

OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
 WORKERS' COMPENSATION DIVISION  
 OREGON MEDICAL FEE AND PAYMENT RULES

REVISION-MARKED COPY

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EFFECTIVE JULY 1, 2003

OREGON ADMINISTRATIVE RULES  
 CHAPTER 436, DIVISION 009

NOTE: Only adopted, amended, and repealed rules are included in this document:

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**436-009-0004 Adoption of Standards**

(1) The director adopts, by reference, the Centers for Medicare & Medicaid Services (CMS) 200[2]**3** Medicare Resource-Based Relative Value Scale[System] (RBRVS) Addendum B "Relative Value Units (RVUs) and Related Information" except the "status indicators," and Addendum C "Codes with Interim RVUs," 6[6] 7 *Federal Register* No. 251[2], [November 1]**December 31**, 200[1]**2** as the fee schedule for payment of medical service providers except as otherwise provided in these rules.

(2) The director adopts, by reference, the *American Society of Anesthesiologists (ASA), Relative Value Guide 200[2]**3*** as a supplementary fee schedule for payment of anesthesia service providers except as otherwise provided in these rules for those anesthesia codes not found in the Federal Register.

(3) The director adopts *Current Procedural Terminology (CPT<sup>®</sup>[<sup>TM</sup>] 200[2]**3**)*, Fourth Edition Revised, 200[1]**2** for billing by medical [service] providers except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

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(4) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 shall control over any conflicting provision in Addenda B and C, 6[6]7 Federal Register No. 251[2], [November 1] **December 31**, 200[1]2, ASA Relative Value Guide 200[2]3, or CPT<sup>®</sup>[TM] 200[2]3.

**Stat Auth:** ORS656.248, 656.726(4)

**Stats Implemented:** ORS656.248

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#### **436-009-0005 Definitions**

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made part of these rules.

(a) Durable medical equipment (DME) is equipment which is primarily and customarily used to serve a medical purpose, can withstand repeated use, appropriate for use in the home, and not generally useful to a person in the absence of an illness or injury.

(b) Medical supplies are expendable materials including, but not limited to, incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(c) Ambulatory surgical center (ASC) is any distinct entity licensed by the state of Oregon and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization. Any ambulatory surgical center outside of Oregon must meet similar licensing requirements, or be certified by Medicare or a nationally recognized agency.

(2) Abbreviations used in these rules are defined as follows:

(a) ADA means American Dental Association

(b) ASA means American Society of Anesthesiologists

(c) ASC means ambulatory surgical center

(d) CARF means Commission on Accreditation of Rehabilitation Facilities

(e) CMS means Centers for Medicare & Medicaid Services **(formerly HCFA, Health Care Financing Administration)**

(f) CPT<sup>®</sup>[TM] means Current Procedural Terminology

(g) DME means Durable Medical Equipment

(h) DMSO means Dimethyl sulfoxide

(i) DRG means diagnosis related group

(j) EDI means Electronic Data Interchange

(k) EMG means electromyography

(l) HCFA means Health Care Financing Administration **(former name of CMS)**

(m) HCPCS means [HCFA (Health Care Financing Administration)] **Healthcare** Common Procedure

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Coding System

(n) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3

(o) JCAHO means Joint Commission on Accreditation of Healthcare Organizations

(p) MCO means Managed Care Organization

(q) MRI means magnetic resonance imaging

(r) NCPDP means National Council for Prescription Drug Programs

(s) NPI[N] means National [Practitioner] **Provider Identifier**[cation Number]

(t) OSC means Oregon specific code

(u) PCE means physical capacity evaluation

(v) RBRVS means Medicare Resource-Based Relative Value [System]**Scale**

(w) RVU means relative value unit

(x) TC means technical component

(y) UB means Universal Billing

(z) WCE means work capacity evaluation

**Stat. Auth.:** ORS656.726(4)

**Stats. Implemented:** ORS656.726(4)

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**436-009-0008 Administrative Review, Fee Disputes and Contested Cases**

Administrative review before the director:

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical fees and non-payment of compensable medical bills. A party need not be represented to participate in the administrative review before the director except as provided in ORS chapter 183 and OAR chapter 436, division 001.

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

(c) All issues pertaining to disagreement about medical fees or non-payment of bills within an MCO are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting administrative review of the matter by the director. If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the

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medical provider or worker that they may request review by the director.

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. Administrative review by the director must be requested within 60 days of receipt of the MCO's final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process.

(b) For all claims not enrolled in an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

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

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

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

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

(b) Specify the issues in dispute and the relief sought.

(c) Provide the specific dates of the unpaid disputed treatment.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original HCFA/CMS bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that the involved parties have been provided a copy of the request for review and attached supporting documentation and, if known, that there is no issue of causation or compensability of the underlying claim or condition.

(4) The division shall investigate the matter upon which review was requested.

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(a) The investigation may include, but shall not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider's peers.

(b) Upon receipt of a written request for additional information, the party shall have 14 days to respond.

(c) Pursuant to section (5) of this rule, within 30 days of the administrative order, any party may appeal to a contested case before the director.

(5) Contested cases before the director: Pursuant to 183.310 through 183.550, as modified by OAR Chapter 436, Division 001 and ORS 656.704(2), any party that disagrees with an action or order of the director pursuant to these rules, may request a contested case before the director. For purposes of these rules, "contested case" has the meaning prescribed in ORS 183.310(2) and OAR chapter 436 division 001. A party may appeal to the director as follows:

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

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

(6) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as described in OAR 436-010-0008 (14).

(7) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (6) of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

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

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

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (5) of this rule.

**Stat. Auth.:** ORS 656.704, 656.726(4)

**Stats. Implemented:** ORS 656.704

**Hist:** Renumbered from OAR 436-010-0110(1), (2), (3), (4), and (5) to OAR 436-009-0008(2), (3), (4), and (5);  
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**436-009-0010 General Requirements for Medical Billings**

(1) Only treatment that falls within the scope and field of the practitioner's license to practice will be paid under a worker's compensation claim.

(2) All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a current [form]UB92 or [form]HCFA/CMS 1500 form, except for:

(a) dental billings which shall be submitted on ADA dental claim forms;

(b) pharmacy billings, which shall be submitted on the most current NCPDP form;

(c) EDI transmissions of medical bills pursuant to OAR 436-009-0030(3)(c). Computer-generated reproductions of these forms may also be used. Billings shall include the worker's full name, date of injury, the employer's name and, if available, the insurer's claim number.

(3)(a) All original medical provider billings shall be accompanied by legible chart notes documenting services which have been billed, and identifying the person performing the service and license number of person providing the service. Medical doctors are not required to provide their medical license number if they are already providing other identification such as tax identification, NPI<sup>[N]</sup>, and social security numbers.

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) Codes listed in CPT<sup>®</sup>[<sup>TM</sup>] 200<sub>[2]</sub>3 or Oregon Specific Codes (OSC) shall be used when billing medical services. All billings shall be fully itemized and include ICD-9-CM codes. Services shall be identified by the code numbers and descriptions provided in these rules.

(a) If there is no specific code for the medical service, the medical provider shall use the appropriate unlisted code at the end of each medical service section of CPT<sup>®</sup>[<sup>TM</sup>] 200<sub>[2]</sub>3 and provide a description of the service provided.

(b) Any service not identifiable with a code number shall be adequately described by report.

(5) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings may be subject to discounts, not to exceed 10 percent for each 30 day period or fraction thereof, beyond 60 days, provided the medical provider has notice or knowledge of the responsible workers' compensation insurer or processing agent.

(6) Rebillings shall indicate that the charges have been previously billed.

(7) The medical provider shall bill their usual and customary fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons

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who receive medical services subject to specific billing arrangements allowed under the law which require providers to bill other than their usual fee.

(8) Medical providers shall not submit false or fraudulent billings. As used in this section, "false or fraudulent" shall mean an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. The medical provider shall not bill for services not provided.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but in no event later than 30 days following receipt of the request. Thereafter, worker copies shall be furnished during the regular billing cycle.

**Stat. Auth.:** ORS 656.245, 656.252, 656.254

**Stats. Implemented:** ORS 656.245, 656.252, 656.254

**Hist:** Renumbered from OAR 436-010-0010(5) and (6) to OAR 436-009-0010(1) and (2);  
from 436-010-0040(3)(d) and (e) to 436-009-0010(3) and (4);  
from 436-010-0040(7) and (9) to 436-009-0010(4) and (5);  
from 436-010-0040(11) to 436-009-0010(11); and  
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#### **436-009-0015 Limitations on Medical Billings**

(1) An injured worker shall not be liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer pursuant to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment that has not been prescribed by the attending physician or specialist physician upon referral of the attending physician. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period as set forth in OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director pursuant to OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has

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been determined to be unscientific, unproven, outmoded, or experimental pursuant to OAR 436-010-0300.

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3) of this rule.

(3) The preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service.

(4) No fee shall be paid for the completion of a work release form or completion of a [physical capacity evaluation] **PCE** form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or the department or for a Worker Requested Medical Examination. Except as provided in OAR 436-009-0070 (10)(d), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider shall be paid at 50 percent of the examination or testing fee. A medical arbiter may also receive payment for a file review as determined by the director.

(6) Pursuant to ORS 656.245 (3), the director has excluded from compensability the following medical treatment. While these services may be provided, medical providers shall not be paid for the services or for treatment of side effects.

- (a) DMSO, except for treatment of compensable interstitial cystitis,
- (b) Intradiscal electrothermal therapy (IDET),
- (c) Surface EMG tests,
- (d) Rolwing,
- (e) Prolotherapy, and
- (f) Thermography.

(7) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician: once near the beginning, once near the middle, and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient.

(9)(a) When a physician provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's office, such services shall be identified by CPT<sup>®</sup>[<sup>TM</sup>] codes and paid according to the fee schedule.

(b) 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. Diagnostic testing done prior to inpatient treatment

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shall be considered part of the hospital services subject to the hospital fee schedule.

(10) Physician assistant or nurse practitioner fees shall be paid at the rate of 80 percent of a physician's **allowable** fee for a comparable service. The bills for services by these providers shall be marked with modifier "81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(11) **Except as otherwise provided in OAR 436-009-0070**, [W]hen a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT<sup>®</sup>[TM] Codes such as 99080. Refer to specific code definitions in the CPT<sup>®</sup>[TM] for other applicable codes. The billing should include the actual time spent reviewing the records or reports.

**Stat. Auth.:** ORS 656.245, 656.252, 656.254

**Stats. Implemented:** ORS 656.245, 656.252, 656.254

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#### **436-009-0020 Hospital Fees**

(1) Hospital inpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes. Unless otherwise provided for by a governing MCO contract, insurers shall pay hospitals for inpatient services using the current adjusted cost/charge ratio (see Bulletin 290). For purposes of this rule, hospital inpatient services include, but are not limited to, those bills coded "111" through "118" in space #4 on the UB92 billing form. The audited bill shall be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes, CPT<sup>®</sup>[TM] codes, HCPCS codes, and NDC codes, where applicable. Unless otherwise provided for by a governing MCO contract, insurers shall pay hospitals for outpatient services according to the following: the insurer shall first separate out and pay charges for services covered under the CPT<sup>®</sup>[TM] and RBRVS. These charges should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the non-facility total column. All other charges billed using both the hospital name and tax identification number will be paid as if provided by the hospital.

(3) Each hospital's HCFA/CMS [Form] 2552 **form** and financial statement shall be the basis for determining its adjusted cost/charge ratio. **If a current 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost/charge ratio is determined from estimated data, the hospital will receive the lower ratio of (1) the hospital's last published cost/charge ratio or, (2) the hospital's cost/charge ratio based on estimated data.**

(a) The basic cost/charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (b), by the total patient

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revenues from Worksheet G-2.

(b) The net expenses for allocation derived from Worksheet A shall be modified by adding, from Worksheet A-8, the expenses for:

- (A) Provider-Based physician adjustment;
- (B) Provider-Based physician adjustment - general services cost center;
- (C) Telephone service;
- (D) Television and radio service; and
- (E) Expenses identified as for physician recruitment.

(c) The basic cost/charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost/charge ratio calculated in (3)(a) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate, and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's HCFA/CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(e) The factors resulting from subsections (3)(c) and (3)(d) of this rule will be added to the ratio calculated in subsection (3)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(f) The adjusted cost/charge ratio for each hospital <sup>[shall]</sup>**will** be revised annually, at a time based on their fiscal year, as prescribed by bulletin. Each hospital shall submit a copy of their HCFA/CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Management Division, Department of Consumer and Business Services. The adjusted cost/charge ratio schedule <sup>[shall]</sup>**will** be published by bulletin twice yearly,<sup>[on or before March 20 of each year]</sup> to be effective for the <sup>[subsequent]</sup> six-month period beginning April 1, and <sup>[on or before September 20 of each year]</sup> to be effective for the <sup>[subsequent]</sup> six-month period beginning October 1.

(g) For those newly formed or established hospitals for which no HCFA/CMS 2552 has been filed, or for those hospitals that do not file Worksheet G-2 with the submission of their HCFA/CMS <sup>[form]</sup>2552, the division shall determine an adjusted cost/charge ratio for the hospital based upon the adjusted cost/charge ratios of a group of hospitals of similar size and/or geographic location.

(h) If the financial circumstances of a hospital unexpectedly and/or dramatically change, the division may revise the hospital's adjusted cost/charge ratio to allow equitable payment.

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(i) If audit of a hospital's HCFA/CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost/charge ratio to reflect the data developed subsequent to the initial calculation.

(j) Notwithstanding subsections (c) through (i) of this section, the cost/charge ratio shall be 1.000 for out-of-state hospitals, unless a lower rate is negotiated between the insurer and the hospital.

(k) Notwithstanding section (1) and (2) of this rule, the director may exclude rural hospitals [as defined in ORS 442.470] from imposition of the adjusted cost/charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index, as originally developed by Dr. William Cleverley. All rural hospitals having a financial flexibility index at or below the median for hospitals nationwide with a bond rating of BBB+, BBB, or BBB- will qualify for the rural exemption. **Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost/charge ratio.**

**Stat. Auth.:** ORS 656.726(4), **also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)**

**Stats. Implemented:** ORS 656.248; sec. 2, ch. 771, Oregon Laws 1991; 656.252; 656.256

**Hist:** Renumbered from OAR 436-010-0090(1) thru (4), (7) thru (32) to OAR 436-009-0020(1) thru (29), (32) and (33);  
from OAR 436-010-0040(4)(b)(A) and (c) to OAR 436-009-0020(30) and (31);  
from OAR 436-010-0047(6) and (7) to OAR 436-009-0020(34) thru (37), and;  
filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96

Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97

Amended 4-21-97 as Admin. Order 97-053, eff. 7-1-97

Amended 7-9-97 as WCD Admin. Order 97-056, eff. 7-9-97 (Temp)

Amended 12-15-97 as WCD Admin. Order 97-056, eff. 12-15-97

Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98

Amended 5/27/99 as Admin. Order 99-057, eff. 7/1/99

Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01

Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02

**Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03**

#### **436-009-0022      Ambulatory Surgical Center Fees**

(1) Bills from an ASC shall be submitted on HCFA/CMS[-]\_1500 **form**. The modifier "SG" shall be used to identify facility charges.

(2) Fees shall be paid at the usual and customary fee, or in accordance with the fee schedule, whichever is less. For all MCO enrolled claims, payment of fees shall be as provided by the MCO contract, at the provider's usual and customary fee, or according to the fee schedule, whichever is less.

(3) Payment shall be made using the Medicare ASC groups, except:

(a) Arthroscopies (CPT<sup>®</sup>[TM] codes [29815]**29819** through 29898 except 29888 and 29889) are paid as Group 6.

(b) Arthroscopies (CPT<sup>®</sup>[TM] codes 29888 and 29889) are paid as Group 7.

(c) Procedures not listed in the Medicare ASC groups shall be paid at the provider's usual and customary rate.

(4) The ASC fee schedule is:

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Group 1	\$ 853.28
Group 2	\$ 1,143.88
Group 3	\$ 1,307.68
Group 4	\$ 1,616.75
Group 5	\$ 1,838.68
Group 6	\$ 2,108.00
Group 7	\$ 2,551.95
Group 8	\$ 2,485.78

(5) The ASC fee includes services, such as:

- (a) Nursing, technical, and related services;
- (b) Use of the facility where the surgical procedure is performed;
- (c) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of the surgical procedure;
- (d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- (e) Administrative, record-keeping, and housekeeping items and services;
- (f) Materials for anesthesia; and
- (g) Supervision of the services of an anesthetist by the operating surgeon.

(6) The ASC fee does not include services, such as physicians services, laboratory, x-ray or diagnostic procedures not directly related to the surgical procedure, prosthetic devices, orthotic devices, durable medical equipment, and anesthetists services.

(7) When multiple procedures are performed, the highest payment group shall be paid at 100% of the maximum allowed fee. Each additional procedure shall be paid at 50% of the maximum allowed fee.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.248; 656.252

**Hist:** Adopted 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02

**Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03**

### **436-009-0030 Insurer's Duties and Responsibilities**

(1) The insurer shall pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(2) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0070(1). If the evaluation of the records must be conducted on-site, the provider shall furnish a reasonable work-site for the records to be reviewed at no cost. These records shall be provided or made available for review within 14 days of a request.

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(3) Insurers shall date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form must be returned or a request for chart notes on EDI billings must be made, to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer shall retain a copy of each medical provider's bill received by the insurer or shall be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2) and insurer action, for any fee reduction other than a fee schedule reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(b) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided.

(c) When a medical provider renders a bill via EDI, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(5) Failure to pay for medical services timely may render insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(6) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer shall, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code. Resolution of billing disputes shall be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(7) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(8) The insurer shall establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, 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. The insurer shall provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation shall include, but not be limited to, medical bills, internal audit forms, and

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any medical charge summaries prepared by private medical audit companies.

(9) Insurers [and self-insurers] that have at least 100 accepted disabling claims in a calendar year, as determined by the director, are required to transmit detailed medical service and billing data to the Information Management Division of the Department of Consumer and Business Services. Once an insurer has been determined to have the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. In such circumstances, the insurer may apply for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will publish a bulletin identifying the affected insurers and advising the insurers of the data and format requirements for data transmission;

(b) The data shall include all payments made during each calendar quarter for medical services which are covered by the department's fee schedules. These fee schedules include anesthesiology, surgery, radiology, laboratory and pathology, medicine, physical medicine **and rehabilitation**, evaluation and management services, multidisciplinary and other Oregon-specific codes, all hospital services, pharmacy, and durable medical equipment;

(c) The affected insurers shall submit the medical data within 45 days of the end of each calendar quarter. However, a grace period of two calendar quarters may be granted for revised requirements and also for insurers which are newly affected by these requirements.

(d) Data Quality: The director will conduct electronic edits for blank or invalid data. Listed insurers are responsible for pre-screening the data they submit to check that all the required information is reported. Files which have more than five percent missing or invalid data in any field, based on initial computerized edits, will be returned to the insurer for correction and must be resubmitted within three weeks (21 days) from the date it was returned by the department.

(e) Audit Quality: The director may also conduct field audits of actual payments reported for individual claims. When an audit occurs, in order to be in compliance with this rule and OAR 436-010-0275(10), audited data must have no more than 15 percent inaccurate data in any field.

**Stat. Auth.:** ORS656.726(4)

**Stats. Implemented:** ORS656.252, 656.325, 656.245, 656.248, 656.260, 656.264

**Hist:** Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82  
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84  
Renumbered from OAR 436-69-801, eff. 5/1/85  
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86  
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88  
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88  
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90  
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)  
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Renumbered from OAR 436-010-0100(8) thru (15), (27) and (28) to OAR 436-009-0030 and  
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Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98  
Amended 5/27/99 as Admin. Order 99-057, eff. 7/1/99  
Amended 03/15/00 as Admin. Order 00-051, eff. 04/01/00

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Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02  
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03

**436-009-0040      Calculating Medical Provider Fees**

(1) Medical fees shall be paid at the provider's usual and customary fee or in accordance with the fee schedule whichever is less. For all MCO enrolled claims, payment of medical fees shall be at the provider's usual and customary fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract.

(2)(a) When using RBRVS, the RVU is determined by reference to the appropriate CPT<sup>®</sup>[TM] code. Where the procedure is performed inside the medical service provider's office, use Year 200[2]3 non-facility total column. Where the procedure is performed outside the medical service provider's office, use Year 200[2]3 facility total column. Use the global column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Year 200[2]3 non-facility total column. No other column applies.

(b) When an Oregon Specific Code is assigned, the RVU for multidisciplinary program services is found in OAR 436-009-0060(5), or for other services in OAR 436-009-0070 (1[2]3).

(c) When using the ASA Relative Value Guide, a basic unit value is determined by reference to the appropriate Anesthesia code. The basic unit value includes unit value, time units, and modifying units.

(3) Payment according to the fee schedule shall be determined by multiplying the assigned RVU or basic unit value by the applicable conversion factor. Where the code is designated by an RVU of "0.00" or IC (individual consideration) for Anesthesia codes, it shall be paid at the provider's usual and customary rate.

(4) The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical professionals.

<b>Service Categories</b>	<b>Conversion Factors</b>
Evaluation / Management	\$ [55.70] <b><u>66.84</u></b>
Anesthesiology	\$ [45.42] <b><u>52.23</u></b>
Surgery	\$ 91.53
Radiology	\$ [78.17] <b><u>66.45</u></b>
Lab & Pathology	\$ [89.43] <b><u>58.63</u></b>
Medicine	\$ [89.43] <b><u>73.33</u></b>
Physical Medicine and Rehabilitation	\$ [66.42] <b><u>64.29</u></b>
Multidisciplinary and Other Oregon-Specific Codes	\$ [9.53] <b><u>58.63</u></b>

**Stat. Auth.:** ORS 656.726(4)  
**Stats. Implemented:** ORS 656.248  
**Hist:** Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99  
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Amended 2/25/02 as WCD Admin. Order 02-052, eff. 4/1/02  
Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03

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**436-009-0050 CPT<sup>®</sup>[TM] Sections**

Each CPT<sup>®</sup>[TM] section has its own schedule of relative values, completely independent of and unrelated to any of the other sections. The definitions, descriptions, and guidelines found in CPT<sup>®</sup>[TM] 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<sup>®</sup>[TM].

(1) Evaluation and Management services.

(2) Anesthesia services.

(a) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(b) Anesthesia basic unit values are to be used only when the anesthesia is personally administered by either a licensed physician or nurse anesthetist who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

(c) When a regional anesthesia is administered by the attending surgeon, the value shall be the "basic" anesthesia value only without added value for time.

(d) When the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the modifier "NT" (no time) shall be noted on the bill.

(e) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the relative value unit for the surgical procedure.

(3) Surgery services.

(a) When a worker is scheduled for elective surgery, the immediate pre-operative visit, in the hospital or elsewhere, necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed global value of the surgical procedure. If the procedure is not elective, the physician is entitled to payment for the initial evaluation of the worker in addition to the global fee for the surgical procedure(s) performed.

(b) When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

(c) Multiple surgical procedures performed at the same session shall be paid as follows:

(A) When multiple surgical procedures are performed by one surgeon, the principal procedure is paid at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures are paid at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid accordingly.

(B) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures

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paid at 50 percent of the value listed.

(C) When more than one surgeon performs surgery, each procedure shall be billed separately. The maximum allowable fee for each procedure, as listed in these rules, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation, each is entitled to an additional fee of 20 percent of the other surgeon's allowable 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' allowable fees.

(D) When a surgeon performs surgery following severe trauma that requires considerable time, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. Such a request must be accompanied by written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(E) When a surgical procedure is performed bilaterally, the modifier "-50" shall be noted on the bill for the second side, and paid at 50% of the fee allowed for the first side.

(d) Physician assistants or nurse practitioners shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The bills for services by these providers shall be marked with a modifier "-81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The operation report shall document who assisted.

(4) Radiology services.

(a) In order to be paid, x-ray films must be of diagnostic quality. Billings for 14" x 36" lateral views shall not be paid. Billings for X-rays shall not be paid without a report of the findings.

(b) When multiple areas are examined by CAT scan or MRI, 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 of these rules.

(5) Pathology and Laboratory services.

(a) The laboratory and pathology conversion factor applies only when there is direct physician involvement.

(b) Laboratory fees shall be billed in accordance with ORS 676.310. If any 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 physician charges.

(6) Medicine services.

(7) Physical Medicine and Rehabilitation services.

(a) Increments of time for a time-based CPT<sup>®</sup>[TM] code shall not be prorated.

(b) Payment for modalities and therapeutic procedures shall be limited to a total of three

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separate CPT<sup>®</sup>[TM]-coded services per day. CPT<sup>®</sup>[TM] codes 97001, 97002, 97003, or 97004 are not subject to this limit. An additional unit of time (15 minute increment) for the same CPT<sup>®</sup>[TM] code is not counted as a separate code.

(c) All modality codes requiring constant attendance (97032, 97033, 97034, 97035, 97036, and 97039) are time-based. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day.

(d) CPT<sup>®</sup>[TM] codes 97010 through 97028 shall not be paid unless they are performed in conjunction with other procedures or modalities which require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by a machine, device or table there shall be a notation on the bill that treatments were provided simultaneously by a machine, device or table and there shall be one charge.

**Stat. Auth.:** ORS656.726(4)

**Stats. Implemented:** ORS656.248

**Hist:** Filed 5/27/99 as Admin. Order 99-057, eff. 7/1/99

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#### **436-009-0060 Oregon Specific Code, Multidisciplinary Services**

(1) Services provided by multidisciplinary programs not otherwise described by CPT<sup>®</sup>[TM] codes shall be billed under Oregon-Specific Codes.

(2) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program shall not be paid unless the program is accredited for that purpose by the CARF or the JCAHO.

(a) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to 6 months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(b) Notwithstanding OAR 436-009-0010(4), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(c) All job site visits and ergonomic consultations must be preauthorized by the insurer.

(3) When an attending physician approves a multidisciplinary treatment program for an injured worker, the attending physician must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Billings using the multidisciplinary codes must include copies of the treatment record which specifies the type of service rendered, the medical provider who provided the service,

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whether treatment was individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(5) The table below lists the **Oregon Specific Codes for Multidisciplinary Services**.

<b><u>Codes</u></b>	<b><u>Relative Value</u></b>	<b><u>Description</u></b>
97642	[5.6] <b><u>0.91</u></b>	Physical conditioning - group - 1 hour Conditioning exercises and activities, graded and progressive
97643	[2.8] <b><u>0.46</u></b>	Each additional 30 minutes
97644	[8.9] <b><u>1.45</u></b>	Physical conditioning – individual 1 hour Conditioning exercises and activities, graded and progressive
97645	[4.5] <b><u>0.73</u></b>	Each additional 30 minutes
97646	[5.6] <b><u>0.91</u></b>	Work simulation - group 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors
97647	[2.8] <b><u>0.46</u></b>	Each additional 30 minutes
97648	[9.2] <b><u>1.50</u></b>	Work simulation - individual 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors
97649	[4.6] <b><u>0.75</u></b>	Each additional 30 minutes
97650	[5.0] <b><u>0.81</u></b>	Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals
97651	[2.5] <b><u>0.41</u></b>	Each additional 15 minutes
97652	[3.3] <b><u>0.54</u></b>	Therapeutic education - group 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals
97653	[1.7] <b><u>0.28</u></b>	Each additional 15 minutes
97654	[2.5] <b><u>0.41</u></b>	Professional Case Management – Individual 15 minutes Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician)
97655	[2.4] <b><u>0.39</u></b>	Brief Interdisciplinary Rehabilitation Conference - 10 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits
97656	[4.8] <b><u>0.78</u></b>	Intermediate Interdisciplinary Rehabilitation Conferences - 20 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits

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97657	[8.3] <b><u>1.35</u></b>	Complex Interdisciplinary Rehabilitation Conferences – 30 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits
97658	[4.2] <b><u>0.68</u></b>	Each additional 15 minutes Complex conference-up to 1 hour maximum
97659	[10.6] <b><u>1.72</u></b>	Job site visit - 1 hour (includes travel) - must be preauthorized by insurer A work site visit to identify characteristics and physical demands of specific jobs
97660	[5.3] <b><u>0.86</u></b>	Each additional 30 minutes
97661	[14.3] <b><u>2.32</u></b>	Ergonomic consultation - 1 hour (includes travel) - must be preauthorized by insurer Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications
97662	[5.8] <b><u>0.94</u></b>	Vocational evaluation - 30 minutes Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options
97663	[2.9] <b><u>0.47</u></b>	Each additional 15 minutes
97664	[7.8] <b><u>1.27</u></b>	Nursing evaluation - 30 minutes Nursing assessment of medical status and needs in relationship to rehabilitation
97665	[3.9] <b><u>0.63</u></b>	Each additional 15 minutes
97666	[6.3] <b><u>1.02</u></b>	Nutrition evaluation - 30 minutes Evaluation of eating habits, weight and required modifications in relationship to rehabilitation
97667	[3.2] <b><u>0.52</u></b>	Each additional 15 minutes
97668	[6.6] <b><u>1.07</u></b>	Social worker evaluation - 30 minutes Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome
97669	[3.3] <b><u>0.54</u></b>	Each additional 15 minutes
97670	[41.2] <b><u>6.70</u></b>	Initial Multidisciplinary conference - up to 30 minutes
97671	[46.5] <b><u>7.56</u></b>	Initial Complex Multidisciplinary conference - up to 60 minutes

**Stat. Auth.:** ORS656.726(4)  
**Stats. Implemented:** ORS656.248  
**Hist:** Filed 5/26/99 as Admin. Order 99-057, eff. 7/1/99  
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**Amended 5/28/03 as WCD Admin. Order 03-055, eff. 7/1/03**

**436-009-0070 Oregon Specific Code, Other Services**

(1) Copies of requested medical records shall be paid under OSC-R0001.

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(2) A brief narrative by the attending physician, including a summary of treatment to date and current status, and, if requested, brief answers to one to five specific questions related to the attending physician's current or proposed treatment, shall be paid under OSC-N0001.

(3) A complex narrative by the attending physician may include past history, history of present illness, attending physician's treatment to date, current status, impairment, prognosis, and medically stationary information, shall be paid under OSC-N0002.

(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable payment shall be as follows:

(a) **FIRST LEVEL PCE:** This is a limited evaluation to measure the functional performance testing of a specific body part. This level requires not less than 45 minutes of actual patient contact. A first level PCE shall be paid under OSC-99196 which includes the evaluation and report. Additional 15-minute increments may be added for each additional body part to establish endurance (e.g. cardiovascular), or to project tolerances (e.g. repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(b) **SECOND LEVEL PCE:** This is a PCE requested by the insurer, or attending physician, to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level requires not less than two hours of actual patient contact. The second level PCE shall be paid under OSC-99197 which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be necessary to establish endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(c) [WORK CAPACITY EVALUATION]**WCE:** This is a residual functional capacity evaluation with special emphasis on the ability to perform essential physical functions of the job based on specific job analysis. This level requires not less than 6 hours of actual patient contact. The primary purpose of this evaluation is to establish if a worker can return to work at a specific job(s). A WCE shall be paid under OSC-99198 which includes the evaluation and report.

(d) In addition, if requested, a musculoskeletal evaluation (e.g., ROM, strength, sensory, etc.) with up to 30 minutes of actual patient contact for the first body part may be added to a first level PCE, second level PCE or WCE. An additional 15 minutes may be requested for each additional body part tested. Musculoskeletal evaluation and each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(5) When an attorney requires a consultation with a medical provider, the medical provider shall bill under OSC-D0001.

(6) The fee for a deposition shall be billed under OSC-D0002. This code should include time for preparation, travel and deposition. Payment of the hourly rate may be limited to a customary fee charged by similar providers.

(7) When an insurer obtains an Insurer Medical Examination (IME), the medical service provider shall bill under OSC-D0003. This code shall be used for a report, file review or examination.

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(8) The fee for interpretive services shall be billed under OSC-D0004.

(9) Fees for all arbiters and panel of arbiters used for director reviews pursuant to OAR 436-030-0165 shall be established by the director. This fee determination will be based on the complexity of the examination, the report requirements and the extent of the record review. The level of each category is determined by the director based on the individual complexities of each case as compared to the universe of claims in the medical arbiter process. When the examination is scheduled, the director shall notify the medical arbiter and the parties of the authorized fee for that medical arbiter review based on a combination of separate components.

- (a) Level 1 OSC-A0001 Exam
- Level 2 OSC-A0002 Exam
- Level 3 OSC-A0003 Exam
- Limited OSC-A0004 Exam

As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors. A limited exam generally involves a newly accepted condition, or some other partial [review]exam.

- (b) Level 1 OSC-A0011 Report
- Level 2 OSC-A0012 Report
- Level 3 OSC-A0013 Report

As determined by the director, a level 1 report generally includes standard questions. A level 2 report generally includes questions regarding complicating factors. A level 3 report generally includes questions regarding multiple complicating factors.

- (c) Level 1 OSC-A0021 File Review
- Level 2 OSC-A0022 File Review
- Level 3 OSC-A0023 File Review
- Level 4 OSC-A0024 File Review
- Level 5 OSC-A0025 File Review

As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of a large record or disability evaluation without an exam. A level 4 file review generally includes an extensive record. A level 5 file review generally includes an extensive record with unique factors.

(d) The director shall notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review.

(e) If the director determines that a supplemental medical arbiter report is necessary to clarify information or address additional issues, an additional report fee may be established. The

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fee is based on the complexity of the supplemental report as determined by the director. The additional fees are established as follows:

Limited      OSC-A0031

Complex      OSC-A0032

(f) Prior to completion of the reconsideration process, the medical arbiter may request the director to redetermine the authorized fee by providing the director with rationale explaining why the physician believes the fee should be different than authorized.

(g) The director may authorize testing which shall be paid according to OAR 436-009.

(h) Should an advance of costs be necessary **for the worker** to attend a medical arbiter exam, a request for advancement shall be made in sufficient time to ensure a timely appearance. **After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.**

(10) A single physician selected pursuant to ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under OSC-P0001 for the examination and under OSC-P0003 for the report.

(b) Physicians selected pursuant to OAR 436-010-0008, to serve on a panel of physicians shall each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. Each physician shall bill for the record review and panel examination under OSC-P0002. The panel member who prepares and submits the panel report shall receive an additional payment under OSC-P0003.

(c) The director may in a complex case requiring extensive review by a physician pre-authorize an additional fee. Complex case review shall be billed under OSC-P0004.

(d) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician shall bill under OSC-P0005.

**(e) Should an advance of costs be necessary for the worker to attend an exam under ORS 656.327 or 656.260, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.**

(11) The fee for a Worker Requested Medical Examination shall be billed under OSC-

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W0001. This code shall be used for a report, file review, or examination.

(12) The table below lists the **Oregon Specific Codes for Other Services**.

Codes	Relative Value	Description
R0001		Copies of medical records when requested shall be paid at \$10.00 for the first page and \$.50 for each page thereafter and identified on billings
N0001	[10.50] <b>1.71</b>	Brief narrative by the attending physician
N0002	[21.00] <b>3.41</b>	Complex narrative
99196	[16.79] <b>2.73</b>	First Level PCE
99197	[29.96] <b>4.87</b>	Second Level PCE
99198	[63.25] <b>10.28</b>	[Work Capacity Evaluation] <b>WCE</b>
99193	[4.28] <b>0.70</b>	Additional 15 minutes
D0001	0.00	Attorney consultation time
D0002	0.00	Deposition time
D0003	0.00	Insurer Medical Examination and report
D0004	0.00	Interpretive services
A0001	[31.48] <b>5.12</b>	Level 1 <b>arbiter</b> exam
A0002	[41.98] <b>6.82</b>	Level 2 <b>arbiter</b> exam
A0003	[52.47] <b>8.53</b>	Level 3 <b>arbiter</b> exam
A0004	[15.74] <b>2.56</b>	Level 4 <b>arbiter</b> exam
A0011	[5.43] <b>0.88</b>	Level 1 <b>arbiter</b> report
A0012	[8.15] <b>1.32</b>	Level 2 <b>arbiter</b> report
A0013	[10.86] <b>1.77</b>	Level 3 <b>arbiter</b> report
A0021	[5.43] <b>0.88</b>	Level 1 <b>arbiter</b> file review
A0022	[13.58] <b>2.21</b>	Level 2 <b>arbiter</b> file review
A0023	[32.58] <b>5.30</b>	Level 3 <b>arbiter</b> file review
A0024	[62.96] <b>10.23</b>	Level 4 <b>arbiter</b> file review
A0025	[83.95] <b>13.65</b>	Level 5 <b>arbiter</b> file review
A0031	[5.43] <b>0.88</b>	Limited <b>arbiter</b> report
A0032	[10.86] <b>1.77</b>	Complex <b>arbiter</b> report
P0001	[26.24] <b>4.27</b>	[Single] <b>Director single</b> medical review[er] <b>/exam</b>
P0002	[26.24] <b>4.27</b>	[Panel] <b>Director</b> [of] <b>panel</b> medical review[ers] <b>/exam</b>
P0003	[13.32] <b>2.17</b>	[Single] <b>Director single</b> medical review[er]/report
P0004	[31.48] <b>5.12</b>	<b>Director</b> [C]complex case review <b>/exam</b>
P0005	[13.32] <b>2.17</b>	Failure to appear <b>director</b> required examination
W0001	0.00	Worker Requested Medical Examination and report

**Stat. Auth.:** ORS656.726(4)

**Stats. Implemented:** ORS656.248

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**436-009-0090 Pharmacy Fees**

(1) Pharmacy fees shall be paid at 95% of the Average Wholesale Price (AWP) + \$6.70 (dispensing fee) for both brand name and generic, effective on the day the drug was dispensed except for in-patient hospital charges. Payment will be the lower of either the provider's usual and customary charge or 95% of the AWP + dispensing fee. All providers who are licensed to dispense medications in accordance with their practice must be paid similarly regardless of profession.

(2) All prescription medications are required medical services and do not require prior approval under the palliative care provisions of OAR 436-010-0290.

(3) Under ORS 689.515(2) licensed providers may dispense generic drugs to injured workers.

(4) Insurers shall use the prescription pricing guide published by First DataBank Inc., **Thomson Healthcare, Inc., or Facts & Comparisons (a Wolters Kluwer Health, Inc., Company)** [RedBook] for calculating payments to the licensed provider. Insurers must update their source at least monthly.

(5) The worker shall have the right to select the pharmacy, except for claims enrolled in a managed care organization (MCO) where pharmacy service providers are specified by the MCO contract.

(6) This rule shall not apply to a worker's direct purchase of prescription medications, and shall not limit a worker's right to reimbursement for actual out-of-pocket expenses pursuant to OAR 436-009-0025.

(7) The insurer shall be required to pay the retail-based fee for over-the-counter medications.

(8) Drugs dispensed by a hospital (inpatient or outpatient) shall to be billed pursuant to OAR 436-009-0020.

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