In the ORS 656.248 Medical Fee Dispute of

Sebastian J. Nocita, Claimant

Contested Case No: 08-052H

FINAL ORDER

December 1, 2008

SAIF CORPORATION, Petitioner
SACRED HEART MEDICAL CENTER, Respondent

Before John Shilts, Workers' Compensation Division Administrator

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This is one of twenty cases involving the same parties, SAIF Corporation (SAIF) as petitioner and Sacred Heart Medical Center (Sacred Heart) as respondent, and addressing the same legal issue. Sacred Heart billed for services provided by radiologic technologists and SAIF paid for those charges at a reduced rate. Sacred Heart sought administrative review. The Workers' Compensation Division Medical Section Resolution Team found in each case in Sacred Heart's favor and ordered that SAIF pay for the services at a higher rate. SAIF appealed those orders and Administrative Law Judge (ALJ) Chuck Mundorff heard the cases as a consolidated matter. The ALJ issued proposed and final orders in all of the cases on July 18, 2008. The orders affirmed the resolution team's orders and found in Sacred Heart's favor.

The issue in all of the cases is whether hospital charges for services provided by radiologic technologists should be paid under current procedural terminology (CPT®) codes and their associated resource based relative value units (RBRVS) as services provided by "licensed medical service providers" or should instead be paid under the adjusted cost/charge ratio method. OAR 436-009-0020(2).[1] The resolution team in each case found in Sacred Heart's favor that these services should be billed under the cost/charge ratio. The resolution team issued its order in this case on April 17, 2008.

SAIF filed exceptions to ALJ Mundorff's orders and the matter is before me for review. I

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[1] CPT® is a copyrighted system of describing and coding medical procedures developed and owned by the American Medical Association.

The cost/charge ratio is an element of the fee schedule the director establishes which is used to determine the amount of fees to be paid to hospitals and medical service providers who provide services to injured workers. ORS 656.248; OAR 436-009-0020(1), (2); WCD Bulletin 290, September 26, 2008. Hospital charges are divided into two categories. There are those for "physicians and other licensed medical service providers," the fees for which are calculated under the CPT and RBRVS, and all other charges, which are calculated using the cost/charge ratio. OAR 436-009-0020(1), (2).

OAR 436-009-0020(2) states in part:

> "Unless otherwise provided . . . insurers must pay hospitals for outpatient services according to the following: the insurer must first separate out and pay for charges for services by physicians and other licensed medical service providers assigned a code under the CPT© and assigned a value in RBRVS for physician fees as identified by the revenue codes indicating professional services. These charges must be subtracted from the total bill and the adjusted cost/charge ratio applied only to the balance."

affirm the resolution team's and the ALJ's orders.

SAIF asks that I strike Sacred Heart's "Response to Exceptions" because Sacred Heart initially failed to serve all of the claimants as required by rule. OAR 436-001-0004(1)(k), 436-001-0023(2).[2] As SAIF lacks standing to make the objection on behalf of the claimants and has not suffered any prejudice, and because Sacred Heart cured the failure, I deny the motion to strike.

FACTUAL SUMMARY

I adopt the facts as found by the ALJ and the resolution team. Claimant sustained a compensable injury and Sacred Heart performed radiological studies as part of claimant's treatment. Sacred Heart billed SAIF. SAIF paid a reduced amount that it asserted was justified under the CPT®. Sacred Heart believed a higher amount was owed under the cost/charge ratio.

The following facts concerning testimony at the hearing are substantially quoted from the ALJ's order:

SAIF called Kathy Loretz, medical program manager for SAIF. She testified that her duties included auditing bills and paying medical service providers for service on workers' compensation claims. She stated that during her tenure SAIF had paid for radiologic services using the CPT® Code and applying the Relative Value Unit multiplier. She noted that this had been the standard under a former version of OAR 436-090-0020 until this rule was changed in April of 2006.[3] Ms. Loretz testified that the change was intended to be fiscally neutral. However her evaluation was that the rule change would have a significant impact on SAIF and other workers' compensation insurance carriers. She stated that in her experience other similar providers of services, such as physical, occupational, and speech therapists, were properly paid under the CPT® code.

SAIF called radiologic technologist instructor Barbara Smith to testify. She described the training that her students received and the nature of the practice itself. She said that radiologic

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[2] OAR 436-001-0004(1)(k) states in part: "'Party' may include, but is not limited to, a worker . . . ."

OAR 436-001-0023(2) requires that:

> "A copy of any filing, motion, request, document, or correspondence must be sent to the other parties, or their legal representatives, at the same time it is filed or submitted to the division or administrative law judge."

[3] The rule prior to amendment read:

> "(2) [T]he insurer shall first separate out and pay charges for services covered under the CPT® and RBRVS. These charges should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance." (emphasis added) Admin. Order 02-052, eff. April 1, 2002.

technologists must be licensed by taking a national exam and that they must observe practice standards. She testified that a medical doctor refers patients for imaging. The technologist then takes a patient history, may deliver contrast media or medication, monitors the patient's vital signs, and obtains the proper image. She also noted that technologists provide post-care instructions to patients and are trained in emergency medical care. On cross-examination she acknowledged that the patient history is not taken for diagnosis or treatment purposes and medication or contrast is only administered on physician order. She finally agreed that technologists do not read or interpret x-rays, do not prescribe care, do not give prognoses, and overall are generally supervised by the ordering doctor.

In response to SAIF's witnesses, Sacred Heart called Cliff Hendargo, Hospital Finance director. He described the difference between billing under a CPT® code and RBRVS and the cost to charge ratio. Mr. Hendargo stated that a key component in determining how a service is charged is whether it is classified as a "professional" versus a "technical" service.

Sacred Heart next called Carol Doyle, the Director of Radiology at Sacred Heart. She testified that she had been in radiology for 36 years. In response to the testimony of Barbara Smith, she noted that taking a patient history is limited to identifying the body part to be imaged. She testified that radiologic technologists are not healthcare providers. Ms. Smith said that technologists do not diagnose, interpret images, or order treatment.

The Department of Justice, on behalf of the Workers' Compensation Division, called Deborah Buchanan, a former manager for the division's medical review unit. Ms. Buchanan was at the division at the time OAR 436-009-0020 was amended and participated in the advisory committee that drafted the rule. She testified that the change in the rule was intended to separate professional billings from technical billings and that, in particular, the committee wanted to separate billings for practitioners of the "healing arts," in her experience, a term of art. She testified that SAIF participated in the public hearing on the proposed rule change and that the stakeholders raised no concerns regarding the fiscal impact of the rule change.

In rebuttal to Ms. Buchanan's testimony, SAIF recalled Kathy Loretz. She testified that the fiscal impact statement attached to the rule at the time of adoption indicated a slightly positive fiscal impact to the carriers as it was intended to eliminate duplication of billings and to streamline and expedite payment. She testified that her calculation was that paying for these services under the cost/charge ratio would result in a significant detrimental impact for the carriers.

In its exceptions, SAIF challenges two aspects of the ALJ's factual findings. SAIF first asserts the ALJ did not specifically note the dollar amount of the impact on SAIF of this rule interpretation, about which SAIF presented testimony. The ALJ's order adequately captured this point with its description of Kathy Loretz's testimony that adopting this "interpretation of the rule would result in a significant detrimental impact for the carriers."[4]

SAIF also challenges the order's failure to describe further testimony by Barbara Smith

[4] July 18, 2008, Proposed and Final Order, at p. 3.

about additional specific duties that radiologic technologists perform. As will be shown below, the relevant factors concerning the duties and responsibilities of radiologic technologists are that they do not have the authority to independently determine whether to perform an x-ray, do not determine which x-ray is appropriate, and do not use the x-ray to make diagnoses or to recommend or provide treatment. None of the contested facts that SAIF raises conflict with these conclusions.

CONCLUSIONS OF LAW

As this is a medical fee dispute my review is de novo. ORS 656.248(1), 656.704(2)(a); OAR 436-001-0225(1).

The issue here is whether radiologic technologists qualify as "licensed medical service providers" under OAR 436-009-0020(2). The services of licensed medical service providers are billed and paid for under CPT® codes while all other hospital charges are subjected to the cost/charge ratio. OAR 436-009-0020(1), (2). As in this case, where radiologic technologists' charges are paid under the CPT® code, this results in lower payments to hospitals.

The term "medical service provider" is defined in the workers' compensation statutes as "a person duly licensed to practice one or more of the healing arts . . . ." ORS 656.260(12). OAR 436-010-0005(27) also defines a medical service provider as "a person duly licensed to practice one or more of the healing arts."[5] There is no dispute that radiologic technologists are licensed. The question is whether they practice one of the "healing arts" for the purposes of workers' compensation law.

Radiologic technologists must be licensed by the state in order to practice. ORS 688.415. The licensing statutes also require that a "licensed practitioner" must supervise radiologic technologists in their practice. ORS 688.405(3). The radiologic technologist licensing statutes define a radiologic technologist as a person "other than a licensed practitioner." ORS 688.405(12). The same statutes define "licensed practitioner" as a person licensed in Oregon to practice one of the healing arts. ORS 688.405(5). The legislature thus has clearly and specifically concluded that not only are radiologic technologists not practitioners of the healing arts but that a person who does meet that definition must supervise them.

SAIF points out the definitions section of the statutory references cited above concerning radiologic technologist licensing states the definitions are for use within those licensing statutes. ORS 688.405, title. While the statute may not, on its face, be controlling for workers' compensation purposes, the legislature's clear and specific determination that radiologic technologists do not practice the healing arts is very strongly persuasive. SAIF does not explain why the same term should have different meanings in the licensing statutes and the workers'

[5] In its argument, petitioner at times substitutes the phrase "medical provider" or "medical provider services" for "medical service provider." The term "medical service provider" refers to an individual and is expressly defined as "a person duly licensed to practice one or more of the healing arts." In contrast, "medical provider" includes individuals, such as medical service providers, but also includes institutions such as hospitals. OAR 436-010-0005(27), (28). It is not unreasonable to apply different billing principles to services provided by hospitals and individual medical service providers, or between professional and technical services. Arguments that rely on blurring the difference between the terms are not persuasive.

compensation statutes, or why the definitions stated in the licensing statutes should not be followed here.

The central case on this subject is *Cook v. Workers' Compensation Division,* 306 Or 134 (1988). In that case the court was asked to define the term "healing arts" in the process of interpreting whether a workers' compensation rule improperly excluded nurse practitioners from the definition of "physician." The rule in question barred nurse practitioners from acting as "attending physicians" and physicians were defined as people licensed to practice one of the healing arts. *Former* OAR 436-10-050; ORS 656.005(12). 306 Or at 137-138.

As its central analytical tool, the court asked the question of whether "nurse practitioners do things that make them 'practitioners of the healing arts' . . . ." *Cook*, 306 Or at 142. The court answered this question affirmatively. Factors the court considered relevant included that nurse practitioners are independently responsible and accountable for promoting and maintaining health, preventing illness, and managing health care, and that they can also obtain prescription privileges. *Id.* at 142-143. The court summarized: "[a] nurse practitioner is qualified to provide comprehensive, independent medical care in the form of diagnosis, treatment, advice and referrals. Those services certainly fall within the commonly understood meaning of a 'healing art.'" *Id.* at 143.

Since *Cook*, there have been a number of decisions addressing the issue of which professions are or are not practitioners of the healing arts. In SAIF *Corp. v. Johnson*, 198 Or App 504 (2005), the court determined that a licensed audiologist or hearing specialist practiced a healing art in performing a hearing exam and fitting a hearing aid. The court found that a person qualifies for this designation where they take actions or provide care or medication intended to alleviate or cure a disease or injury. *Id.* at 509.

In *Driver v. Rod and Reel Restaurant*, 125 Or App 661 (1994), the court found physical therapists also practice a healing art. This is because physical therapists evaluate a patient's condition and take action based on that evaluation to restore the patient's health. *Id.* at 664-665.

During the hearing, SAIF's witness, radiologic technologist instructor Barbara Smith, acknowledged that radiologic technologists do not read or interpret x-rays, do not diagnose, do not prescribe treatment, and are supervised by the doctor who orders the x-ray. Smith also testified that radiologic technologists do take a patient history but that this is not for diagnostic or treatment purposes. She testified radiologic technologists only administer medication or contrast substances if the supervising doctor has ordered them. Sacred Heart's witness, Carol Doyle, director of radiology at Sacred Heart Medical Center, also testified that radiologic technologists do not diagnose conditions, interpret radiological images, or prescribe treatment.

Given the legal definitions for "healing arts practitioner" established by the courts, and the straightforward testimony about radiologic technologists' duties and responsibilities, the resolution team reviewer and the ALJ were correct in concluding that radiologic technologists are not practitioners of the healing arts. Radiologic technologists do not act independently. They do not manage care. They do not diagnose. They do not recommend or provide treatment intended to cure or alleviate injuries or disease. Although they are highly trained and skilled

professionals, they do not meet the Oregon workers' compensation statutory definition of being practitioners of a healing art.

SAIF argues the meaning of OAR 436-009-0020(2) as to whether or not radiologic technologists are licensed medical service providers must be determined by examining the "context" of the rule. The focus in interpreting a rule is to give effect to the intent of the enacting body. I look at the rule's text and that of related rules. *Abu-Adas v. Employment Dept.,* 325 Or 480, 485 (1997).

The meaning of the rule here is clear under these interpretive principles. In the case of hospital charges, only physicians and licensed medical service providers are paid under the CPT® codes. The phrase "licensed medical service provider" is defined in the workers' compensation statute and rule to apply to a person licensed to practice one of the healing arts. Case law establishes radiologic technologists do not practice one of the healing arts. The text of the rule, and its context, support the resolution team's and the ALJ's interpretations.

The context of the history of the rule also supports this interpretation. OAR 436-009-0020(2) previously stated in part that: ". . . the insurer shall first separate out and pay charges for services covered under the CPT® and RBRVS." Admin. Order 02-052, eff. April 1, 2002. The rule was amended to the present language which states: ". . . the insurer must first separate out and pay charges for services <u>by physicians and other licensed medical service providers assigned a code</u> under the CPT® and assigned a value in RBRVS <u>for physician fees</u> as identified by the revenue codes <u>indicating professional services</u>." Admin. Orders 06-052, eff. April 1, 2006 and 07-051, eff. July 1, 2007 (emphasis added).

The wording of this sentence of this rule was expressly addressed in the rulemaking process when the current language was being proposed. At an external advisory committee meeting the division commented that:

> "The rule is not clear. Some insurers may read the rule as taking all the charges that have a CPT code on the bill and then subtract them from the bill. However, the intent is to subtract only professional charges, those from medical service providers." Minutes of 11/21/05 OAR 436-009 Advisory Committee Meeting, p. 6, Ex. E to the division's Response to Exceptions.

The division also stated the purpose of the change in its order adopting the modified rule. This was to "[c]larify procedures for separating hospital outpatient charges subject to the hospitals cost/charge ratio from all other charges." Admin. Order 06-052, eff. April 1, 2006.

Thus, the division's stated intent in inserting the present language into the rule was expressly to not have insurers subtract an item from the bill only because it had a CPT® code. Rather, the intent was that insurers would assign charges under the CPT® only for "medical service providers." It was the division's intent to clarify that the rule specifically excludes from CPT® billing charges for practitioners who are not licensed medical service providers.

Other wording in the rule also supports this interpretation. The rule states insurers should separate and pay CPT® charges where there is an assigned RBRVS value "for physician fees as identified by the revenue codes indicating professional services." OAR 436-009-0020(2). This emphasizes the difference between charges for technical and professional services and makes clear the intent is to use CPT® codes for the professional component of a service. The RBRVS allows for separately valuing the professional and technical components of a given procedure in order to account for the different values of physicians' services and non-physicians' services provided as part of the same procedure. 72 Federal Register, No. 227, November 27, 2007, pp. 66225-66227, 66488-66516.

SAIF makes a number of arguments based on the premise that radiologic technologists should be considered medical service providers simply because there are CPT® codes for some radiologic services. This premise is wrong on multiple grounds.

First, the CPT® was created by, and is controlled by, the American Medical Association. Its purpose is to facilitate communication among medical professionals and to improve billing efficiency. The CPT® was not created with the purpose of determining how billing should be performed in workers' compensation cases, nor is its purpose to define whether a particular practice or practitioner is an example of the healing arts under Oregon law.

Second, SAIF disregards language used in the relevant rules that adopt the CPT® for use as a reference in the medical provider fee schedule. The CPT® is not a billing tool and it does not provide billing values. It is merely a list of codes for medical procedures. This is clear because the rule at issue here, OAR 436-009-0020(2), refers to procedures "assigned a code under the CPT® <u>and assigned a value in RBRVS</u> . . . " (emphasis added.) RBRVS is the system of resource-based relative value units adopted by the federal government that are attached to CPT® codes in order to determine the cost or value of a medical procedure. 72 Federal Register, No. 227, November 27, 2007, pp. 66222, 66225-66226. The RBRVS itself, as adopted by division rule, is found at Addendum B, Medicare Resource-Based Relative Value Scale, 72 Federal Register, No. 227, November 27, 2007. OAR 436-009-0004(1).

The distinction between the CPT® and RBRVS is significant because the issue here concerns charges for hospital services. As will be explained below, the RBRVS does not provide an assigned value for non-physician radiologic services performed in a hospital. Addendum B, Medicare Resource-Based Relative Value Scale, 72 Federal Register, No. 227, November 27, 2007, at pp. 66488-66516.

The division's rule specifically adopts only certain columns of the RBRVS. The adopted columns include "Year 2008 Transitional Facility PE RVU's" and "Year 2008 Transitional Non-Facility PE RVU's." OAR® 436-009-0004(1). The difference is that "Facility" RVU's are for procedures performed in a hospital and the "Non-Facility" column is for services not provided in a hospital, such as those provided at a doctor's office. (See OAR 436-009-0040(4)(a)).[6]

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[6] OAR 436-009-0040(4)(a) provides in part:

> "The PE RVU is determined by the location where the procedure is performed. If the procedure is performed inside the medical service provider's office, use Year 2008 transitional non-facility PE

The distinction between the facility and non-facility charge categories is important because both of those categories are affected by another piece of information in the table. The RVU's for radiology are found in the RBRVS at the 70000 sequence CPT® codes. Another column in the table, the "Mod" column, modifies RVU's to provide for separate elements of a given procedure. The "Mod" column distinguishes between charges for "technical components" and "professional components" of a single procedure. The purpose of distinguishing between facility and non-facility services, and between the professional and technical components, is to be able to pay doctors for services they provide at a hospital, and for non-physician services and expenses incurred as part of a procedure performed at the doctor's office. 72 Federal Register, No. 227, November 27, 2007, pp. 66225-66227, 66488-66516; OAR 436-009-0040(4).

In the columns the division's rule adopts, under the codes for radiologic procedures, the RVU given for technical, facility services, is "NA." Addendum B, Medicare Resource-Based Relative Value Scale, 72 Federal Register, No. 227, November 27, 2007. The "NA" means there is not an RVU for the service identified at that column entry. This means that, while there may be a CPT® for radiologic services, there is not an RBRVS for the non-physician-provided portion of radiologic services performed at a hospital. Thus, the fee for these services is not found in the CPT®-based section of the division's fee schedule, but in the adjusted cost/charge ratio segment of the fee schedule.

SAIF contends language in related rules should be read as supporting its interpretation of OAR 436-009-0020. SAIF points out that OAR 436-009-0050(4) establishes billing limits and conditions for certain radiologic services which are expressly supplementary to the CPT®.[7] SAIF asserts this supports its position that radiologic services should be billed under the CPT®. This rule actually controverts SAIF's argument.

RVU's column; if the procedure is performed outside the medical service provider's office, use Year 2008 transitional facility PE RVU's column."

[7] OAR 436-009-0050 provides in part:

> ". . . The definitions, description, and guidelines found in CPT® shall be used as guides governing the descriptions of services, except as otherwise provided in these rules. The following provisions are in addition to those provided in each section of CPT®.
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> * * * * *
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> (4) Radiology services.
> (a) In order to be paid, x-ray films must be of diagnostic quality and include a report of the findings. Billings for 14" x 36" lateral views shall not be paid.
> (b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), the technical component for the first area examined shall be paid at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent under these rules. The discount applies to multiple studies done within 2 days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days. No reduction is applied to multiple areas for the professional component."

First, the rule distinguishes between the "technical" and "professional" components of radiologic services. The RBRVS makes this same distinction and it is obvious from the context that "professional" services refers to physicians while "technical" services are those provided by non-physicians. The RBRVS and this rule therefore categorize and value services provided by physicians and non-physicians differently, which is consistent with the division's interpretation of rule 0020.

Second, as discussed above, the RBRVS, as attached to the CPT®, does provide values for some radiologic services. However those services are ones provided outside of a hospital. The present case concerns charges for services provided at a hospital. The language of this rule is meaningful and not superfluous at the very least because the language applies to the CPT® and RBRVS systems when they address non-hospital charges.

Finally, the limitations in this rule can easily be read as limitations on charges for radiologic services whether or not they are based in the CPT® because the rule states its requirements ". . . are in addition to those provided in each section of CPT®."As explained above, charges for radiologic technologist services provided in a doctor's office will not be subject to the cost/charge ratio and therefore will be calculated under the CPT®. The limits set in OAR 436-009-0050(4) will apply to all of the radiologic services they describe, whether they are performed in a doctor's office and billed for under the CPT®, or performed in a hospital and billed under the cost/charge ratio. The language of this rule does not contradict the division's interpretation of OAR 436-009-0020 and can be interpreted to be consistent with that rule.

SAIF also argues the rule should be interpreted to require that radiologic technologist services be billed under the CPT® because the fiscal impact statement filed with the proposed rule amendment stated there would be a minimal financial impact. SAIF presented testimony at this hearing that there will be a large financial impact on insurers if the rule is interpreted as it has been by the resolution team and the ALJ. SAIF reasons backwards from this information to conclude the division did not intend to change the billing procedures for radiologic technologists.

The division expressed its intent in developing the rule. The division stated at meetings on the proposed rule and in the adoption order that the changes were intended as a clarification. Minutes of 11/21/05 OAR 436-009 Advisory Committee Meeting, p. 6, Ex. E to WCD's Response to Exceptions; Admin. Order 06-052, eff. April 1, 2006. This is consistent with the division's view expressed in the fiscal impact statement that its intent was not to create substantial changes in the rule. The division's understanding was that radiologic technologist services were previously not supposed to be charged under the CPT® and that restating the rule would only clarify what was understood to be the existing practice.

SAIF participated in the development of the rule changes before their implementation. SAIF had the opportunity to challenge the rule's wording and the fiscal impact statement and to offer its own evidence on fiscal impact. SAIF did not do so. If SAIF was previously following a billing practice that was contrary to the rule's intent, and the division took steps to clarify that intent, SAIF cannot now argue that the division should interpret its rule in a manner that enables SAIF to continue a practice that has been contrary to the rule's purpose all along.

SAIF further argues there is a conflict between the language of two provisions of the fee schedule rules that therefore requires that radiologic technologists be paid under the CPT®. OAR 436-009-0040 generally states rules for setting medical provider fees. OAR 436-009-0020 establishes a procedure specific to calculating hospital fees. SAIF seems to argue that applying the cost/charge ratio to charges for radiologic technologist services provided in a hospital somehow establishes a fee system that is outside of the normal "fee schedule" for medical services established in OAR 436-009-0040.

The relevant rules make clear that the cost/charge ratio is part of the fee schedule. OAR 436-009-0004 (1) adopts columns of the RBRVS, including CPT® codes, as the basis for the fee schedule "except as otherwise provided in these rules." Section (3) of the same rule states the rules adopt the CPT® ". . .except as otherwise provided in these rules." Section (4) of the same rule states: "Specific provisions contained in OAR 436, division . . . 009 . . . control over any conflicting provision in . . . CPT© 2008 . . . ." Thus, the rules which adopt the CPT® as the basis for the fee schedule at the outset expressly state there are exceptions where the CPT® does not apply and further state that the rules control where they differ from the CPT®. The cost/charge ratio is an additional, valid, basis for portions of the fee schedule.

Adopting SAIF's logic would render OAR 436-009-0020 meaningless, as SAIF argues all fees should be set exclusively under rule 436-009-0040. Rule 0040 deals with setting provider fees generally while rule 0020 is labeled "hospital fees." Rule 0040 thus applies where no more specific rule gives guidance and rule 0020 applies when the fee to be determined is for hospitals. To interpret the rules otherwise would render rule 0020 superfluous and meaningless.

SAIF also argues this interpretation of the rule conflicts with the concept that the fee schedules are supposed to be based on what is deemed the customary fee for a service. ORS 656.248(1). SAIF contends the CPT® represents the average reimbursement for radiologic technologist services. As described above, the CPT®/RBRVS does not set a value for radiologic technologist services provided in a hospital. The cost/charge ratio also represents a reasonable reflection of costs because the ratio is based on a hospital's actual operational costs. OAR 436-009-0020(3). The cost/charge ratio is applied to the hospital's standard fee and an insurer can ask the director to review a fee it believes is excessive. OAR 436-009-0020(2). 436-009-0040(3). The cost/charge ratio is therefore consistent with the principles contained in the fee schedule.

IT IS HEREBY ORDERED

The April 17, 2008 administrative order and July 19, 2008 proposed and final orders are affirmed.

DATED this 1st day of December, 2008.