid Services, payments to individual providers and provider types may increase or decrease slightly as follows:

- "A" codes are mainly supplies that are billed by medical service providers and DME providers. The agency projects a small increase in payments to these providers.
- "E" codes mainly affect DME providers. The agency projects a very small increase in payments to these providers, though the impact is less significant than for the "A" codes.
- "K" codes are temporary codes and difficult to assign to a specific provider group. Providers who bill "K" codes might see a slight decrease in payments. However, these codes represent a very small percentage of payments and the effect on any provider group should be minimal.
- "L" codes are mainly used for prosthetics and orthotics, and these providers might see a very slight decrease in payments.
- "V" codes are mainly vision services and represent a very small portion of the DMEPOS services. Providers billing V codes might experience a very slight decrease in payments.

Services under the proposed rule that are not listed in the DMEPOS schedule will be paid at 80% of the provider's usual fee unless otherwise provided by contract. This could result in up to a 20% reduction in payment for unlisted services, but the impact on providers will depend on the number of unlisted services they provide. (Medical supplies are subject to the 80% ceiling under the current rule.)

Proposed changes to OAR 436-010 will implement House Bill 2743. The agency projects a small positive effect on podiatric physicians and surgeons, because these providers will be authorized to serve as attending physicians without limitation in the workers' compensation system. Increased use of podiatric care will likely be offset by decreased use of other forms of care, and therefore may have a small negative impact on other providers.

Statement of Need and Fiscal Impact

Page 2

Proposed changes to OAR 436-015 will implement House Bill 2093. The agency does not project a significant economic impact due to these rule amendments.

Proposed changes to OAR 436-030 will implement House Bill 2094. The agency does not project a significant economic impact due to delays in reconsideration during settlement negotiations.

Except as described above, the agency projects no significant negative or positive economic impact of the proposed rule changes on any party. However, the agency invites public testimony on potential impacts.

Statement of Cost of Compliance:

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

- The agency projects no significant cost of compliance for state agencies, including SAIF Corporation, or units of local government.
- The agency projects no significant cost of compliance to the public, except as described under “Fiscal and Economic Impact” above.

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

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

- The types of small businesses potentially affected by proposed rule changes are primarily health care providers, specifically providers of durable medical equipment, orthotic and prosthetic services, and medical supplies. The agency does not have an exact count of these providers, though available data suggests fewer than 250 unique business entities are operating in Oregon. The agency also does not have data showing how many workers are employed by each provider, but based on discussions with the advisory committee members, probably a substantial percentage of the providers would be defined as small businesses under OAR 183.310.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

- The agency projects no significant economic impact.

c. Equipment, supplies, labor and increased administration required for compliance:

- The agency projects no significant economic impact.

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

- Several health care providers, representing the interests of providers of durable medical equipment, orthotic and prosthetic services, and medical supplies, participated in a rulemaking advisory committee – see more below.

Administrative Rule Advisory Committee consulted?:

Yes – regarding OAR 436-009-0080, on Aug. 4, 2011. No* – regarding OAR 436-010, 436-015, and 436-030.

If not, why? *Because proposed changes to OAR 436-010, 436-015, and 436-030 are mostly limited to what is required to implement 2011 legislation, the agency was uncertain about the value of an advisory committee meeting or public interest. The agency issued a “request for advice; possible formation of advisory committee” to approximately 2,700 people. One person asked to meet with the agency, and this was done via teleconference.

/s/ John L. Shilts

Signature

John L. Shilts

Printed name

Sept. 15, 2011

Date



Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Proposed

TABLE OF CONTENTS

Rule		Page
436-010-0210	Who May Provide Medical Services and Authorize Timeless Time Loss	1
436-010-0230	Medical Services and Treatment Guidelines	3
436-010-0280	Determination of Impairment.....	7
Appendix A	Matrix for health care provider types.....	9

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**

436-010-0210 Who May Provide Medical Services and Authorize ~~Timeless~~ Time Loss

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

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

(3) Authorized primary care physicians and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO. An MCO may allow greater latitude for the provider types to treat a worker enrolled under ORS 656.260.

(4) Attending physicians and authorized nurse practitioners may prescribe treatment or services to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment or services to be carried out by persons not licensed to provide a medical service or treat independently only when such services or treatment is rendered under the physician's direct control and supervision. Reimbursement to a worker for home health care provided by a worker's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

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

(5) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(4)(a), nor under the direct control and supervision of the attending physician.

(6) ~~Effective October 1, 2004, i~~In order to provide any compensable medical service under ORS chapter 656, a nurse practitioner licensed under ORS 678.375 to 678.390 must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request and must have been assigned an authorized nurse practitioner number by the director. An authorized nurse practitioner may:

(a) Provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim. Thereafter, medical services ~~provided by an authorized nurse practitioner~~ **provides** are not compensable without **the attending physician's** authorization ~~of an attending physician~~; and

(b) Authorize temporary disability benefits for a period of up to 60 days from the date of the first nurse practitioner visit on the initial claim.

(7) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer must give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

(a) If the insurer does not approve the worker's out-of-state physician, notice to the worker must clearly state the reason(s) for the denial, which may include, but are not limited to, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010, and identify at least two other physicians of the same healing art and specialty whom it would approve. The notice must also inform the worker that if the worker disagrees with the denial, the worker may refer the matter to the director for review under the provisions of OAR 436-010-0220.

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the medical service provider in writing of the following:

(A) The Oregon fee schedule requirements;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon injured workers; and

(C) **The insurer may not pay B** billings for compensable services in excess of the maximum allowed under the fee schedule ~~may not be paid by the insurer.~~

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

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

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

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.005(12), 656.245, 656.260

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

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

436-010-0230 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 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~~**must** 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 **authorized** 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~~**chiropractic physician, naturopath naturopathic physician, or** acupuncturist, ~~or podiatrist~~ will be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

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

(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 after every visit if the worker is seen less frequently. The progress report may be included in the provider's chart notes. The progress report must include:

- (A) Subjective status of the worker;
- (B) Objective data from tests and measurements conducted;
- (C) Functional status of the worker;
- (D) Interpretation of above data; and
- (E) Any change in the treatment plan.

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

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker will be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090.

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

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

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 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 **aids the** 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;

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

- (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 ~~spondylolysis~~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

- (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;

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

- (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 3/1/11 as Admin. Order 11-051, eff. 4/1/11

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

436-010-0280 Determination of Impairment

(1) On disabling claims, when the worker becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. For workers under the care of an authorized nurse practitioner or a type B attending physician other than a ~~chiropractor~~ **chiropractic physician**, the provider must refer the worker to a type A attending physician to do a closing exam if there is a likelihood the worker has permanent impairment. The closing exam must be completed under OAR 436-030 and OAR 436-035.

(2) The attending physician or authorized nurse practitioner has 14 days from the medically stationary date to send the closing report to the insurer. Within eight days of the medically stationary date, the attending physician may arrange a closing exam with a consulting physician. This exam does not count as an IME or a change of attending physician.

(3) When an attending physician requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report for the

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

concurrence or objections of the attending physician. The attending physician must also state, in writing, whether they agree or disagree with all or part of the findings of the exam. Within seven days of receiving the report, the attending physician must make any comments in writing and send the report to the insurer. (See "Matrix for Health Care Provider types" Appendix A)

(4) The attending physician must specify the worker's residual functional capacity or refer the worker for completion of a second level physical capacities exam or work capacities exam (as described in OAR 436-009-0070(4)) pursuant to the following:

(a) A physical capacities exam when the worker has not been released to return to regular work, has not returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A work capacities exam when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(5) If the insurer issues a major contributing cause denial on the accepted claim and the worker is not medically stationary, the attending physician must do a closing exam. An authorized nurse practitioner or a type B attending physician other than a ~~chiropractor~~ **chiropractic physician** must refer the worker to a type A attending physician for a closing exam. (See "Matrix for Health Care Provider types" Appendix A)

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

- (a) Objective findings of permanent impairment; and
- (b) A statement of the validity of the impairment findings.

(7) The director may prescribe by bulletin what comprises a complete closing report, including, but not limited to, those specific clinical findings related to the specific body part or system affected. The bulletin may also include the impairment reporting format or form to be used as a supplement to the narrative report.

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

Stats. Implemented: ORS 656.245, 656.252

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

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

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Appendix A - Matrix for health care provider types *

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

* This matrix does not apply to Managed Care Organizations