

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

In the Matter of the Amendment of	)	
436-010, Medical Services	)	
436-055, Claims Examiner Certification	)	SUMMARY OF
436-060, Claims Administration	)	TESTIMONY AND
436-070, Workers' Benefit Fund Assessment	)	AGENCY RESPONSES

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

The proposed amendment to the rules was announced in the Secretary of State's *Oregon Bulletin* dated May 1, 2006. On May 22, 2006, a public rulemaking hearing was held as announced at 10:00 a.m. in Room 260 of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon 97301-3879. Fred Bruyns, from the Workers' Compensation Division, acted as hearing officer. Business Support Services audio-recorded the hearing and created a written transcript. The record was held open for written comment through May 26, 2006.

Eight people testified at the public rulemaking hearing. The transcript of the hearing is marked as Exhibit 11 through 18. In addition, 25 written documents were submitted as testimony.

**Testimony list:**

Exhibit	Rule divisions	Testifying
1	010	John W. Thompson, M.D.
2	010	Joseph A. Graffeo, D.C.
3	010	Robert B. Neighbor
4	010	Lis Houchen, National Association of Chain Drug Stores
5	010	John Di Paola, M.D., Occupational Orthopedics
6	010	John Di Paola, M.D., Occupational Orthopedics
7	010	Marcus a. Cecchini, R.Ph., Director of Pharmacy, Fred Meyer Stores
8	010	Ember Skidmore, Liberty Northwest Insurance "WORKING PAPER   Paying for Repackaged Drugs Under the California Workers' Compensation Official Medical Fee Schedule" by Barbara O. Wynn, April 2005
9	010	Dan Floyd, Oregon Grocery Association
10	010	Lisa M. Trussell, Vice President, Associated Oregon Industries

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11	010	John Di Paola, M.D., Occupational Orthopedics
12	010	Eli Bahou, Director of Managed Care, Rite-Aid Corporation
13	010	Marcus a. Cecchini, R.Ph., Director of Pharmacy, Fred Meyer Stores
14	010	Ember Skidmore, Liberty Northwest Insurance
15	010	Dave Widen, Director of Pharmacy, Safeway Stores
16	010	Mark Davison, Director of Risk Management, Safeway Stores
17	010	George Goodman, AAL, Independent Medical Examination Association
18	010	Tim Craven, M.D., Concentra Medical Center
19	010	Katherine Wallace, Administrator, Impartial Medical Opinions, Inc.
20	010	S. David Glass, M.D.
21	010	Stephen Fuller, M.D.
22	010	Lynne Adams Bell, M.D.
23	010	Frederick T. Waller, M.D.
24	010	Paul L. Tesar, M.D.
25	010	John Di Paola, M.D., Occupational Orthopedics
26	010	J. L. Wilson, Oregon Director, NFIB
27	010	Dale C. Johnson, Blount International, Inc.
28	010, 055	Liberty Northwest Insurance
29	010	Jim Thompson, Executive Director, Oregon State Pharmacy Association
30	010	Linda Barno, Legislative Co-Chair, Oregon Self Insurers Association
31	010	Medical Advisory Committee
32	010	Independent Medical Examination Association
33	010, 060	Chris Davie, Vice President of Corporate Policy and External Affairs, SAIF Corporation

**Testimony: OAR 436-010-0220(2) Exhibit 28**

**This Workers' Compensation Division should obtain advice on this issue from a future rulemaking advisory committee:** This was a new issue raised after the advisory meetings. It should be deferred for a future advisory meeting. The issue deserves discussion and thoughtful consideration and the rules should not be changed until the processes that are in place for rule changes are exercised.

**The proposed change does not address some important questions:** What happens if the attending physician has no knowledge of the treatment plan? What happens if the attending physician disagrees with the treatment plan?

**Response:** The issue did arise just after external advisory committee meetings (EAC) had been held, however, the division did contact, solicit and receive input on the issue from the EAC via email. In addition, the division has received input via the proposed rules process. The proposed rule language was modified to reflect some suggested language in testimony and input received. The revision language reaffirms the attending physician's responsibilities under workers' compensation law. If the attending physician is referring the worker to another provider we assume the attending physician has confidence in the specialist physician's abilities and judgment. If however, there are significant and unanticipated difficulties with the revised wording, the rule may be revisited at the next rule making process.

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**Testimony: OAR 436-010-0220(2) Exhibit 33**

This change may be intended to address attending-physician-to-surgeon referrals and the confusion around who is authorized to do what. However, this modification would make the coordination of care more difficult as well. We recommend the addition of the following sentence: "Nothing in this rule diminishes the attending physician's responsibility to fulfill all the responsibilities of an attending physician, including reporting to the insurer, authorizing time loss, and coordinating care."

**Response:** The rule language is intended to clarify the intent and application of referrals in the workers' compensation setting. Attending physicians refer to specialists when they feel the need for a consultation or to gather other ideas about diagnosis and/or treatment options or to have other treatment provided by the specialist provider. The division has for some time heard complaints from physicians about repetitive and unnecessary paperwork; this rule attempts to address part of those complaints and the excess paperwork burden. Yet, attending physicians do need to fulfill their responsibilities as attending physicians, and this rule is not attempting to diminish that, but rather, to find balance in that role and the referral scenario. Some of the wording offered has been incorporated into the permanent rule. We can continue to review this rule and scenario and address any unforeseen problems in future rulemaking processes.

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**Testimony: OAR 436-010-0230(2)(b) Exhibit 28, 33**

The following testimony requests clearer wording to carry out the intent of the proposed rule change.

With regard to consent forms for employer or insurer representative to attend worker's medical appointments, new proposed language says, "the consent form must be written in a way that allows the worker to understand it." The proposed language is vague. We prefer the language that is in Bulletin 318, which is what prompted this proposed rule change. That language is "employers who wish to send a representative to any medical examination must obtain written consent of the worker, and the consent must include any translation or explanation necessary to overcome language or cultural differences."

We do not know whether the department intends the form to be produced in a language that the worker would understand. We attempt to do this whenever it is feasible, but the rule could be

read to require the form to be translated into any language or dialect, no matter how obscure. We assume this is not the department's intent and the rule should be clarified accordingly.

**Response:** The issue of whether an employer or insurer wants to send a representative to a worker's medical examination is another important and sensitive one. The rule is clear that an employer or insurer cannot send a representative without written consent of the worker. It is vital the worker understand the issue and their rights and responsibilities surrounding this. The worker cannot fully understand or fulfill those responsibilities unless they are able to understand the forms sent to them. While the director understands that this may be more challenging in some instances than others, the need for the worker to know and understand is not diminished by the severity of the difficulty in achieving the goal.

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**Testimony: OAR 436-010-0230(2)(b) Exhibit 33**

We understand that the department used to have a form for this purpose. The department should prescribe a form, thus eliminating any debate about whether an insurer's form meets the standard in the rule.

**Response:** The director has not had a form for this purpose, nor was one associated with former Bulletin 318. Overall, the director is trying to be less prescriptive rather than more, where possible. Many rules reflect that intent by stating what is necessary, but not prescribing how to get there. This approach leaves the stakeholders some freedom to comply with the law in ways that work best for them.

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**Testimony: OAR 436-010-0230(6) Exhibits 5, 6, 11, 18, 25**

**The following testimony is provided in support of eliminating the 10-day limit on physician dispensing of medication from their office:**

**The attending physician should be able to provide a broad spectrum of services:** Studies show that physicians who are most experienced in the care of injured workers, such as occupational medicine physicians, produce the best outcomes; these providers have a positive economic impact on the care of injured workers; they provide a broad spectrum of services in a "one stop shopping" setting, that can include dispensing of medications.

**Response:** Providers that treat injured workers do provide a very valuable service. The revised rule still allows dispensing of generic oral medications, as it did before with a slight change noting the requirement to adhere to the requirements of the provider's licensing board.

**The laws and (other) rules in place support the right of a physician to dispense medication:** ORS 689.515 and 656.245 clearly give the attending physician the authority to dispense generic drugs to injured workers. In OAR 436-010, "medical service provider" is defined as a person duly licensed to practice one or more of the healing arts; these rules also state that a "medical service" would include drugs and medicine. OAR 436-010-0230(6) states, "A pharmacist, dispensing physician, or authorized nurse practitioner shall dispense generic drugs to injured workers in accordance with and pursuant to ORS 689.515." and "Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract." Under the OAR, providers must be paid similarly regardless of profession. Physicians cannot

afford to dispense medications without being reimbursed. The proposed rule change would eliminate the only contradictory statement in all the rules and regulations relating to the provision of medications to injured workers.

**Response:** The rule sets parameters for when an insurer is liable for oral medications dispensed from a provider's office. Providers can still choose to dispense from their offices if they desire. The director acknowledges the situation where providers are allowed by their licensing boards to dispense from their offices, and yet run into compensation issues in the workers' compensation setting. However, many factors surround this issue, including cost control measures, patient safety, and the other issues testified to. It is the responsibility of the director to make rules that are reasonably required in the performance of the director's duties, see ORS 656.726(4). After careful consideration of all testimony, the limitations reflected in the rule are in line with the director's charge and authority to administer the workers' compensation system in Oregon. There are many issues surrounding prescription medications for injured workers, i.e., first-fill issues, adequate access to prescriptions for workers, how to control rising costs, the status of third party administrators in the system, etc.. The department is reviewing many medical issues, some via the Medical Quality Initiative. Pharmacy issues are part of that initiative. As these other issues are reviewed and addressed it may impact this particular issue, and may be revisited in the future.

**The proposed change reflects common practice, though not consistent practice:** The majority of Oregon workers' compensation insurers do reimburse physicians for generic medicines dispensed from a physicians' clinic in accordance with the fee schedule in OAR 436-009. However, the contradictory statement in OAR 436-010(6) is being utilized to deny payment for medical services.

**Response:** The director is charged with establishing a medical fee schedule that will ensure workers have access to quality medical care, while also considering many other factors. The nature and extent of the problem presented, nor what common practice is, is not reflected in any data that the director is aware of. Therefore, before any change is undertaken, further study should be done and data reviewed. After careful consideration of all testimony, the limitations reflected in the rule are in line with the director's charge and authority to administer the workers' compensation system in Oregon. There are many issues surrounding prescription medications for injured workers, i.e., first-fill issues, adequate access to prescriptions for workers, how to control rising costs, the status of third party administrators in the system, etc.. The department is reviewing many medical issues, some via the Medical Quality Initiative. Pharmacy issues are part of that initiative. As these other issues are reviewed and addressed it may impact this particular issue, and may be revisited in the future.

**Treatment and medications are commonly tied to 30-day cycles:** Treatment patterns and dispensing practices of physicians throughout the United States are predominantly geared towards providing supplies of medications in 30-day increments. This is consistent with the monitoring practices to oversee the utilization of pharmaceuticals prescribed by physicians. Most workers' compensation insurance carriers review eligibility for medical benefits every 30 days.

**Response:** After careful consideration of all testimony, the limitations reflected in the rule are in line with the director's charge and authority to administer the workers' compensation system in Oregon. There are many issues surrounding prescription medications for injured workers, i.e, first fill issues, adequate access to prescriptions for workers, how to control rising costs, the status of

third party administrators in the system, etc.. The department is reviewing many medical issues, some via the Medical Quality Initiative. Pharmacy issues are part of that initiative. As these other issues are reviewed and addressed it may impact this particular issue, which may be revisited in the future.

**Workers sometimes do not receive appropriate medication due to primarily financial reasons; workers are harmed; workers' compensation patients are treated differently than non-workers' compensation patients, and litigation is increased; time-loss is prolonged:** This rule creates an adverse financial impact by requiring Oregon injured workers to seek medications at other sources despite the availability of those medications within some providers' offices. Some workers lack the understanding (of pharmacy benefits), transportation, or funds to obtain medications from a pharmacy. This rule penalizes the least sophisticated and "weakest" of those injured workers. For traumatic injuries, delay in obtaining appropriate medications increases the likelihood of chronic changes, resulting in increased utilization of medical services and prolongation of disability. In one case, delay in antibiotic treatment may ultimately result in a total knee replacement. When a physician does not know a worker is going without medication (some workers are embarrassed to say they could not afford the drug), the physician may recommend more aggressive and invasive types of treatment because he or she is under the impression that conservative measures have failed. In addition, disputes about reimbursement for prescribed medications causes litigation and prolongs claim activity, including time-loss and added expense for the time required by the attending physician to mitigate the financial impact on the worker and dispel his or her anger and frustration. In one such case, claim closure was likely delayed by two to three months. Workers may not understand how to document their out-of-pocket purchases, and have been frustrated to learn that a receipt alone may not be sufficient, but the reimbursement request must include a copy of the prescription. In other instances, patients have presented their pharmacy cards for prescriptions written from our office only to be told that certain generic medications are not covered under the pharmacy benefit program. This again results in the need for them to pay for these medications out of pocket which is usually not feasible.

Oregon physicians are allowed to dispense in general medical care; why is workers' compensation different? If there is a restriction, it should be across the board, not just in workers' compensation, because the same arguments can be made about drug interactions.

Occupational physician colleagues report that even when workers are told to go to certain large retail pharmacy to receive medicines, they have been told they must pay cash for their medicines. Either they do not get their medicines or they experience denied or extremely delayed repayment from the carrier.

**Response:** There are many challenging and complex issues surrounding prescription medications and their availability to injured workers' in a timely manner. The director acknowledges that some injured workers may suffer physical setbacks and disability due to delayed treatment, and that certainly needs to be addressed to the greatest extent possible. As noted prior, the director is looking into these issues in multiple ways, including the Medical Quality Initiative, and a few years ago was reviewed by a Pharmacy Fee Task Force made up of stakeholders with subsequent recommendations reflected in the rules. The current 10 day limit was a result of that task force. The director recognizes the difficulty of some workers having the funds to pay for prescriptions

as an issue to be addressed. The director is currently working with stakeholders to try to address first fill issues, access to medications, controlling costs and third party billing issues. The director is hopeful that the stakeholders working on this issue will reach agreement and create methods to increase the number of workers who have access to medications in a timely manner while decreasing the number of workers who walk away from a pharmacy without their medication because they couldn't afford it and the pharmacy would not dispense without payment.

It seems that another component of this issue is the education of the injured worker, the provider and even pharmacies about their rights and responsibilities in the workers' compensation system. It is challenging to ensure that injured workers know and understand their rights due to many impacting factors, including language barriers. The department will also be reviewing the issue of education as part of the Medical Quality Initiative. Components may include how to educate providers about the rules regarding prescription medications, and how they can help inform injured workers about their responsibilities and the rules surrounding this issue. For instance, the division 009 rules do not specifically state that workers must submit a copy of the prescription in order to receive reimbursement, but rather the rules allow insurers to require "reasonable documentation to support the request". If the worker feels the documentation is not "reasonable" the worker may appeal the requirement of the insurer to the director via the Medical Review Unit, 350 Winter ST. NE, Salem, OR 97309; or [mruhelp.wcd@state.or.us](mailto:mruhelp.wcd@state.or.us). The Medical Review Unit will review the medical record and evidence and either facilitate resolution of the dispute through agreement of the parties, or via an order of the director. In addition, part of the resolution of this problem involves communication difficulties which needs to be addressed in a comprehensive approach by the stakeholders as well as the director.

**The proposed change will have a positive impact on the workers' compensation system:**

Removal of this statement from OAR 436-010(6) will reduce the costs to the workers' compensation system, and would likely impact only those few physicians in Oregon who do the highest volume of injured-worker care. Physicians who specialize in non-injured worker care have no incentive to offer generic medicines in their offices. The possibility of large numbers of physicians providing unregulated services would not be a factor. Any negative impact on pharmacy benefit management plans will be more than offset by improved outcomes in medical treatment, time loss, and impairment.

**Response:** More study and data is needed regarding outcomes to offset the potential for increased costs that could flow from the proposed rule language.

**The physician can educate the patient in ways the pharmacist cannot:** This rule change would facilitate educating the patient - through the use of language interpreters as needed - in the use of these medications and insuring their compliance with treatment. A pharmacist is skilled in explaining dosage and side effects but can't explain to the worker the specific reasons why it is important to their recovery to take the medicine.

**Response:** Providers have a responsibility to communicate and educate the injured worker regarding their condition and any treatment, including medications. We assume this obligation is met whether the physician is dispensing the medication or not.

**Testimony in response to testimony opposing the proposed change:**

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(Exhibit 18 ) Our medications come pre-packaged, usually in amounts of 20-30 tablets. Patients do not need to set an appointment to obtain a refill and do not pay an appointment fee just to pick up a refill. Drugs are dispensed by a medical assistant with medical training, who shows me the prescription. I initial it and make sure that the right prescription is being given and that it is the dose that I ordered. We log it so we know who got the medication. Our labels are computer-generated, not hand-written. If a patient has multiple pharmacies, the doctor knows more about the patient's medications than the pharmacist. I believe I will be held responsible if there is a bad drug interaction – the doctor is ultimately responsible. In certain circumstances, such as the prophylactic treatment for HIV-exposure/needle-stick injuries, early administration is critical.

(Exhibit 11) I noted in my clinic that dispensing samples (from pharmaceutical representatives) drives up costs. When my patients found those medicines to be effective, that was the medicine they wanted. This practice drives up the cost of the pharmacy portion of workers' compensation, and that was the big issue in 2003, when I was a member of the fee schedule advisory committee. Physicians should be allowed to dispense generic drugs in the same manner [as the samples]. I have a limited formulary of generic drugs. If a patient needs one of the medicines I stock, I give them the medicine while they're in my clinic. I don't have them jump through another hoop to obtain the medication. If a patient needs a refill, he or she can pick one up at my clinic – no appointment required. I am consulted, and I am in full control of what medicines they get, how much, and how often. If the patient prefers, we will call in the refill to a pharmacy. Regarding the potential financial impact on small pharmacies, I think that pharmacy benefit managers are a much greater threat. If we use the alternative of handing out many samples, this likely denies pharmacies more cash flow than the generics I dispense.

(Exhibit 11) Most injured workers are young, healthy people, so drug interactions are not common, but we are trained and responsible to manage the prescriptions we hand out. We take a detailed history for all new patients, including what medicines they're on and what medical conditions they have.

(Exhibit 25) The Rite-Aid medication data system is so expensive, it is uncertain whether regional pharmacies such as Fred Meyer and Safeway have the same capabilities. Small business pharmacists do not have access to such a system. Occupational specialists see polypharmacy occurring, and whatever systems are in place are not effective in removing polypharmacy abuses.

(Exhibit 25) Regarding the testimony that indicated my description of a patient who required a total knee replacement was due to some pre-existing cause or long-standing medical problem, the facts are that this was a man who had a low-grade post-surgical infection that required a simple oral antibiotic from the pharmacy. He ended up with a devastating infection in his knee, requiring hospitalization for many days and three to four surgical procedures to control the infection. Despite physical therapy, two additional surgeries, and pain management, this man in his late 40s will require a total knee replacement in the near future. The opportunity of his treating physician to hand him a bottle of antibiotics in the clinic would very likely have averted the entire scenario.

(Exhibit 25) There is much concern about the impact of this simple rule change. One fear is that problem prescribers will use the rule to institute bad behavior; these individuals will behave badly regardless of who dispenses the drugs, and these behaviors are not confined to the workers' compensation system. I believe the concern regarding this rule change is highly inflated and I can find no documentation that such a rule will result in the financial or clinical impacts suggested in

the testimony. Most of this appears to be speculation about a worst-case scenario. I am aware of no abuses related to the current rule or harm to Oregon pharmacies; there will be no significant impacts caused by the clarification of the rule as proposed.

**Response:** All of this information is valuable for consideration in formulating a system that addresses timely access to medications, controlling costs, and provider and pharmacy responsibilities in the system. As noted above important components of any system in controlling costs would be not charging for office visits on refills. Safety factors in dispensing the medications would need to be addressed by assuring the provider is responsible and knowledgeable about what, when, and how the worker is getting their prescription filled. In addition, exploring pharmacy responsibilities, data systems and the effects of pharmacy benefit managers on small pharmacies are all worthwhile and significant issues to consider. These factors can be addressed in future discussions about prescription issues.

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**Testimony:** OAR 436-010-0230(6)      *Exhibits 3, 4, 7, 8, 9, 10, 12, 13, 14, 15, 16, 26, 27, 28, 29, 30, 31, 33*

**The following testimony is provided in opposition to eliminating the 10-day limit on physician dispensing of medications:**

**Pharmacists are subject to more controls on dispensing:** Drug costs are a primary driver of medical costs. With pharmacy costs growing at a faster rate than many other health care costs, it would be irresponsible to add to this cost escalation. There are many controls on pharmacies by insurers, such as the use of generic drugs; there would be few or no controls on physicians. This proposal could result in all drugs being dispensed out of a physician's or nurse practitioner's office for the lifetime of the claim, reducing the cost savings provided by pharmacy networks. There is a loss of the group-buying advantage and elimination of competition for the best prices for drugs. There are no limits to the mark-up by the physician. Drugs may be repackaged in amounts that are not covered by published average wholesale prices, resulting in higher fees for physician-dispensed than for pharmacy-dispensed drugs. Repackaging companies create their own average wholesale prices, leaving no cost controls. These companies will target physician dispensing and market this as means of increasing profits. Refer to the "WORKING PAPER | Paying for Repackaged Drugs Under the California Workers' Compensation Official Medical Fee Schedule" by Barbara O. Wynn, April 2005. Pharmacies have to abide by the average wholesale prices published by First Databank. Prescription drugs compose a significant cost to the medical delivery system in both group health insurance and in workers' compensation. At a time when the Workers' Compensation Division is looking at ways to control costs of medical care while maintaining quality, this rule seems to go in the opposite direction. The workers' compensation reforms of the 1990's were meant to eliminate unnecessary costs in the workers' compensation system that drove up costs for employers. The proposed rule would add costs back into the system without benefiting employers or injured workers. The financial impact statement by the Workers' Compensation Division grossly understates the potential costs to employers. It seems to assume that dispensing would be consistent with today's practices. Every time a worker needs a refill, instead of going to the pharmacy to pick it up, he or she will schedule an office visit just to pick up the medication, and insurers will pay for additional appointments. The proposed rule would increase costs relative to PBM costs, e.g., \$17.43 for a specific medication payable to the physician (as recently billed by a physician) versus \$4.95 through our PBM's

network. We calculate that this change would drive up prescription costs by 100 to 700%.

**Response:** After careful consideration of all the testimony, the director has chosen to leave the rule as it was formerly, at this time. There was one minor change to the rule. The director acknowledges the potential for increased costs to the system. Prescription medication costs will be reviewed in the Medical Quality Initiative and be a topic of discussion for stakeholders and the director for the foreseeable future.

**The proposed change will have a negative economic impact on pharmacies, especially small, independent pharmacies:** For one independent pharmacy, workers' compensation and automobile accidents – those two categories of patients constitute over 65 percent of the business. The loss of the workers' compensation prescriptions for the life of the claim would be a tremendous impact to pharmacies such as that.

**Response:** The director is sensitive to the economic needs and health of independent pharmacies. Another consideration for the director is the impact currently and in the future to small independent medical providers. Overall health and balance to the system is needed and will largely depend on the ideas and collaboration of the stakeholders as we partner in creatively and thoughtfully addressing this challenging issue.

**Physicians have a conflict of interest when dispensing medications:** This change would create a conflict of interest in favor of physicians; granting unlimited physician dispensing of drugs is both expensive and unnecessary. The physicians that want to do this are going to benefit financially from it.

**Response:** This issue must be considered carefully along with the other issues raised through testimony. The director will make every effort to do so through future rulemaking processes and the Medical Quality Initiative. Safeguards for inappropriate usage in this type of scenario should and will be explored in ongoing discussions. While conflicts of interest are best regulated by the appropriate licensing boards, the department does not want to create an incentive to violate a professional responsibility.

**Pharmacists check for harmful drug interactions using data systems and methods unavailable to physicians:** The proposed changes can potentially cause harm to the very patients the rules are supposed to help. Physicians do make errors in prescribing and these errors are caught by pharmacies on a regular basis. Pharmacists check a patient's prescription for potential drug interactions and duplicate prescriptions at the time the prescription is dispensed by the pharmacist, through a drug utilization review check. The pharmacist is more likely to have an accurate record of a patient's medications. Federal law - OBRA-90 - mandates that every patient on every new prescription gets face-to-face counseling from a pharmacist. Workers' compensation patients should have access to medication therapy management, i.e. pharmacy patient care and counseling, increasingly important as drug therapies become more potent and complex. The pharmacist is the expert on medication counseling, including drug-drug, drug-disease state, and drug-food interactions and other side effects. Removing the expert from the process could very well result in increased claims costs.

**Response:** The director acknowledges the valuable service that pharmacies that check for drug interactions provide. Any future consideration of physician dispensing would have to take into account federal law applicable to provider dispensing.

**The existing 10-day and emergency dispensing provisions are adequate to meet short-term patient needs, and these provisions were recommended by the Pharmacy Fee Taskforce:**

There is insufficient data to show that this is a problem, or the extent and nature of the problem. The 10-day supply of medication is sufficient to meet short term needs of the patient and allows time for a claim to be established by the insurance company. The current rules also allow the physician to dispense in emergency situations. Several years ago, the Pharmacy Fee Taskforce recommended the current dispensing standards. The Injured Worker Ombudsman's Office recently noted that they received very few calls from workers complaining about access to medications, even on their first fill. We could identify no need for the expansion of practitioner dispensing from the Ombudsman's Office, our worker contacts, worker surveys or our MCOs.

**Response:** As noted above, after careful consideration, the director has decided to leave the rule essentially as it was. Other data may be available for future consideration and should be explored thoroughly.

**Physicians may dispense the medications in stock rather than the most effective drugs:**

Because the physician can only carry a limited number of medications, they may not use the most effective product for the worker, but what they have on hand. A pharmacy carries over 1,000 medications, a physician's armamentarium may have only 50 medications.

**Response:** As noted above, the rule has essentially not changed. During testimony and some advisory meetings it appeared that the main concern by providers was to be able to provide medications that would be effective; particularly when a worker may not be able to buy the medication if the pharmacy would not dispense prior to claim acceptance.

**Quality control and standards for storage and dispensing may be inadequate:** There are no regulations for Oregon physicians related to storage - temperature, humidity - and dispensing as there are for pharmacies and pharmacists. Medical staff other than the treating physician may actually fill the prescription, perhaps an RN or an office assistant; there currently is no regulation to require initialing by the person who does fill the prescription in the doctor's office. Physicians do not consistently label medications properly. After the office visit, physicians may not be as available to answer questions about medications as a pharmacist would be, and may even be away from the office for an extended period. Pharmacies have longer business hours for refills.

**Response:** It is the director's understanding that there are Oregon laws that provide parameters for providers regarding dispensing and storing medications which would not be replaced or superceded by Workers' Compensation rules.

**Injured workers are not forced to pay for medications out-of-pocket:** The proposed rule will not reduce out-of-pocket expenses for workers. Our pharmacies supply up to a 30 days supply of

medication on the first fill. The patient need only provide some basic information, such as their employer's name and the date of the injury. If a worker is asked to pay out-of-pocket and has a credit card, that worker has the time until the credit card bill is due to catch up and be reimbursed by the employer, the self-insured employer, or the insurer.

**Response:** It seems that some people believe that injured workers are not having to pay for medications and some people believe that they are. There is enough information to cause the director concern. In order to attain data, the director will consider a large survey of injured workers and research other data which would be helpful in any future discussions.

**Physician dispensing limits patient choice:** Oregon's regulations allow workers to choose brand name or generic drugs, and to choose a pharmacy. When doctors dispense, this limits patient choice.

**Response:** Worker choice is an important aspect the director considers when making policy decisions within the workers' compensation system regarding medical treatment and services. Future discussions and decisions relating to this issue will include careful consideration of worker choice.

**Physician dispensing slows data flow to the carrier and may increase litigation:** There is no notification of the prescription until much after the fact. The carrier cannot check to see if the drugs require authorization based on injury compensability or potential toxicity. We expect that this change would result in more disputes needing resolution by the Workers' Compensation Division. Specific pharmacy data fields, for example days' supply and National Drug Codes are not a part of the CMS 1500 forms used in medical practices, making case management more difficulty.

**Response:** Since the director did not substantively change the permanent rule, the details of how to charge for drugs do not need to be addressed here. However, if in the future this issue is reviewed again, this is a point that should be addressed.

**The Management-Labor Advisory Committee (MLAC) should be consulted:** Significant proposals such as this should be brought before MLAC, especially when the proposals originate with a specific workers' compensation interest group not affiliated with management or labor. We request that the department recognize the significant opposition from Oregon's business community and refer the issue back to the proponents so they can work this issue through proper channels, which is the MLAC process and the Legislature.

**Response:** The director acknowledges the request for the Management-Labor Advisory Committee to be involved in future decisions regarding medical providers dispensing medications from their offices. As part of the rulemaking process, all parties and stakeholders are able to participate. The director strives to involve MLAC as best as can be determined at any given time and for any given issue. While the department did not formally address the issue before MLAC, committee members were asked to participate in the rulemaking process.

**Testimony in response to testimony supporting the proposed change:**

(Exhibit 12) Regarding the assertion that use of multiple pharmacies creates drug interaction

risks, when a pharmacist fills a prescription for any drug that was billed to an insurance carrier, whether that patient went to Albertson's, Walgreen's, Rite-Aid, Safeway, Fred Meyer – it doesn't matter – over 55,000 pharmacies nationwide. The computer system can identify that using something we call NCPDP 5.1, and therefore checks for drug-to-drug interactions.

(Exhibit 12) One other comment on patients not being able to get their prescriptions filled. I read something that says that some pharmacies won't dispense a medication if it's not a compensable claim or within the first ten days until a claim is established. At Rite-Aid we don't have that policy. We use a rebiller called Third Party Solutions that actually guarantees us payment. We go ahead and dispense that prescription – all we need is the patient's name, social security number, date of birth, and date of injury.

(Exhibit 16) Regarding the example of knee deterioration related to a lack of early anti-biotic treatment, I don't think that is an initial ten-day situation. That is likely an old claim, and someone is trying to attach the knee replacement to an old claim that may not be part of the original claim. There may be a dispute about whether the medication being dispensed is related to the original injury. I think these things are going to happen on every claim, whether the physicians provide the medications to the injured worker or not. If it becomes a denied part of the claim or an initial denial, physicians are going to be held responsible for the cost of the medication.

(Exhibit 28) Supporters of this change recognize a valid concern about abuse and over-prescribing, and concede that physicians should be limited to dispensing C-3 medications and should never be allowed to dispense C-2 medications. However, the proposed rules do not consider any such limitation. It would be irresponsible to adopt the proposed rule change without further thought and consideration of such restrictions.

**Response:** After careful consideration of all testimony, the director decided to leave the rule essentially as it was in the permanent rules. Any future rulemaking regarding this issue could explore cost containment issues as well as appropriate safeguards regarding what types of medications can be dispensed, and other appropriate limitations as determined at that time.

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**Testimony:** OAR 436-010-0230(6) *Exhibits 6, 11*

**Medical providers should be paid according to OAR 436-009-0090 or the MCO-contracted amount, and not be required to be price competitive with pharmacy benefits managers (PBMs):** The pricing structure under which a small business (like a medical clinic) functions is vastly different from the high-volume discounting of PBMs, and would preclude the ability of the provider to support generic dispensing. If the provider has a contracted discount for medical services in place with an MCO, the same discount should apply to the provision of generic drugs to MCO-enrolled workers.

**Response:** Varying cost control measures can be considered in the future if the rule is changed to allow physicians to dispense more medications from their offices. Stakeholder discussions should address the differences between the office, PBMs, and pharmacies and what is a reasonable expectation for pricing.

**Testimony:** OAR 436-010-0230(6) *Exhibits 6, 11*

Limit dispensing of narcotics to specific categories: There is a valid concern for abuse of this rule by its over zealous application by providers whose practice patterns might lead to over prescribing. The application of this rule should be limited to Category 3 narcotics (Hydrocodone/APAP, Codeine/APAP) and below, muscle relaxants, anti-inflammatories, antibiotics, and non-narcotic analgesics. Dispensing of Category 2 narcotics, such as Oxycodone, Oxycontin, Meperidine, and MS Contin should be prohibited. These medications require certain controls, and they are already the biggest cost drivers in the workers' compensation pharmacy. Providers who abuse the system do not confine their practices to workers' compensation patients. The rule change will not create new problem physicians. Current dispensing by pharmacies has not discouraged problem physicians from over-prescribing. MCOs control the behavior of outlaw physicians.

**Response:** Certain cost control measures, such as suggested above, were reviewed. However, at this time, the decision was made to retain the current rule with only a minor change.

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**Testimony:** OAR 436-010-0230(6) *Exhibits 18*

The 10-day rule is confusing. Does it apply to the initial office visit only, or does it also apply to subsequent visits?

**Response:** The rule does apply only to initial visits. The rule will be reviewed to determine if it can be made clearer.

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**Testimony:** OAR 436-010-0230(6) *Exhibit 33*

The department should revisit the current rule that permits a 10 day initial supply of medications. The earlier rule allowed for emergency prescribing when necessary. The current rule allows dispensing for a longer period of time at a rate that serves to increase pharmacy claim costs.

**Response:** The current 10 day allowance arose from the Pharmacy Fee Task Force group that met several years ago. The task force discussed this issue and determined 10 days was reasonable. Of note, the Medical Quality Initiative includes reviewing pharmacy-cost issues.

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**Testimony:** OAR 436-010-0265(2)(d) *Exhibit 17, 28, 32*

The following testimony is provided in opposition to the proposed requirement that an independent medical examination (IME) report may not be used for any action in the claim, if it is challenged, and if the IME exceeded the number of exams allowed by law or was performed by a physician who was not on the director's list of approved IME providers at the time of the exam.

**Other remedies are available to effect compliance:** The three-examination limitation and requirement to use an approved Independent Medical Examination (IME) physician are already clearly specified in law. If claims handlers are scheduling IME's with providers who are not on the IME list or if they are exceeding their limitation of three exams without getting the director's approval, these actions will be identified during compliance audits, and the claims processors are subject to penalties. There is no evidence of abuse that would justify this onerous and unauthorized expansion of the rule.

**Compliance errors may not be identified until long after the fact; enforcement is not possible:** Adjustors sometimes do not know when they have scheduled an examination in excess of three, and the “challenge” will not occur until the case is before an administrative law judge, potentially years after the fact. Many claims processing decisions and treating doctor decisions would already have been made based on what’s in the IME report. The claims processor cannot undo all of these actions. There appears to be no time limit for the worker to raise the issue of an invalid IME, providing opportunity to go back many years to search through the prior claim record for any prior actions that could be used to invalidate a subsequent IME report.

**Insurers may act in good faith but miscount IMEs:** What constitutes an IME is not totally clear. An insurer may schedule an IME believing it to be the third IME in the claim. This examination may produce uncontroverted medical information that changes the direction of the claim. At a later date, a worker’s representative may assert that an examination that took place months or years earlier in the claim was, in fact, an IME. If the worker prevails in that contention, the current examination would be wiped out, despite the validity of its findings.

**The Workers’ Compensation Division does not have jurisdiction:** The Workers’ Compensation Board has jurisdiction over exclusion of evidence rules. Any rule on this should come from the Board. The division should consult with the Department of Justice about its ability to implement language of this nature.

**Additional concerns:** The rule states “any” IME could not be used, and if the intent is to invalidate only IMEs beyond the permitted three, the rule should say this. If a challenge is successful, what exactly would the insurer be required to do - how does the insurer undo whatever claims processing activity that has occurred? There is no definition of “claims processing purposes” - what exactly does that mean?

**Response:** The director will use compliance audits to determine if insurers are exceeding their limitation of three exams without getting the director’s approval. That language will be deleted from the proposed rule. The language about using a provider who is not on the list will be modified and retained.

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**Testimony:** OAR 436-010-0265(2)(d) *Exhibit 28*

The proposed rules provide that there will be acceptable, extraordinary cases where an IME can be performed by a non-approved physician, when there are location issues or specialist issues. This exception needs to be referenced here.

**Response:** The proposed rules do not allow a non-authorized provider when there are location issues. OAR 436-010-0265(13) will be modified to be clear that under extraordinary circumstances a non-authorized provider will be authorized and placed on the list for the time required to conduct that specific exam, but that does not need to be repeated in this rule.

**Testimony:** OAR 436-010-0265(2)(d) *Exhibit 17*

The rules are not clear whether listing is a requirement when the appointment is scheduled or at the time of the examination and report. What happens if the insurer schedules an IME two months in advance, and unbeknownst to the insurer the doctor is removed from the IME list?

**Response:** The language in SB 311 is, "...the examination must be conducted by a physician selected from a list..." The director cannot by rule change statutory language. If the director removes a provider from the list, we will inform the industry and advise the provider to notify any insurers who may have future appointments scheduled to allow the insurer to reschedule with an authorized provider.

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**Testimony:** OAR 436-010-0265(2)(d) *Exhibit 33*

The appointment notice sent to the worker could include a statement to the effect that if the worker believes the IME exceeds the authorized number, the worker must appeal to the department before the examination. The notice would also encourage the worker to call the Ombudsman's Office for advice. At the most, the worker should have 60 days to raise the issue.

**Response:** The department will include this concept in a future division 060 rule revision process.

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**Testimony:** OAR 436-010-0265(11) *Exhibit 28*

The proposed rules require that the insurer provide the IME provider with the Worker IME Survey Form, along with instructions to give the form to the worker at the time of the IME. Instead, the IME provider should be required to maintain a supply of the survey forms to give to workers. It is inefficient and burdensome to require the insurer to send these forms. Another proposed rule requires that the insurer is send the form to the worker with the appointment notice. These two methods – stocking/distribution by the IME providers and inclusion with appointment notices by insurers – were supported (by consensus) by the rulemaking advisory committee.

**Response:** As a result of this testimony, the external advisory meeting notes were reviewed. Distribution of the survey by the IME provider was reflected, but how the provider obtains the survey was not reflected in the notes. We modified the rule to require the insurer to "ensure" the provider has the survey available. That can be done by phone when the appointment is scheduled. The director is more concerned that the IME provider have the survey to give to the worker than how the provider obtains the survey.

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**Testimony:** OAR 436-010-0265(11) *Exhibit 28*

The proposed language create an unintended problem. While the insurer was already providing the invasive procedure form to the IME provider, the provider was only required to give it to the worker if an invasive procedure was going to be performed. The wording of the proposed rule seems to require the form be provided to the injured worker regardless if an invasive procedure will be performed. This is both unnecessary and potentially confusing to the injured worker.

**Response:** This testimony caused us to realize the proposed rule would create an unintended consequence even though OAR 436-010-0265 (12) clearly indicates the provider is only required to give the form to the worker if an invasive procedure is going to be performed. The rule will be

modified.

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**Testimony:** OAR 436-010-0265(13)(a)(B) *Exhibit 17, 30, 32*

The Legislature and the Management Labor Advisory Committee (MLAC) would not support such a broad grant of authority. If additional training is needed due to future legislative changes, the division should convene stakeholder meetings and obtain input through rulemaking, as has been done to prepare the current rules. The sentence granting this authority should be deleted.

**Response:** The intent of this proposed rule was only to require additional training if there were changes in the law which impact the IME process. However, the requirement will be deleted.

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**Testimony:** OAR 436-010-0265(13)(a)(B)(i) and (ii)- *Exhibit 17*

We recommend simplification of rule numbering.

**Response:** The Secretary of State controls how rules are numbered. However, a reorganization of rule language can lead to a simplification of numbering. The director will review this at a future rule revision to see if the rule numbering can be simplified.

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**Testimony:** OAR 436-010-0265(13)(a)(B)(i) and (ii)- *Exhibit 11, 17, 30, 32*

This testimony supports the concept of providing a means to use highly specialized physicians who are not on the IME provider list, but finds a conflict with statutory wording.

Physicians who frequently provide IME services or exclusively provide IME services should obtain additional training. The rules do need to allow for the occasions when additional expertise is needed from a physician who rarely performs IME's. Highly specialized physicians who rarely perform IMEs or out-of-state IME providers should be able to receive certification and placed temporarily on the director's approved IME list.

The director cannot "exempt" or "except" physicians from the statutory training requirement, and instead should provide for "temporary" listing of certain out-of-state and specialized physicians based on a reduced training requirement. This requirement should only be that the physician sign a statement attesting to the fact that that he or she has read or studied the ABIME code of conduct and will abide by the code. The department should adopt language that allows claims examiners to petition the director for "reduced training and temporary certification." The Director should be required to accept or deny such petitions within seven [calendar] days or within five working days.

**Response:** The rule will be modified to allow providers to be authorized and temporarily placed on the list for special or extenuating circumstances. Since the director will handle such petitions as expeditiously as possible, there is no need for a time frame to be added to the rule.

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**Testimony:** OAR 436-010-0265(13)(a)(B)(i) and (ii)- *Exhibit 32*

If the insurer and worker agree on who should conduct the IME, there will obviously be no objections down the road, meaning it is a waste of resources to have to seek agency approval in that setting.

**Response:** The director has been charged by the legislature with this responsibility. Otherwise,

the insurer and worker could potentially agree on a provider to conduct the IME that is not on the director's list and bypass the intent of SB 311. Requiring the parties to seek the director's approval allows tracking of the number of times a specific provider has been authorized and temporarily placed on the list. If one provider performs several exams in this manner, he or she would then be required to complete the required training before conducting more IMEs.

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**Testimony: OAR 436-010-0265(13)(a)(B)(i) and (ii)- Exhibit 30, 32**

The easier it is to distribute training to the medical practitioners, the better it will be for the Employers and the Injured Workers of Oregon. This will also be helpful in allowing a larger group of medical practitioners to participate, particularly in the less populated areas of Oregon. New practitioners would have to have immediate access to training. Therefore, we suggest language in the draft rule that refers to "attend" training be changed to "participate" in or "complete" training. We also feel that a signed statement certifying that the provider has listened to audio training, viewed the video would be sufficient to comply with Senate Bill 311. Video and audio training are common practice in many professional disciplines (e.g. Oregon State Bar, Oregon Medical Association).

**Response:** The director had anticipated eventually providing training using video, DVD, or on-line access to training. The rule will be modified to accommodate this. However, after surveying several stakeholders on this subject we determined that a signed statement alone will not be enough to verify the medical provider completed the training. We are developing interactive testing on the agency's website which will verify the provider completed the training.

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**Testimony: OAR 436-010-0265(13)(new subsection) Exhibit 32**

Prior to issuing a sanction, the director should convene a group of stakeholders to assist the director in determining if a sanction is necessary and to discuss the nature and extent of sanction that should be applied. A stakeholder group that has expertise with the IME industry would provide the director with valuable input.

**Response:** The director has other sanction responsibilities for which no groups are convened. There could be a potential problem with confidentiality if the director used a group of stakeholders in the manner suggested. In the interest of an efficient process and to reach substantial justice, this idea will not be added to the rules.

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**Testimony: OAR 436-010-0265(13)(new subsection) Exhibit 32**

In addition to appeal rights for providers who are excluded from the director's list, provide appeal rights for providers who have been sanctioned.

**Response:** If a provider is excluded from the list, she or he has appeal rights under ORS 656.328 and OAR 436-010-0265(13)(d). If a provider is sanctioned she or he will be given appeal rights; it is unnecessary to put this into the rules

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**Testimony: OAR 436-010-0265(16) Exhibit 1, 19, 20, 21, 22, 23, 24**

The following testimony supports rescinding or modifying the requirement of submitting a report of an IME to the Insurer within seven days:

**Seven-day turnaround is not needed or requested in most cases:** In only a small percentage of cases is it urgent to get a report to the insurer within seven days. Carriers usually do not request that reports be delivered within seven days.

**Quality will be reduced to achieve rapid turnaround:** Hastily prepared reports are prone to superficiality and snap judgments, and are thus of little benefit to the system they are meant to facilitate. Many of these evaluations are complicated; what looks like a quick and easy case turns out to be quite complex when investigated. The seven-day restriction will inhibit the physician's capacity to perform a thoughtful, comprehensive, and fair evaluation of all material that pertains to the injured worker's case.

**Review of medical records and generating comprehensive reports is time-consuming:** The medical record may be very large – dating back three to ten years or more – and require substantial time for review. Dictation, transcription, and proofing of some reports require more than seven days. Large reports may involve 10-15 hours of dictation, and some reports require multiple specialty evaluations. When more than one doctor dictates a report, extra time is required to coordinate compilation of a the full report. The best transcriptionist can produce just five pages per hour. A thirty-page report takes eight to ten dedicated staff hours to proof, correct, and finalize.

**A comprehensive medical record may not be available within seven days:** The IME provider may order imaging studies or NCV testing, and the results may not be available for several days. Depending on the doctor's schedule, he or she may not be able to review the results immediately upon receipt. In addition, prior medical records are often not provided by the day of the examination, and the insurer may request that the report not be dictated until the records are available.

**The deadline is often unachievable and will drive doctors away from the workers' compensation system:** The seven-day rule is set up to fail. Physicians have multiple obligations – office hours, surgeries, emergencies, etc. – and at times will find it impossible to meet the seven-day requirement. The examining physician must have whatever time is necessary to create a comprehensive report. Constant, unachievable deadlines, and the potential for sanctions, will lead to increased doctor burn-out. We will lose good doctors who will choose quality of life over Oregon workers' compensation timeline pressures.

If I do not believe that I can consistently be fair and impartial and produce a report within a short timeframe, I will withdraw from performing IMEs.

**Market forces are sufficient to encourage timeliness:** IME physicians who cannot complete reports in a reasonable period of time will probably not be asked by the carriers to continue to do exams for them.

**Response:** After reviewing this issue, the director has determined that when the report needs to be returned to the insurer is primarily an issue between the provider and the insurer. The director is not persuaded that there is a need to regulate this. The rule will be deleted.

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**Testimony:** OAR 436-010-0265(16) *Exhibit 2, 28*

The following testimony is provided in opposition to rescinding the requirement of submitting a

report of an IME to the Insurer within seven days:

**The current seven-day requirement is effective in promoting timely delivery of IME reports:** IME providers know the workers' compensation rule and generally comply with it. In comparison, Personal Injury Protection has no such reporting time frame, so reports typically take two to four weeks or more, sometimes resulting in hardship for beneficiaries while the claim is delayed. Market forces are not favoring speedy IME reporting among PIP carriers and will not favor quick IME reporting in workers' compensation claims. The proposed change seems inconsistent with increased accountability of IME service providers. The current law does and will enforce speedy reporting.

**The issue was not discussed by the rulemaking advisory committee:** This issue was not on the "issues document" given to the rulemaking advisory committee.

**Response:** The director received a lot of input from providers on this issue, just after the external advisory meetings. The director may take input from the public in a variety of ways, including external advisory groups and direct contact. While the director makes every effort to gather and compile all issues prior to external advisory meetings, it is not always possible. While the seven-day requirement may be helpful, the insurer and the provider are making an agreement for services. The director is not persuaded that there is a need to regulate this. The rule will be deleted.

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**Testimony:** OAR 436-010-0265(16) *Exhibit 30, 32*

Date stamp surveys upon receipt. This will help determine if the survey was completed prior to or after the IME results. This data collection will help us understand whether the data reflects on the IME process or the effect of the IME results on the claim.

**Response:** This a process the director will do, but does not need to added to the rule.

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**Testimony:** OAR 436-055-0070(6)(b) & 055-0085(3) *Exhibit 28*

The following testimony requests correction of contradictory statements.

The statements in these two rules are contradictory. The first statement is:

"For renewals on or after 1/1/07, three hours of training related to interactions with IME providers that covers all the components in OAR 436-055-0085(2). The next one states: To be approved, a training curriculum for renewal of certification must incorporate some or all of the components in (2).

To achieve the intent of the rule change, I would suggest adding at the end of OAR 436-055-0070(6)(b): "The three hour training does not need to be done all at once, but may be done in increments."

**Response:** The intent of what appears to be contradictory language is to provide the director latitude to approve claims examiner training curriculum of less than three hours that covers portions of the full three hour requirements. The suggested language provides clarification; the rule will be modified to clarify that the three hours of training may be completed in increments.

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**Testimony:** OAR 436-060-0095(5) *Exhibit 33*

**Oregon Administrative Rules, Chapter 436**  
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This testimony requests an additional content requirement for IME appointment letters.

The Notice of Appointment letters should inform workers who are attending psychological IMEs that the physician has the right to refuse having an observer present during the exam. This would be consistent with OAR 436-010-0265(15)(a).

**Response:** We agree and have amended the rule to address the concerns of the testimony.

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

Dated this 14<sup>th</sup> day of August, 2006.

WORKERS' COMPENSATION DIVISION

*Fred Bruyns*

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Fred Bruyns, Hearings Officer