City of Portland, Oregon

BUREAU OF FIRE AND POLICE DISABILITY AND RETIREMENT

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Statement of Rulemaking Need and Fiscal Impact

Purpose of Administrative Rule Amendment Recommendations – Staff proposes FPDR Administrative Rule amendments when it is deemed essential to providing clarity, consistency of application of Chapter 5 provisions, and full disclosure to all stakeholders.

Summary of Amendments:

FPDR Staff recommends amending Section 5.9, Medical Benefits for FPDR Two and Three, as follows:

Issues:

#1: Amends Section 5.9.01 – "Definitions"
- Deletes terms that are not used in this section of the Administrative Rules.
- Adds Doctor of Podiatry to definition of Attending Physician
- Redefines Date of Disability to be consistent with definition in other sections of the Administrative Rules.
- Adds the term Required Duties to define the type of work a Member must be incapable of performing in order to be eligible for disability benefits.
- Adds the term Usual and Customary Fee.
- Adds the term Work Capacity Evaluation.
- Redefines the term Worsening.
- Makes housekeeping changes.

#2 Amends 5.9.02 – "Recipients of Disability Benefits"
- Makes housekeeping changes.

#3 Amends Section 5.9.03 – "Medical Services"
- Change the word Board to Director as it is the Director who enters into fee agreements with medical and hospital service providers
- Makes housekeeping changes.

#4 Amends Section 5.9.04 – "Medical Services Guidelines"
- Change the word Board to Director as it is the Director who enters into fee agreements with medical and hospital service providers
- Makes housekeeping changes.

#5 Amends Section 5.9.05 – "Noncovered Services"
- Makes housekeeping changes.

#6 Amends Section 5.9.06 – “Independent Medical Examinations”

- Corrects language to ensure a consistent process and rule application in all sections of the Administrative Rules.
- Makes housekeeping changes.

#7 Amends Section 5.9.07 – “Medical Management Programs”

- Adds language under Utilization Review that states the Director may deny a Medical Services request if the organization that the Director has a fee agreement with denies pre-certification of the request.
- Makes housekeeping changes.

#8 Amends Section 5.9.08 – “Medical Fees and Payments”

- Adds timelines for submitting health care provider billings to FPDR, the consequence of late submission and an iteration that Members are held harmless by the health care provider whose bill is reduced or denied for untimely submission.
- Makes housekeeping changes.

#9 Amends Section 5.9.10 from “Post-Retirement Medical Benefits”

- Makes housekeeping changes.

#10 Adds Section 5.9.11 – “Disability Retirement Age”

- Adds section on Disability Retirement Age.

NOTE: Housekeeping changes consist primarily of typographical and grammatical corrections.

Desired Outcome:

Board adopts amendments as recommended by staff.

Fiscal Impact Statement

FPDR finance staff has reviewed the proposed rules changes for fiscal impact:

No impact anticipated.

City of Portland, Oregon

FIRE AND POLICE DISABILITY, RETIREMENT

AND DEATH BENEFIT PLAN

Administrative Rules

FPDR TWO AND THREE BENEFITS

SECTION 5.9 – MEDICAL BENEFITS

Page

Adopted November 12, 1991
Effective February 1, 1992

As Amended by:

Resolution No. 287 on August 8, 1995, Resolution No. 288 on September 12, 1995, Resolution No. 298 on October 14, 1997, Resolution No. 320 on December 14, 1999, Resolution No. 323 on April 11, 2000, Resolution No.332 on April 17, 2001, Resolution No. 335 on August 14, 2001, Resolution No. 338 on December 11, 2001, Resolution No. 340 on January 15, 2002, Resolution No. 345 on April 9, 2002, Resolution No. 349 on August 13, 2002, Resolution No. 350 on August 13, 2002, Resolution No. 351 on September 10, 2002, Resolution No. 352 on October 8, 2002, Resolution No. 365 on August 12, 2003, Resolution No. 372 on February 10, 2004, Resolution No. 381 on August 10, 2004, Resolution Nos. 388, 389 and 390 on June 14, 2005, Resolution No. 392 on November 8, 2005, Resolution No. 393 on December 13, 2005, Resolution No. 405 on May 9, 2006, Resolution No. 419 on March 13, 2007, Resolution No. 423 on November 27, 2007; Resolution No. 432 on March 23, 2009; Resolution No. 438 on May 26, 2009; and Resolution No. 472 on November 27, 2012.

5.9.01 – DEFINITIONS

"Aggravation." The term "Aggravation" means a Worsening of an approved service-connected injury/illness or occupational disability that occurs after the Member's condition has been deemed Medically Stationary.

"Ancillary Services." The term "Ancillary Services" means services that supplement the care provided by the Member's physician or other authorized health care provider (e.g., physical therapy, occupational therapy, etc.).

"Attending Physician." The term "Attending Physician" means:

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the ~~Board of Medical Examiners for the State of Oregon~~ ***Oregon Medical Board, or a podiatric physician or surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry*** or a similarly licensed doctor in any country or in any state, territory or possession of the United States, or

(B) For a period of 30 days from the first visit on the initial Claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory, or possession of the United States. ~~All Members drawing disability benefits shall be examined at least once during each twelve-month period by the Member's identified physician or a physician appointed by the Director, unless otherwise determined by the Director.~~

"Chart Note." The term "Chart Note" means a chronological documentation in a~~n individual's~~ ***Member's*** medical record, and includes subjective and objective findings, diagnosis, treatment rendered and proposed, status, and recovery and return to work objectives.

"Claim." The term "Claim" means a written request to FPDR for a retirement, disability or death benefit and may be filed by an active ~~m~~***M***ember, his/her representative or legal beneficiary, or surviving spouse or other legal beneficiary of a deceased ~~m~~***M***ember. This term may be used synonymously with the term "application."

"Curative Care." The term "Curative Care" means Medical Services required to diagnose, heal or permanently relieve or eliminate a medical condition.

~~"Current Procedural Terminology." The term "Current Procedural Terminology or "CPT" ® means the codes and terminology most recently published by the American Medical Association.~~

~~"Customary Fee." The term "Customary Fee" means a fee that falls within the range of fees normally charged in Oregon for a given service.~~

"Date of Disability." The term "Date of Disability" means the date that the ~~Member's physician determines that the~~ Member is unable to perform the Member's ~~r~~***R***equired ~~d~~***D***uties ***as a result of a service-connected injury/illness or an occupational disability that has been determined to arise out of and in the course of the Member's employment in the Bureau of Police or Fire***.

"Director." The term "Director" where used in these Administrative Rules shall mean the Fund Director and/or Fund Administrator or his or her designee.

"Elective Surgery." The term "Elective Surgery" is surgery which may be necessary in the process of recovery from an injury or illness, but need not be done as an emergency to preserve life, function or health.

~~"Home Health Care." The term "Home Health Care" means medically necessary medical and medically related services provided in the Member's home environment. These services may include professional nursing care, medical administration, or personal hygiene, or assistance with mobility and transportation.~~

"Independent Medical Examination (IME)." ***The term "Independent Medical Examination" means*** ~~A~~***a***n examination by one or more licensed medical providers in order to provide an opinion of findings in connection with a~~n~~ ***service-connected*** injury/illness or ***an*** occupational ***disability*** Claim. A Physical Capacities***y*** Evaluation (PCE) or a Work Capacities***y*** Evaluation (WCE) ~~is~~ ***may be*** considered an "IME" under these rules.

~~"Medical Evidence." The term "Medical Evidence" means expert written testimony, statements and opinions; sworn affidavits and testimony of medical experts; records, reports, documents, diagnostic test results authored, produced, generated, or verified by medical professionals; and medical research and reference material utilized, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.~~
acronym
"Medical Service." The term "Medical Service" means any medical treatment, including:

(A) Surgery
(B) Diagnostic procedures
(C) Chiropractic
(D) Dental
(E) In-patient and Out-patient hospitalization
(F) Professional nursing
(G) Ambulance transport
(H) Prescription drugs
(I) Medicine
(J) Durable medical equipment
(K) Crutches
(L) Braces and supports
(M) Prosthetic appliances

(N) Physical Restorative Services

“Medical Treatment.” The term “Medical Treatment” means the management and care of a Member by a licensed medical provider for the purpose of combating disease, injury, or disorder.

"Medically Stationary." The term "Medically Stationary" means that no further material improvement can reasonably be expected from medical treatment or the passage of time**.**

“Nurse Case Manager.” A licensed nurse assigned by the Director to follow and monitor the progress of recovery of an injury/illness or occupational Claim.

“Original Injury.” The term “Original Injury” means the period from the first occasion of medical treatment or disability resulting from a service-connected or occupational disability through the date the member reaches a Medically Stationary status.

“Palliative Care.” The term “Palliative Care” means post-Medically Stationary Medical Services required to reduce or temporarily moderate the intensity of an otherwise stable condition. It does not include those Medical Services needed to diagnose, heal, or permanently alleviate a medical condition.

“Physical Capacity Evaluation.” The term “Physical Capacity Evaluation” means an objective, directly observed, measurement of a Member’s ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship’s Functional Evaluation, and Functional Capacity Assessment will be considered to have the same meaning as Physician Capacity Evaluation.

“Physical Restorative Services.” The term “Physical Restorative Services means services prescribed by the Member’s physician that are designed to restore and maintain the Member to the highest functional ability consistent with the Member’s condition.

“Preponderance of the Evidence.” The term “Preponderance of the Evidence” means the greater weight of the evidence.

~~“Primary Physician.” See “Attending Physician.”~~

“Proximate Cause.” The term “Proximate Cause” means a cause that directly produces an event and without which the event would not have occurred.

“Recurrence.” An Aggravation of a service-connected injury/illness or occupational disability that requires Claim re-opening for additional disability benefits and/or medical benefits after the Member has reached Medically Stationary status with respect to the approved service-connected injury/illness or occupational disability.

“Required Duties.” The term “Required Duties” means the essential functions of the work that is assigned to the Member by the Bureau of Police or Fire.

“Significant Factor.” The term a “Significant Factor” means an important, Proximate Cause.

"Specialty Physician." The term "Specialty Physician" means a licensed physician who qualifies as an Attending Physician who provides evaluation, diagnosis or temporary specialized treatment at the request of the Member's "Attending Physician" on an approved Claim.

"Usual and Customary Fee." The term "Usual and Customary Fee" means a treatment service fee that falls within the range of fees normally charged for treatment of occupational injuries and illnesses in Oregon.

"Work Capacity Evaluation." The term "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 will be considered to have the same meaning as Work Capacity Evaluation.

"Worsening" The term "Worsening" means objective findings indicating a ~~Worsening of~~ ***deterioration due to*** the approved service-connected injury/illness or occupational disability based on expert medical opinion or an expert medical opinion explaining why the Member's symptoms indicate a ~~worsening~~ ***decline*** ~~of~~ ***in*** the approved service-connected injury/illness or occupational disability.

5.9.02 – RECIPIENTS OF DISABILITY BENEFITS

All Members drawing disability benefits, of whatever nature shall identify a physician as defined in and under the conditions prescribed for under "~~Primary~~ ***Attending*** Physician" in Section 5.9.01 of this Administrative Rule.

5.9.03 – MEDICAL SERVICES

(A) Reimbursement for actual, reasonable and necessary expenses, as determined by the Director, ***paid for or*** incurred by a Member as a result of a service-connected or occupational injury or illness shall be paid as provided below:

(1) Members shall be reimbursed for the actual, reasonable and necessary medical expenses they have ***paid for or*** incurred. Payment directly to the medical care provider shall be deemed to be reimbursement of the Member.

(2) Actual, reasonable and necessary costs for travel, prescriptions and other necessary expenses paid by the Member will be reimbursed upon request by the Member.

(3) All requests for reimbursement shall be made on forms provided by the Director and accompanied by itemized documentation which supports the request. For example, requests for reimbursement for prescriptions must be accompanied by a receipt from the provider identifying the prescription and its price and requests for mileage reimbursement must be accompanied by a statement reflecting the actual mileage traveled.

(4) Reimbursement for the cost of meals, lodging, public transportation or use of a private vehicle shall be at the rate of reimbursement paid to City employees when incurring such expenses.

(5) Reimbursement for the cost of meals, lodging, or travel exceeding 50 miles will be paid only if such expenses are pre-approved by the Director.

(6) Expenses incurred for public transportation or the use of a private automobile will be reimbursed based on the most direct route between the Member's home and the facility where the service is to be performed.

(7) All requests for reimbursement for expenses paid by the Member must be submitted to and received by the Director within 60 days of ***making payment for or*** incurring the expense for which reimbursement is sought.

(8) Initial determinations regarding actual, reasonable and necessary medical and other expenses shall be made by the Director. Members shall be advised, in writing, of any denials. In the event that a denial is issued by the Director, the Member may appeal such determination by filing with the Director a written notice of appeal requesting reconsideration before a hearings officer. However, the reconsideration shall not be granted unless the notice of appeal is received by the Director within 60 days after the mailing of the determination, unless the Member can establish good cause why the notice of appeal was not received until ***after*** the required 60 days.

(9) Medical or hospital service providers that have fee ~~arrangements~~ ***agreements*** with the ~~Board~~ ***Director***. Notwithstanding the provisions of subsection (1) above, Members receiving disability benefits ~~under FPDR Two and Three~~ must obtain hospital and Medical Services for service-connected or occupational injuries or illnesses from providers or organizations that have fee ~~arrangements~~ ***agreements*** with the ~~Board~~ ***Director***, except in those circumstances described in subparagraph (~~3~~***10***) below. A listing of such providers shall be on file in and available from the Director's office.

Medical or hospital service providers or organizations that have a fee arrangement agreement with the ~~Board~~ ***Director*** shall provide Medical Services to Members that are subject to the terms and conditions of said agreement.

(10) Medical or hospital service providers that do not have a fee ~~arrangement~~ agreement with the ~~Board~~ ***Director***. Members may obtain and will be reimbursed for the actual and reasonable costs of necessary medical or hospital services received from providers who do not have fee ~~arrangements~~ ***agreements*** with the ~~Board~~ ***Director***, in the circumstances described below. Payment directly to the provider will be considered to be reimbursement to the Member.

(a) The Member has a life-threatening emergency requiring immediate medical care at the nearest emergency facility. ~~The Member has a~~

~~life-threatening emergency requiring immediate medical care at the nearest emergency facility.~~ Life-threatening emergencies include, but are not limited to, situations such as profuse bleeding, loss of consciousness, breathing difficulty or sudden severe head trauma.

(b) The Member is traveling in an area in which there are no providers who have a fee ~~arrangement~~ ***agreement*** with the ~~Board~~ ***Director*** and a service~~-~~connected ~~or occupational~~ injury or illness or ***occupational disability*** requires immediate medical treatment.

(c) The Member is referred by either the Bureau of Police or the Bureau of Fire ~~and Rescue~~ to a provider with whom the Bureau has made arrangements for vaccinations or evaluation and treatment for on-the-job exposures to blood borne pathogens or hazardous materials.

(d) Other exceptions specifically authorized by the Director or his or her designee. The Director or his or her designee may waive the requirement that a Member seek hospital or Medical Services from a provider who has a fee ~~arrangement~~ ***agreement*** with the ~~Board~~ ***Director*** upon a showing by the Member that it is a necessity that the Member be treated by another provider or that it would cause an undue hardship on the Member to require that he or she seek treatment only from a provider who has a fee arrangement with the ~~Board~~ ***Director***.

(11) Medical treatment and services provided by approved health care providers must be consistent with the nature of the approved ***service-connected*** injury or ***illness or occupational*** ~~disease~~ ***disability***, and care that is reasonable and necessary to promote recovery.

(B) The Director reserves the right to request of the Member's ~~Primary~~ ***Attending*** or Specialty Physician, evidence of the frequency, extent and efficacy of treatment and services.

(C) Ancillary Services provided by a health care provider other than the Member's ~~Primary~~ ***Attending*** Physician will not be reimbursed unless prescribed by the Member's ~~Primary~~ ***Attending*** or Specialty Physician. These services must be according to a treatment plan that has been provided to the Member's ~~Primary~~ ***Attending*** or Specialty Physician within a reasonable time of when the ancillary treatment begins. The treatment plan must include the following:

(1) Objectives of planned treatment;

(2) Description of modalities to be provided;

(3) Frequency of treatments; and

(4) Duration of treatments.

The Member's ~~Primary~~ ***Attending*** or Specialty Physician shall sign off on the ancillary treatment plan and send a copy to the Director.

5.9.04 – MEDICAL SERVICES GUIDELINES

Medical Services provided to the injured Member must not be more than is reasonable and necessary to treat the approved service-connected injury/illness or occupational disability. The Director may deny services that are shown to be more than the nature of the approved ***service-connected*** injury/illness ***or occupational disability,*** or the process of recovery requires. Accepted professional standards will be relied upon in making these determinations.

(A) The utilization and treatment standard for physical therapy included in any fee arrangement agreement with a medical or hospital service provider will be followed. If none exists, the number and duration of therapy visits covered will not exceed what is medically reasonable and necessary under accepted professional standards. The Member's ~~Primary~~ ***Attending*** or Specialty Physician will be required to provide the Director with a written explanation for visits exceeding this standard.

(B) Attending Physicians may prescribe treatment or services to be carried out by persons not licensed to provide a Medical Service or treat independently only when such services or treatment is rendered under the ***Attending or Specialty*** ~~p~~***P***hysician's direction.

(C) Massage therapy not administered under the direct oversight of a***n Attending*** ~~p~~***P***hysician must comply with the requirements for "Ancillary Services" in these rules.

(D) Prescription ~~D~~***d***rugs may be purchased by the Member at a pharmacy of the Member's choice. The Director may ask that the Member access the services of providers that the ~~Board~~ ***Director*** has made fee ~~arrangements~~ ***agreements*** with. Except in an emergency, drugs and medicine for oral consumption supplied by a***n Attending*** ~~p~~***P***hysician must not exceed that which is medically necessary to treat the Member.

(E) Post-Medically Stationary medical care may fall into one of the following categories:

Curative Care – Medical care necessary to stabilize a temporary and acute flare up of symptoms of the Member's condition; or

Palliative Care - Medical care that is reasonable and necessary to reduce or temporarily moderate the intensity of an otherwise stable condition and/or is reasonable and necessary to enable the Member to continue current employment or a vocational training program.

In both cases, the Member's ~~Primary~~ ***Attending*** Physician will be required to submit to the Director a written request that provides the following:

(1) A description of the objective findings;

(2) The diagnosed medical condition for which the care is being requested, to include the appropriate ICD-9-CM diagnosis code;

(3) Provide an explanation of how and why requested care is reasonable and necessary and will improve the Member's condition; and/or is reasonable and necessary to enable the Member to continue current employment or a vocational training program.

(4) A description of how the care is medically reasonable and necessary to treat the approved Claim.

5.9.05 – ~~NON-COVERED~~ *NONCOVERED* SERVICES

(A) Medical treatment that is excessive, unscientific, unproven as to its effectiveness, outmoded, inappropriate or experimental in nature is not reimbursable. Accepted professional standards will be relied upon in making these determinations.

(B) Dietary supplements, unless prescribed by the Member's ~~Primary~~ ***Attending*** or Specialty Physician specifically as medical treatment for an approved dietary deficient~~t~~***cy*** condition are not reimbursable.

(C) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not covered unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth why the Member requires an item not usually considered necessary in the great majority of workers with similar impairments.

(D) Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist that render such treatment medically reasonable and necessary.

(E) Physical Restorative Services may include but are not limited to a regular exercise program, gym membership or swim therapy. Such services are not compensable unless the nature of the Member's limitations requires specialized services to allow the worker a reasonable level of social and/or functional activity. The Attending Physician must justify by report why the Member requires services not usually considered necessary for the majority of injured workers.

(F) The Director may deny services that are shown to be more than the nature of the approved ***service-connected*** injury/illness or ***occupational disability or*** the process of recovery requires. Accepted professional standards will be relied upon in making these determinations.

5.9.06 – INDEPENDENT MEDICAL EXAMINATIONS

(A) If requested by the Director, any Member ***potentially*** eligible to receive benefits under this program is required to undergo a***n IME*** by one or more licensed

physician***(s)*** or psychologist***(s)***. Should the Member fail to submit to the examination, or obstructs the same, the Member's rights to benefits may be suspended or reduced by the Director until the examination has taken place.

(B) The Director is not required to schedule an IME appointment during a Member's work hours. Members will be required to attend an IME during off work hours, as well as work hours, if so scheduled~~, and unless there is good cause for not attending the IME. An IME scheduled during a Member's off work hours is not considered good cause, of and by itself, for not attending an IME~~.

~~(C) Independent Medical Examinations (IME) during the course of a Member's Injury/Illness or Occupational Claim.~~

~~(1) The Member will be notified in writing by certified and regular mail at least 14 calendar days prior to the IME appointment date.~~

~~(2) The Member may request a change in the appointment date, time or place for good cause.~~

~~(3) The Member must cooperate with a scheduled IME by arriving at the date and time of the scheduled appointment and cooperating with the examination unless the Member can show good cause for non-cooperation.~~

~~(4) Suspension or reduction of benefits may result from non-cooperation in participation with an IME.~~

~~(D) When Elective Surgery is recommended by the Member's Primary or Specialty Physician the Member may be required to attend an IME with an independent consultant prior to approval of the surgery.~~

~~(1) The Director will notify the physician within 7 days of receiving a request to approve surgery that an IME will be required prior to approval of the surgery. The Director will arrange the IME as soon as possible, but no later than 30 days following the request for surgery by the Member's Primary Physician or Specialty Physician.~~

~~(2) The Director will issue a decision to approve or deny the request for surgery as soon as possible, but no later than 21 days, following the date of the IME.~~

(C) FPDR will mail a written notice to the Member by certified and regular mail at least 14 calendar days prior to the IME appointment date. If the Member has an attorney, the Member's attorney shall be simultaneously notified in writing of a scheduled medical examination under these Administrative Rules. FPDR may provide fewer than 14 days notice if the Member agrees.

(D) The Member's notification of the medical examination shall include the following information:

(1) The name of the examiner or facility;

(2) A statement of the specific purpose for the examination and identification of the medical specialties of the examiners;

(3) The date, time and place of the examination; and

(4) The first and last name of the Member's Attending Physician and verification that the Member's Attending Physician was informed of the examination.

(E) The Member may request a change in the appointment date, time or place ~~for good cause~~. With approval of the director, attempts will be made to reschedule the IME. Until a new IME appointment is scheduled and approved by the director, the member is required to attend the original IME appointment.

(F) When Elective Surgery is recommended by the Member's Attending or Specialty Physician the Member may be required to attend an IME with an independent consultant prior to approval of the surgery.

(1) The Director will notify the Attending or Specialty Physician within 7 days of receiving a request to approve surgery that an IME will be required prior to approval of the surgery.

(2) The Director will arrange the IME as soon as possible, but no later than 30 days following the request for surgery by the Member's Attending Physician or Specialty Physician.

(3) The Director will issue a decision to approve or deny the request for surgery as soon as possible, but no later than 21 days, following the date of the IME.

(G) When necessary, the following expenses associated with the Member's attending the medical examination will be considered by the Director:

(1) Reimbursement of reasonable cost of public transportation or use of a private vehicle; and

(2) Reimbursement of reasonable cost of child care, meals, lodging and other related services.

(H) Requests for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely review and consideration prior to the date of the examination. Mileage reimbursement will be based on City of Portland rates in effect at the time of incurred expense.

(I) The Member must cooperate with a scheduled IME by arriving at the date and time of the scheduled appointment and cooperating with the examination and

IME Physician ~~***unless the Member can show good cause for noncooperation.***~~

(J) Suspension or reduction of benefits may result from noncooperation in participation with an IME.

5.9.07 – MEDICAL MANAGEMENT PROGRAMS

(A) Clinical Case Management – the use of a combination of medical professionals (nurses and physicians) to manage or assist in managing the medical and disability aspects of service-connected ***injury/illness*** and occupational disability Claims.

(1) Typical clinical case management providers and services may include telephonic and field nurse case management services, utilization management, and physician advisor.

(2) A Nurse Case Manager may be assigned to monitor and track recovery of a Member's approved injury***/illness*** Claim when deemed appropriate by the Director.

(a) Members are required to cooperate with the Nurse Case Manager assigned to their injury***/illness*** Claim. Cooperation includes submitting to personal and/or phone contact and answering relevant medical and vocational questions posed to them by the Nurse Case Manager.

(b) Members may decline to allow the Nurse Case Manager to accompany them to their medical appointments.

(c) Members may request a change of Nurse Case Manager. However, it is at the discretion of the Director to assign a new ~~n~~***N***urse ~~c~~***C***ase ~~m~~***M***anager.

(B) Utilization Review - FPDR may require the use of utilization review services to provide pre-certification of surgical and specialty care prior to approval of the Medical Service. ***The Director may deny a Medical Services request if utilization review services deny precertification of such request.***

5.9.08 – MEDICAL FEES AND PAYMENTS

(A) The Director may contract with medical or hospital service providers or groups of providers for medical or hospital services and enter into fee ~~arrangement~~ agreements with such to reimburse medical fees of approved Claims under these rules.

(B) Health care providers will submit their fees for services rendered pursuant to current Charter and ***FPDR*** ~~a~~***A***dministrative ~~r~~***R***ules. Billings must be itemized and include Chart Notes, and must be submitted directly to FPDR~~.~~***, no later than 90 days from the date of service or in accordance with the terms of their provider panel agreement with whom FPDR is contracted. A health care provider must***

establish good cause if billing is submitted later than 90 days from the date of service or in accordance with the terms of their provider panel agreement with whom FPDR is contracted. Failure to show good cause may result in a reduction or nonpayment of allowable charges. Members will be "held harmless" by the health care provider for any costs that, if not for late submission, would have been covered by FPDR.

(C) Medical fees will be reimbursed according to the fee ~~arrangement~~ agreements made between the medical providers and FPDR.

(D) If no fee ~~arrangement~~ agreement has been made with the medical provider, and the service complies with these administrative rules in all other respects, FPDR will reimburse at the "Usual and Customary Fee" for the Medical Service.

(E) FPDR payment shall be considered payment in full. Members will be "held harmless" by the medical provider for any costs above the usual and customary ~~fee schedule~~ ***rate, as defined in 5.9.01 of these Administrative Rules,*** or an agreed upon fee ~~arrangement~~ ***agreement*** amount payable by FPDR on an otherwise approved billing.

(F) FPDR will date stamp each medical bill received. Bills for services rendered on approved Claims will be adjudicated within 30 days of receipt. Payments will be in accordance with adopted fee schedules.

(G) If there is a dispute concerning the amount of a bill, the appropriateness of the service rendered, or the relationship of the services to the approved Claim, FPDR must pay any undisputed portion of the bill and notify the provider of the specific reasons for ~~non-payment~~ ***nonpayment*** or reduction of the remainder of the bill.

5.9.09 – MEDICAL PAYMENT LIMITATIONS

(A) Member shall not pay for any Medical Service that is related to an approved service-connected or occupational disability or any amount that has been reduced by the FPDR in accordance with these administrative rules. A medical provider shall not attempt to collect payment for any Medical Service from a Member, except as follows:

(1) When the Member seeks treatment for conditions not related to the approved Claim;

(2) When the Member seeks treatment that has not been prescribed by the Attending Physician, or a Specialty Physician upon referral of the Attending Physician

(3) When the Member seeks treatment outside the provider panels which FPDR has contracted with, and said treatment was not pre-authorized by FPDR.

(4) When the Member seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or

experimental, or has been notified that the treatment is not approved or outside of these Administrative Rules.

5.9.10 – POST-RETIREMENT MEDICAL BENEFITS

(A) Disability Retirement – Medical and hospital expenses arising from an approved service-connected ***injury/illness*** or occupational ~~injury/illness~~ ***disability*** shall be reimbursable, if the Member's disability benefits continued until the Member reached Disability Retirement Age.

(B) Service Retirement – For Members who are retired as of January 1, 2007, medical and hospital expenses arising from an approved service-connected ***injury/illness*** or occupational ~~injury/illness~~ ***disability*** shall not be reimbursable.

(C) Service Retirement – For Members who are not retired before January 1, 2007, medical and hospital expenses arising from an approved service-connected ***injury/illness*** or occupational ~~injury/illness~~ ***disability*** shall be reimbursable.

(D) The Director shall deny the Claim for medical or hospital expense if the Director determines by a Preponderance of the Evidence that a Claim under subsection (C) from a retired Member is due to the following:

(1) Medical or hospital expenses related to an injury/illness that was based upon fraud, misrepresentation, an omission, or illegal activity by the Member, or

(2) Medical or hospital expenses related to an injury/illness that was accepted in good faith, in a case not involving fraud, misrepresentation, an omission, or illegal activity by the Member, and within two (2) years of the initial acceptance the Director obtains evidence that the Claim is not a service-connected or occupational illness/injury or FPDR is not responsible for the injury/illness, or

(3) Medical or hospital expenses are not related to the service-connected injury/illness ***or occupational disability***.

5.9.11 – *DISABILITY RETIREMENT AGE*

(A) Service-connected injury/illness or occupational disability benefits payable to a FPDR Two Member shall cease at Disability Retirement Age except as provided in Section ~~B~~C hereof. A Member receiving service-connected injury/illness or occupational disability benefits shall be eligible to receive a retirement benefit at Disability Retirement Age, which shall be the earlier of the dates the Member is (1) credited with 30 Years of Service for retirement benefit purposes or (2) the date the Member attains social security retirement age. For purposes of this rule, social security retirement age means the retirement age provided in 42 USC § 416(l)(1).

(B) Service-connected injury/illness or occupational disability benefits payable to a FPDR Three Member shall cease at Normal Retirement Age under PERS

except as provided in Section C hereof.

(C) If the Director determines the service-connected injury/illness or occupational disability to be temporary, benefits may continue after Disability Retirement Age for a FPDR Two Member or PERS Normal Retirement Age for a FPDR Three Member up to two (2) years from the date of such disability. A Member, who is actively employed and suffers a service-connected illness/injury, or occupational disability after attaining Disability Retirement Age for a FPDR Two Member or PERS Normal Retirement Age for a FPDR Three Member, shall be eligible to receive disability benefits for a period of up to two (2) years from the date of such disability if the Director determines the disability to be temporary.