

**DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION**

**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10**

MEDICAL SERVICE

EFFECTIVE FEBRUARY 1, 1988

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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 10**

436-10-003 Applicability of Rules

(1) These rules are effective to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.325, and 656.794.

(2) The provisions of OAR 463-10-090 shall be applicable to all services rendered subsequent to the effective date of these rules.

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436-10-005 Definitions

Unless the context otherwise requires:

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

(2) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(3) "Claim" means a written request for compensation from a worker or worker's agent, or any compensable injury or illness of which an employer has notice or knowledge.

(4) "Claimant" means the worker making a claim.

(5) "Consulting Physician" means a licensed physician who examines a worker, or the worker's medical record, at the request of the attending physician to aid in diagnosis and/or treatment, and who may, at the request of the attending physician, provide specialized treatment of the compensable injury or illness.

(6) "Current Procedural Terminology" means the Current Procedural Terminology, fourth edition, 1985, published by the American Medical Association.

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

(8) "Department" means the Oregon Department of Insurance and Finance, consisting of the Board, the Director and all their assistants and employees.

(9) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend or take over the medical service at any time.

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A medical service provided at a site removed from the physician, or provided when the physician is not present on the premises, is not under the direct control and supervision of the physician.

(10) "Director" is the Director of the Department of Insurance and Finance.

(11) "Disability Prevention Services" means services provided to an injured worker to prevent the injury from causing continuing disability. Such services include physical restoration and psychologic, psychiatric, and vocational evaluation and counseling.

(12) "Elective Surgery" means surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

(13) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(14) "Insurer" means the State Accident Insurance Fund Corporation, a guaranty contract carrier, or a self-insured employer.

(15) "Major Orthopedic or Neurologic Surgery" means operations on the spine, shoulder, elbow, hip, knee or ankle joints; replacement of any joint; surgery for thoracic outlet syndrome. Surgery for carpal tunnel syndrome is not major neurologic surgery.

(16) "Medical Director" means the physician in the office of the director of the Department of Insurance and Finance.

(17) "Medical Service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device.

(18) "Medically Stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(19) "Peer Review" means the evaluation of the care provided to a worker by review of the pertinent records and/or personal interview with the attending physician or consultant. Such review may be conducted by a committee of the provider's peers and/or any other appropriate body selected by the director.

(20) "Physical Capacity Evaluation" means an objective, directly observed, measurement of worker's ability to perform a variety of physical tasks combined with statements of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, Functional Capacity Assessment, and Work Tolerance Screening shall be considered to have the same meaning as Physical Capacity Evaluation.

(21) "Physician" or "Doctor" means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate.

(22) "Promptly" means without delay.

(23) "Report" means transmittal of medical information in a narrative letter, on a form or in progress notes from the worker's medical file. Reports may be handwritten but all shall be legible and include all relevant or requested information.

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(24) "Treating Physician" means attending physician.

(25) "Usual Fee" means the fee charged the general public for a given service.

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

(27) "Worker" means a subject worker as defined in ORS 656.005.

(28) "Work Hardening" means an individualized, medically ordered and monitored, work oriented treatment process. Involves the worker in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance and productivity to return to work goals.

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436-10-030 Reporting

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any physician, hospital, or other medical vendor to supply relevant information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, or the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. No person who reports to these persons in accordance with Department rules shall bear any legal liability for disclosure of such (ORS 656.252). The physician may require evidence from the representative of his or her representative capacity. The authorization is valid for the duration of the work related injury or illness.

(2) The initial attending physician shall complete the first medical report (Department of Insurance and Finance Form 827) in every detail and mail it to the proper insurer no later than 72 hours after the claimant's first visit (Saturdays, Sundays and holidays will not be counted in the 72-hour period). Diagnoses stated on the 827 and all subsequent reports shall conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(3) Progress reports are essential. The insurer may require progress reports every 15 days through the use of the physician's supplemental report form (Department of Insurance and Finance Form 828). If more information is required, the insurer may request a limited or comprehensive narrative report. Progress notes from the clinical chart, if legible, may suffice to give the insurer all the information the insurer needs.

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(4) ORS 656.252 requires the attending physician to inform the insurer of the anticipated date of release to work, the anticipated date the worker will become medically stationary and the next appointment date. To the extent the physician can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(5) The attending physician shall advise the insurer and the worker within five (5) days of the date the injured worker is released to return to work.

The physician shall not notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

(6) The attending physician shall, after a claim has been closed, advise the insurer within five (5) days after treatment is resumed or the reopening of a claim is recommended. The attending physician need not be the same physician who released the worker when the claim was closed.

(7) The attending physician shall promptly respond to the request for progress reports. If the physician or other vendor of services fails to comply with this requirement within 10 days, the insurer may send another request by certified mail, return receipt requested. If within 10 days the physician or other vendor has not complied with this request, penalties under OAR 436-10-110 may be imposed.

(8) Consultations. The attending physician may request consultation regarding conditions related to an accepted claim. The attending physician shall promptly notify the insurer of the referral (referrals to radiologists and pathologists for diagnostic studies are exempt from this requirement). The attending physician shall provide the consultant with all the available clinical information. The consultant shall submit a copy of his consultation report to the attending physician and the insurer within 10 working days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report.

(9) When an injured worker elects to change attending physicians, the newly selected attending physician shall so notify the insurer not later than five (5) days after the change or the date of first treatment using Department of Insurance and Finance Form 829. The newly selected physician shall make a diligent effort to secure from the previous physician, or from the insurer, all of the available medical information including information concerning previous temporary total disability periods. The previous attending physician shall immediately forward, upon proper request, all requested information and X-rays to the new attending physician.

(10) Injured workers, or their representatives, are entitled to copies of all relevant medical information. This information should ordinarily be available from the insurers, but may be obtained from physicians upon the payment of an appropriate charge for copies. However, reports that contain medical and psychological information relevant to the claim, which in the judgment of the writer of the report should not be shown to the worker because it would not be in the worker's best interest, must be supplied to the worker's representative but need not be supplied to the worker directly. Upon request by the insurer, the director, or the claimant, chart notes containing the relevant information shall be provided subject to the above exception.

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436-10-040 Medical Services

(1)(a) The insurer shall pay for all medical services which the nature of the compensable injury or the process of recovery requires. The insurer will not pay for care unrelated to the compensable injury. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable. Billings for services which appear to the insurer to be in excess of the standards set forth in these rules, or of generally accepted medical standards, may be referred to the medical director. Such referral shall be made within 60 days of receipt of the bill.

(b) Peer review committees shall be composed of health care providers licensed under the same authority as the health care provider who rendered the services being reviewed. The committees shall provide advice and assistance to the medical director on other health matters when requested. The director may solicit recommendations from professional associations, licensing authorities and professional schools.

(c) The report of such committee shall be submitted to the director who may:

- (A) Issue an order compelling compliance with the judgment of the committee, or
- (B) Forward the report to the insurer and provider for appropriate action.

(2)(a) Frequency and extent of treatment shall not be more than the nature of the injury or the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed.

(b) A reasonable fee is payable for this report. A judgment by the insurer that the report does not set forth sufficient grounds for the frequency of treatment in excess of the standard may be referred by the physician to the medical director. The medical director may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(3) X-ray films must be of diagnostic quality. 14" x 36" lateral views are not reimbursable. Billings for X-rays are not reimbursable without a report of the findings. Upon the request of either the director or the insurer, X-ray films shall be forwarded to the director or the insurer. Films shall be returned to the vendor. A reasonable charge may be made for the costs of delivery of films. Refusal of the physician to forward the films to the director or the insurer upon proper request shall result in nonpayment of the fee for the radiological study.

(4)(a) Physical therapy, biofeedback or acupuncture shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment

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and which must be completed and signed by the attending physician within one week of the beginning of treatment. The treatment plan shall include objectives, modalities, frequency of treatment and duration. A copy of the progress notes shall be provided insurer.

(b) The initial treatment plan shall be for no more than 20 therapy visits in the first 60 days. If more than 20 therapy visits are required in the first 60 days or more than four therapy visits a month after the first 60 days, the physician shall submit a report documenting the need for services in excess of the guidelines upon request of the insurer.

(c) A judgment by the insurer that the report does not justify treatment in excess of the guidelines shall promptly be communicated to the physician and the therapist. The physician may appeal to the medical director who may rule in favor of the physician, the insurer, or refer the matter to a peer review committee.

(d) The preparation of a written treatment plan and supplying progress notes are integral parts of the fee for the therapy service. No additional fee shall be paid except a reasonable amount for copies or summaries of the records of treatment.

(5) The attending physician, when requested to complete a physical capacities evaluation form, shall within 20 days perform an evaluation; if necessary, and complete the form, or refer the worker for such evaluation, or notify the insurer and the worker in writing that the worker is incapable of participating in such evaluation.

(6) Except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are not compensable.

(7) Dietary supplements - such as minerals and vitamins are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from compensable gastrointestinal injury.

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

(9) Prolotherapy is not reimbursable without prior authorization by insurer.

(10) Liquid crystal thermography, photographic or electronic, is not reimbursable without prior authorization. Insurer may require documentation to show why its use is preferable to usual diagnostic tests. Insurer may limit the number of times it may be used in each case.

(11) A written request for authorization for prolotherapy or thermography shall be answered within 14 working days of receipt by insurer or approval will be assumed.

(12) The descriptions of medical services for CPT numbers itemized in (a) through (j) shall be the basis for determining the appropriate level of service.

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(a) 95831 - Muscle Testing, Manual, Separate Procedure, Extremity, with Report (also includes 95832, 95833, 95834) - Detailed individual testing of multiple muscles of a patient with a severe neuropathic or myopathic disorder. It does not apply to general or specific muscle testing done during a regular physical examination.

(b) 97110 - Therapeutic Exercises - Instructing a patient in exercises and directly supervising the exercises. Exercising done subsequently by the patient without a physician or therapist present and supervising would not be covered by Code 97110.

(c) 97112 - Neuromuscular Reeducation - The provision of direct services to a patient who has had muscle paralysis and is undergoing recovery or regeneration. Examples would be severe trauma to nervous system, cerebral vascular accident and systemic neurological disease. The code does not apply to massaging or exercising relatively normal muscles or treatment of minor disuse atrophy, e.g. following cast removal.

(d) 97114 - Functional Activities - The development and instruction in specific activities for persons who are severely handicapped or debilitated. The code does not apply to routine exercises for relatively normal individuals.

(e) 97116 - Gait Training - Teaching individuals with severe neurological or muscular-skeletal disorders to ambulate in the face of their handicap or to ambulate with an assistive device. This code does not apply to simple instructions given relatively normal individuals with minor or transient abnormalities of gait who do not require an assistive device.

(f) 97220 - Hubbard Tank - This service involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals.

(g) 97240 - Pool Therapy with Therapeutic Exercises - This service is provided individually, in a pool, to severely debilitated or neurologically impaired individuals. It does not apply to relatively normal individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.

(h) 97540 - Activities of Daily Living - Services provided in an office or clinic to severely impaired individuals, e.g. how to get in and out of a tub; how to make a bed; how to prepare meals in a kitchen. It does not apply to simple instructions or counseling in body mechanics given briefly to a patient.

(i) 97720 - Extremity Testing for Strength, Dexterity, or Stamina - Detailed testing of a patient with a generalized neurological or debilitating disease. It does not apply to routine physical examinations of relatively unimpaired individuals.

(j) 97740 - Kinetic Activities - When there are major impairments or disabilities which preclude the patient performing the activities and exercises that are ordinarily prescribed. Considerable time is spent developing specific, individualized therapeutic exercises and instructing the patient in how to perform them. This code does not apply to instructions in routine exercises.

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436-10-045 Evaluating Treatment

(1) If an insurer, worker or the director feels that any medical treatment recommended for, or provided to, a worker or workers, is unscientific, unproven, outmoded or experimental, either party may request, or the director may initiate on the director's own, an investigation.

(2) The investigation shall include the advice of the licensing boards of practitioners who might be affected.

(3) The director may submit the record of the investigation to the Advisory Committee on Medical Care which shall review the record and conduct any further inquiry the committee considers necessary. The committee shall render a recommendation to the director as to whether or not the committee considers the treatment in question to be unscientific, unproven, outmoded or experimental.

(4) The director may adopt a rule declaring the treatment to be noncompensable.

(5) No sums deleted by an insurer under the rule referred to in (4) above shall be charged to a worker.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

436-10-046 Medical Panels

(1) If a worker, insurer or the director believes a worker's treatment is excessive, inappropriate, ineffectual or in violation of the medical rules either may request, and the director may establish on the director's own motion, a medical panel.

(2) Any party requesting a review shall notify all other parties, including the medical provider, at the same time the request is made to the director. If the director initiates the panel the director shall notify the parties.

(3) No later than five days after receiving the request the director shall notify the parties whether or not a panel will be authorized and shall inform the parties of their responsibilities in the matter.

(4) Once the panel is authorized, the insurer shall not deny the claim for medical services, nor shall the worker request a hearing on any issues subject to the director's jurisdiction, until an order is issued.

(5) The panel, composed of Oregon physicians whose treatment is not under review and licensed in the same healing art as the physician whose treatment is under review, shall be established as follows:

(a) No later than 10 days after the director authorizes the panel the worker and the insurer shall each choose a physician and notify the director.

(b) If either the worker or the insurer fails to inform the director of the physician chosen in the allotted time, the director shall choose the physician.

(c) The two physicians shall choose a third physician no later than 20 days after the director authorizes the panel.

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(d) If the third physician is not chosen in the allotted time, the director shall choose the third panel member.

(e) The director shall inform the panel the date the panel's report is due, which will be no later than 40 days after the selection of the panel is complete.

(6) The director shall inform the worker of the date, time, and location of the examination with copies to the insurer, attending physician and panel members.

(7) The insurer and attending physician shall forward all pertinent medical records, laboratory results and X-rays to the medical panel.

(8) The medical panel may:

(a) Review all medical records and X-rays submitted.

(b) Interview and examine the worker.

(c) Perform any necessary tests, laboratory studies and X-rays except invasive tests.

(d) Submit a report in writing to the director containing the panel's recommendation, with copies to the worker, insurer, and attending physician.

(9) The recommendation may include, but not be limited to:

(a) Reason for the panel examination.

(b) Past medical history.

(c) Current medical problem.

(d) Current treatment

(e) Results of the examination.

(f) Results of tests performed.

(g) Diagnosis.

(h) The medically stationary status.

(i) Whether current treatment is excessive, inappropriate or ineffectual.

(j) Whether or not the current treatment should be continued, modified or terminated.

(10) Within 10 days of receipt of the report the director shall issue a final order.

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436-10-060 Choosing And Changing Doctors

(1) A newly selected attending physician shall notify the insurer not later than five (5) days after the date of change or first treatment, using Form 829 (Change of Attending Physician).

(2) The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician who shall promptly notify the insurer of the request. Fees for treatment by more than one physician at the same time are payable only

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when the medical conditions present are related to the treatment of the compensable injury or illness and are sufficiently different that separate medical skills are needed for proper treatment.

(3) The worker is allowed to change physicians by choice two times after the initial choice. Referral by the attending physician to another attending physician shall not count in this calculation. Examinations at the request of the insurer, and consultations requested by the attending physician, do not constitute a change in attending physician.

(4) When a worker has made an initial choice of attending physician and subsequently changed two times, the insurer shall inform the worker by certified mail that any subsequent changes must have the approval of the insurer or the director.

In the event that the worker again changes physician without the approval of the insurer, the insurer may deny payment for services rendered by the additional physician and inform the claimant of the right to seek approval of the director.

If a physician begins treatment without being informed that the worker has been given the required notification the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the physician that further payment will not be made.

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436-10-090 Charges And Fees

(1) All billings shall be fully itemized and services identified by code numbers and descriptions found in the Current Procedural Terminology or as described in OAR 436-10-040(12)(a) through (j). Hospitals may bill for inpatient services and surgery using the International Classification of Diseases, 9th edition--with Clinical Manifestations (ICD9-CM).

(2) When services are provided in hospital emergency or outpatient departments which are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes and reimbursed at no more than the 75th percentile as shown in the department's relative value schedule. Such services include outpatient physical therapy, outpatient X-rays and emergency department treatment and physician's services.

When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment.

(3) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the vendor for correction or paid at the value of the service provided. Any service not identifiable with a code number shall be adequately described.

(4) The vendor of medical services shall bill the vendor's usual fee charged to the general public. The submission of the bill by the vendor shall serve as a warrant that the fee submitted is the usual fee of the vendor for the services rendered. The department shall have the right to require documentation from the vendor establishing that the fee under question is the vendor's usual fee charged to the general public.

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(5) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker is not liable for payment for any services for the treatment of that injury or illness. The vendor of medical services may charge the patient directly only for the treatment of conditions that are unrelated to the accepted compensable injury or illness.

(6) The insurer may not pay any more than the vendor's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 75th percentile of the usual and customary fees as determined by the director. The vendor may not attempt to collect from the injured worker any sums deleted by the insurer.

In the event of a dispute about fees between the vendor and the insurer, either may appeal to the medical director. The medical director will investigate and advise the director who may issue an order advising either party to comply. If orders are issued, either party may request a hearing pursuant to OAR 436-10-110(5).

(7) For those medical services for which no CPT code or relative value has been established the director shall determine which services are most commonly provided to injured workers and promulgate a reasonable rate for the services, which shall be the same for all primary health care providers. Such services include, but are not limited to, brief narrative report and complete narrative report.

(8) The director shall review and update medical fees annually using data from a statistically valid survey, the physician service component of the National Consumer Price Index, or from any state agency having access to usual and customary medical fee information. The fees at the 75th percentile, as determined by the director, are published as Appendix "A".

(9) Physician assistants or nurse practitioner fees will be paid at the rate of 80 percent of a physician's fee for a comparable service except that assisting in surgery shall be paid at the rate of 50 percent of the comparable fee for a physician assisting in surgery.

(10) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings will be subject to discounts, not to exceed 10 percent, for each 30 day period or fraction thereof, beyond 60 days.

(11) Billings shall include the claimant's full name, date of injury, the employer's name and, if available, the insurer's claim number. Billings not correctly filled out may be returned to the vendor for correction and resubmission.

(12) Laboratory fees shall be billed in accordance with ORS 676.310. If the attending or consulting physician submits a bill for laboratory services that were performed in an independent laboratory, the bill shall show the amount charged by the laboratory and any service fee that the attending or consulting physician charges.

(13) The definitions of commonalty in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services.

(14) Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

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(15) Physician mark-up shall not exceed 20 percent for braces, supports and other medical devices with a unit price greater than \$25. Invoices for these devices shall be provided on request of insurer.

(16) Fees for surgical procedures shall be billed as follows:

(a) When two surgeons operate and one performs a discectomy and one performs an arthrodesis, each procedure is to be billed separately. The maximum allowable fee for each procedure, as listed in the Relative Value Schedule, shall be reduced by 25 percent.

When the surgeons assist each other throughout the operation each may bill an additional fee of 20 percent of the other surgeon's fee as an assistant's fee.

When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' fees.

(b) When one surgeon performs a discectomy and arthrodesis the procedure shall be billed under CPT Codes 22550-22565 and/or CPT Codes 22730-22735.

(c) When multiple surgical procedures are performed, the principal procedure is reimbursed at 100 percent of the maximum allowable fee, the secondary procedure is reimbursed at 50 percent of the maximum allowable fee and all subsequent procedures are reimbursed at 25 percent of the maximum allowable fee.

(d) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value in the RVS and the subsequent procedures paid at 10 percent of the value listed in the RVS.

(e) Surgery following severe trauma, for which several procedures are required and which take considerable time, and for which the surgeon feels his fees should not be reduced, can receive special consideration by the insurer. Such a request must be accompanied by written documentation and justification.

(f) Hospital charges for inpatient myelograms are not subject to the Relative Value Schedule. Physician's services for inpatient myelograms are subject to the Relative Value Schedule.

(17) When two bills are submitted for an X-ray, one by the person taking the X-ray (technical component) and one by the radiologist who interprets the X-ray (professional component), the maximum allowable fee is to be divided between them.

The technical component is reimbursed at 60 percent of the maximum allowable fee and the professional component is reimbursed at 40 percent of the maximum allowable fee.

(18) Outpatient hospital service shall be billed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the Relative Value Schedule, are to be applied to hospital bills only for outpatient services.

(b) CAT scans, when performed as an outpatient service, are subject to the limitations of the Relative Value Schedule. When multiple areas are examined by CAT scan, the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the Relative Value Schedule.

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(19) A physical medicine modality, when applied to two or more areas at one visit, shall be reimbursed at 100 percent of the maximum allowable fee for the first area treated, 50 percent for the second area treated, and 25 percent for all subsequent areas treated.

(20) Fees for reports:

a. A medical service provider may not charge any fee for completing a medical report form required by the director under this chapter.

b. Copies of office progress notes when requested by insurer - \$3.50 for 1st page, \$.50 a page thereafter

c. Brief Narrative - Summary of Rx to date and current status; answer to 3-5 specific questions - \$25

d. Complete narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary? - \$50

(21) Fee for a deposition (Includes preparation time):

a. First hour \$300

b. Each subsequent hour \$100

(22) When a provider of medical services, including a hospital, submits a bill to an insurer for medical services, the provider shall submit a copy of such bill to the worker to whom the services were provided.

The copy to the worker shall be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the worker.

(23) When multiple areas are examined using Magnetic Resonance Imaging (MRI) the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of the Relative Value Schedule.

(24) Mechanical muscle testing shall be reimbursable three times during a treatment program: once near the beginning, once near the middle and once near the end of the treatment program. Additional mechanical muscle testing is reimbursable only when the testing has been prior authorized by the insurer.

The fee for mechanical muscle testing includes an interpretation of the results and a report.

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436-10-095 Advisory Committee on Medical Care

(1) The Advisory Committee on Medical Care shall be appointed by the director pursuant to ORS 656.794.

(2) Committee members shall be reimbursed necessary travel and other expenses from the administrative fund.

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(3) Committee members shall submit to the director, no later than the end of the quarter the expenses were incurred, a standard expense voucher for reimbursement.

(4) The committee shall elect a chairman and vice chairman from its members and establish their terms of office.

(5) The committee shall consist of two Doctors of Medicine, one Doctor of Osteopathy, one Doctor of Chiropractic, one Doctor of Naturopathy and either one Doctor of Dental Surgery or one Doctor of Dental Medicine, all of whom shall be qualified to be attending physicians. The committee shall also include one representative each of insurers, employers and workers.

(6) The members shall serve at the pleasure of the director.

(7) The duties of the committee shall include:

(a) To advise the director on matters relating to the provision of medical care to injured workers.

(b) To review proposed standards for medical evaluation of disabilities, and any proposed future changes in the standards, and to make recommendations to the director.

(c) To prepare and submit to the director rules governing the provision of medical care for compensable conditions, including the rates for medical service, and to advise the director on any other proposed rules regarding medical care.

(d) To advise the director on medical care questions.

(8) The medical director shall provide liaison between the committee and the director and shall provide staff and administration support to the Committee.

Hist: Filed 1/20/88 as Admin. Order 1-1988, eff. 2/1/88

436-10-100 Insurer's Rights and Duties

(1)(a) The Director or insurer may obtain medical examinations of the worker by physicians of their choice. The number of such examinations is limited by ORS 656.325. In the event the insurer believes that a need exists for more than three examinations, the insurer shall request approval of the director. In arriving at a decision the director will consider such matters as the date of injury, date of last examination, nature of examinations that have been performed, the complexities of the medical issues. The worker shall be notified of the purpose of the examination. Such examinations shall be at places, times, and intervals reasonably convenient to the worker, and shall not delay or interrupt proper treatment of the worker.

(b) The examiner shall promptly send a copy of the report to the attending physician and the insurer or person requesting the exam.

(c) Any physician who unreasonably and without good cause interferes with the right of the insurer to obtain examination by physicians of their choice may be subject to penalties.

(d) Independent Medical Examination (IME) is a special consultation which may be requested only by the insurer or with the insurer's prior authorization. The fee for an IME is to be agreed upon prior to the examination. When a worker known to be represented by a lawyer is

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scheduled for an IME, the worker's lawyer shall be sent simultaneously a copy of the notification sent to the worker.

(e) When a worker is required to attend an IME the insurer shall pay for the examination and all necessary related services which include, but are not limited to, child care, travel, meals and lodging. The insurer shall reimburse the worker within 60 days of receipt of an itemized bill and appropriate receipts.

(2) An examination obtained at the request of the Evaluation Section is not considered one of the three examinations allowed to the insurer.

(3) Insurer shall pay bills for medical services within 60 days of receipt of the bill, if the billing is submitted in proper form and clearly shows that the treatment is related to the accepted compensable injury or disease. Failure to do so shall render insurer liable to pay a reasonable monthly service charge after the 60th day, if the provider customarily levies such a service charge to the general public.

(4) In claims which have been denied and are on appeal, the insurer shall notify the vendor promptly of any change of status of the claim.

(5) In the event of a dispute over portions of a billing, the insurer shall pay within 60 days the undisputed portion of the bill.

(6) In the event a vendor of medical services feels aggrieved by the conduct of an insurer, the vendor may request the assistance of the department. If the matter involves treatment or fees, the matter shall be resolved pursuant to OAR 436-10-040(4). If the matter involves actions of the insurer and cannot be resolved informally, the director may issue an order compelling compliance and setting forth the appeal rights of the parties.

(7) The limitations of the workers' right to choose attending physicians (ORS 656.245) and the insurer's right to independent examinations (656.325) begin with the date of injury and extend through the life of the claim. Exceptions to both limitations will be handled on a case by case basis.

(8) The insurer shall establish an audit program for bills for all medical services to determine that services are billed as provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum in the Relative Value Schedule and that bills are submitted in a timely manner.

The audit shall be continuous and shall include no fewer than 10 percent of medical bills.

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436-10-110 Complaint Procedures And Penalties

(1) Complaints shall be directed to the medical director. Complaints shall be in writing and fully documented. If the medical director believes the complaint may have merit, the medical director may investigate the matter and afford the party complained of an opportunity to respond

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to the allegations. The medical director may consult with an appropriate committee of the physician's peers before presenting a recommendation to the director.

(2) The medical director shall upon completion of his investigation recommend an appropriate disposition to the director. The medical director may recommend, and the director may elect, not to investigate the matter or issue an order but rather refer the matter to a referee. Notwithstanding ORS 183.315(1) the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

(a) The order of the referee shall be a final order of the director;

(b) The director shall have the same right to a judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(3) If the medical director finds any violation of OAR 436-10-040, 436-10-050, 436-10-060, 436-10-090 or 436-10-100(1)(c) the medical director may recommend to the director, and the director may impose, one or more of the following sanctions;

(a) Reprimand by the director;

(b) Nonpayment or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board.

(4) If the medical director finds any violation of the rules enforcing the provisions of ORS 656.252 and 656.254 as found in OAR 436-10-030, 436-10-070 and 436-10-080 of these rules, the medical director may recommend to the director, and the director may impose, one or more of the following sanctions:

(a) Reprimand by the director;

(b) Nonpayment 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. The maximum penalty shall be levied only upon repeated or willful violation. 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.

(5) A hearing relating to a proposed order issued under these rules shall be held by a referee of the Hearings Division of the Workers' Compensation Board. A hearing shall not be granted unless a request for hearing is filed within 30 days of receipt of the proposed order. If a request for hearing is not so filed, the order, as proposed, shall be a final order of the department. Notwithstanding ORS 183.315(1) the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

(a) The order of the referee shall be a final order of the director; and

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(b) The director shall have the same right to judicial review of the order of a referee as any person who is adversely affected or aggrieved by such final order.

(6) Insurers who violate these rules shall be subject to the penalties in ORS 656.745.

(7) (a) Under the provisions of ORS 183.310 to 183.550 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, 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.

(b) If the conduct as described in paragraph (a) above 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.

(c) 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.

(d) (a) If an insurer or worker believes penalties under (a) and/or (b) of this section are appropriate, either may submit, in writing, to the director:

(A) Practitioner's name and address;

(B) Claimant's name and claim number;

(C) Reason penalties are thought to be warranted;

(D) Any harm which has befallen, or might befall, the claimant;

(E) Specific examples of failure to comply with the medical rules;

(F) Reasons treatment is thought to be inappropriate, excessive or ineffectual; and,

(G) Reports from any medical consultants supporting the insurer's or worker's position.

(e) The director shall investigate the allegations and may seek advice from the Advisory Committee on Medical Care, practitioner's licensing boards, professional-associations or a medical panel established under OAR 436-10-046.

(f) If the director believes, upon completion of the investigation, that penalties may be in order the director shall issue a complaint and proceed to a contested case hearing under the provisions of ORS 183.310 to 183.550.

(g) At the completion of the hearing, and upon receipt of the hearing officer's report, the director may adopt the hearing officer's recommendations or issue an order of the director imposing penalties.

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APPENDIX A
OREGON RELATIVE VALUE SCHEDULE
FOR MEDICAL SERVICE

(1) The coding structure is that of the Current Procedural Terminology (CPT), Fourth Edition, 1985.

(2) There are five sections, each of which has its own schedule of relative values which is completely independent of and unrelated to any of the other four sections.

(3) In each section the code unit is followed by a relative value number, when such has been established. When no value has been established, the provider must submit with the billing a description of the service in detail sufficient for the payor to judge whether the fee is reasonable.

(4) In the surgery section, a third column shows the number of days of post-operative care included in the fee.

(5) In the radiology section, the second column shows the total value of an examination, i.e., costs of X-ray film, interpretation and making a report of the study.

(6) Physicians who inject air, contrast material or isotopes as part of a radiologic study shall bill for this service using CPT codes from the surgery section, e.g. 62284 - injection for myelography.

(7) The Definitions and Items of Commonalty, Current Procedural Terminology, pp. xiv - xviii, 1985, and the definitions in OAR 436-10-040(12), shall be the basis for determining levels of service. A disagreement about the level of service may be referred, by the physician, to the Medical Director, who may resolve the issue in favor of either party.

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APPENDIX A:

CHANGE RELATIVE VALUE OF CPT NO.	
22325	BR
22326	BR
22327	BR
22720	18.5
27131	30.0
27135	34.0
35161	13.5
45330	0.8
45331	1.0
45332	1.0
52000	1.2
52005	2.1
70551-026 PC*	12.0
70551-027 TC*	54.0
72141-026 PC*	12.0
72141-027 TC*	54.0
73720-026 PC*	12.0
73720-027 TC*	54.0
* PC – Professional component TC – Technical component	
72296	12.2
78300	11.5
78305	16.0
78306	20.0
78310	25.0
78315	30.0
97752	(1) Extremity, 1 plane of motion - 8.7 (2) Extremity, 2 or more planes of motion - 10.9 (3) Trunk, includes cervical, thoracic and L-S Spine - 15.9