

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

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[Bracketed 8 point text is deleted] ; **bold/underlined text is added**

EFFECTIVE APRIL 21, 2000

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010

NOTE: Only adopted, amended, and repealed rules are included in this document:

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436-010-0008 Administrative Review and Contested Cases

(1) Administrative Review Before the Director:

(a) **Except as otherwise provided in ORS 656.704(3)(b)**, [T]the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.260 and 656.327[, such as medical treatment issues; related services; palliative care; medical rule violations; advances in curative care; curative care to stabilize a temporary and acute waxing and waning of a worker's condition; experimental, outmoded, unproven, or unscientific treatment; requests for change of attending physician; and requests for insurer medical examinations in excess of those allowed by statute.

(b) All disputes regarding medical services, whether past, present, or future, that are disapproved for reasons other than a formal denial of the underlying claim will be processed in accordance with subsections (5) through (12) of this rule].

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

[(d)] (c) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, a director's order shall be issued.

(2) Administrative review and contested case processes for change of attending physician issues are in OAR 436-010-0220; additional insurer medical examination (IMEs) matters are in OAR 436-010-0265; and, fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

(3) When there is a formal [decision that denies] **denial of** the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. [Pursuant to ORS 656.262(7)(a) the receipt of a medical bill or request for medical

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services is not a formal claim for aggravation or a request to have a new condition accepted. The director shall not consider a disapproval letter in response to a claim for medical services a denial of the compensability of the underlying claim unless the letter is consistent with the provisions of ORS 656.262 and clearly articulates the basis for the denial.] After the compensability of the underlying claim [or condition] is **finally** decided [before another adjudicatory body], any party may request director's review of appropriate medical issues within 30 days after the date the [compensability of the underlying claim or condition has been adjudicated and that] decision becomes final by operation of law.

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

[(4)] **(5)** All issues pertaining to disagreement about medical services within a Managed Care Organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the injured worker, are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter by the director.

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

(a) For all MCO enrolled claims, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision under the MCO's internal dispute resolution process. If a party has been denied access to an MCO internal dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. **Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438, Division 005.**

(c) Disputes regarding elective surgery shall be processed in accordance with OAR 436-010-0250.

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

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

[(6)] **(7)** Parties shall submit requests for administrative review to the director in the form and format prescribed by the director. The requesting party shall simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker's name, date of injury, insurer, and claim number;

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- (b) Specify what issues are in dispute and specify with particularity the relief sought.
- (c) Provide the specific dates of the unpaid disputed treatment .

[7] **(8)** In addition to medical evidence relating to the medical services dispute, all parties may submit other relevant information, including but not limited to, written factual information, sworn affidavits, and legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain addition evidence consistent with statute.

[8] **(9)** When a request for administrative review is filed pursuant to ORS 656.260 or 656.327, the insurer shall provide a record packet, without cost, to the director and all other parties or their representatives as follows:

(a) The packet shall include certification that there is no issue of compensability of the underlying claim or condition; and, if there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet shall include a complete, indexed copy of the worker's medical record **and other documents** that [is] **are** arguably related to the medical service in dispute [and other information described in section (8) of this rule], arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages and date of the document. The packet shall include the following notice in bold face type:

As required by OAR 436-010-0008⁽⁸⁾, we hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order which could affect reimbursement for the disputed medical service(s).

(c) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer shall provide the record within 14 days of the director's request in the form and format described in this rule.

(e) If the insurer fails to submit the record in the time and format specified in this rule, the director may penalize or sanction the insurer under OAR 436-010-0340.

[9] **(10)** If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an

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invasive test without sanction.

(a) A single physician selected to conduct a review shall be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

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

(c) When such an examination of the worker is required, the director shall notify the appropriate parties of the date, time, and location of the examination. The physician or panel shall not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted [in accordance with sections (6) to (8) of this rule] **to the director** for screening [by the director] as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination may include, but is not limited to:

- (A) a review of all medical records and diagnostic tests submitted,
- (B) an examination of the worker, and
- (C) any necessary and reasonable medical tests.

[⁽¹⁰⁾] **(11)** The director shall review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

(a) If the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order pursuant to ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical services dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

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

(A) The parties will have 30 days from the issuance of the order to request a contested case hearing before the director.

(B) The director may on the director's own motion reconsider any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case order is issued.

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

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submitted by others.

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

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

[(12)] **(13)** Contested Cases Before the Director: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

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

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

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

(d) In the review of orders issued pursuant to ORS 656.327(2) and ORS 656.260(14) and (16), no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, administrative orders may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(e) For claims not enrolled in an MCO, disputes about whether a medical service after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c) and whether a medical treatment is unscientific, unproven, outmoded or experimental under ORS 656.245(3), are subject to administrative review by the director. If appealed, review at contested case hearing is not subject to the "no new medical evidence or issues rule" in subsection [(12)] **(13)**(d) of this rule. However, if the disputed medical service is determined compensable under ORS 656.245(1)(c) or 656.245(3) all disputes and assertions about whether the compensable medical services are excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services are subject to the substantial evidence rule at contested case hearing.

[(13)] **(14)** Contested Case Hearings of Sanction and Civil Penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be filed with the division within [20] **60** days after service of the order or notice of assessment.

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

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

[(14)] **(15)** Director's Administrative Review of Other Actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through [(13)] **(14)** of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within ninety (90) days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section [(12)] **(13)** of this rule.

Stat. Auth.: ORS 656.726(3)

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

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Amended 10/25/99 as Admin. Order 99-061, eff. 10/25/99 (Temp)
Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00

436-010-0200 Advisory Committee on Medical Care

The Advisory Committee on Medical Care shall be appointed by the director [pursuant to ORS 656.794]. **The Committee shall include one representative of insurers, one representative of employers, one representative of workers, one representative of managed care organizations, a diverse group of health care providers representative of those providing medical care to injured workers, and other persons as the director may determine are necessary to carry out the purpose of the committee. Health care providers shall comprise a majority of the Committee at all times. The selection of health care providers shall consider the perspective of specialty care, primary care, and ancillary care providers, and the ability of members to represent the interests of the community at large.**

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 656.794

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
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436-010-0210 Who May Provide Medical Services and Authorize Timeloss

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

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

(3) Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service or by persons not licensed to provide a medical service. Those persons not licensed to treat independently or not licensed to provide a medical service, may only provide treatment prescribed by the attending physician which is rendered under the physician's direct control and supervision.

(4) Nurse practitioners and physician[s] assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits during that 30 day period on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those nurse practitioners and physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are contained in ORS 442.470.

(5) Nurse practitioners and physician[s] 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(3)(a), nor under the direct control and supervision of the attending physician.

(6) A physician assistant, [registered] **licensed** under ORS 677.515, may provide services when the physician assistant is approved for practice by the Board of Medical Examiners.

(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 shall give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

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

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

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following:

(A) The Oregon fee schedule requirements;

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

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

(8) After giving prior approval, if the out-of-state physician does not comply with OAR 436-010, the insurer may object to the worker's choice of physician and shall notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by that physician after notification shall not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

(9) 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(3)

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

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Amended 4/4/00 as Admin. Order 00-052, eff 4/21/00

436-010-0270 Insurer's Rights and Duties

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

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

(3) In claims which have been denied and are on appeal, the insurer shall notify the medical provider and MCO, if any, within ten days of any change of status of the claim.

(4) Immediately following notice or knowledge that the worker is medically stationary, insurers shall notify all injured workers **and the attending physician** in writing which medical services remain compensable under the system and the manner in which they may receive palliative care in accordance with OAR 436-010-0290. The director may, by bulletin, prescribe

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the form or format for such notification.

(5) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician, the insurer shall [provide notice to medical service providers of the medically stationary status within 24 hours] **notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer shall be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician.**

(6) Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(d) and OAR 436-060-0070.

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

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

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

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

Stat. Auth: ORS 656.726(3)

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

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436-010-0340 Sanctions and Civil Penalties

(1) (1) If the director finds any medical provider in violation of the medical reporting

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

- (a) Reprimand by the director;
- (b) Non-payment, reduction or recovery of fees in part, or whole, for services rendered;
- (c) Referral to the appropriate licensing board; or
- (d) Civil penalty not to exceed \$1,000 for each occurrence. In determining the amount of penalty to be assessed, the director shall consider:

- (A) The degree of harm inflicted on the worker or the insurer;
- (B) Whether there have been previous violations; and
- (C) Whether there is evidence of willful violations.

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

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

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

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

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

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

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

(8) If the director finds any insurer in violation of OAR 436-009 or OAR 436-010, **or an order of the director**, the insurer shall be subject to penalties pursuant to ORS 656.745 of not more than \$2000 for each violation or \$10,000 in the aggregate for all violations within any three

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month period. Each violation, or each day a violation continues, shall be considered a separate violation.

Stat. Auth: ORS 656.726(3)

Stat. Implemented: ORS 656.245, 656.254, 656.745

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