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PERMANENT ADMINISTRATIVE ORDER

FILED
03/05/2024 4:16 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

WCD 1-2024
CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

FILING CAPTION: Permanent: Workers' compensation medical fees and payments, medical services, interpreter services, and managed care organizations

EFFECTIVE DATE: 04/01/2024

AGENCY APPROVED DATE: 03/05/2024

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RULES:
436-009-0004, 436-009-0010, 436-009-0012, 436-009-0023, 436-009-0025, 436-009-0030, 436-009-0040, 436-009-0060, 436-009-0080, 436-009-0110, 436-010-0220, 436-010-0240, 436-010-0270, 436-010-0290, 436-015-0030, 436-015-0110

AMEND: 436-009-0004

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0004:
-Adopts, by reference, new medical billing codes and related references; and
-Adopts, in rule or by reference, CPT® codes and descriptors published by the American Medical Association.

CHANGES TO RULE:

436-009-0004
Adoption of Standards ¶

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 202~~3~~4 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 202~~3~~4, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumberg, IL 60173, 847-825-5586, or www.asahq.org.¶
(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 202~~3~~4), Fourth Edition Revised, 202~~2~~3, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 202~~3~~4 govern the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.¶
(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 3~~1~~2, Issue 12, 202~~2~~3. If there is a conflict between CPT® 202~~3~~4 and the CPT® Assistant, CPT® 202~~3~~4 is the controlling resource.¶
(4) To get a copy of the CPT® 2023, CPT® 2024, or the CPT® Assistant, contact the American Medical Association, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885, 312-464-4782, or www.ama-assn.org.¶
(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure

Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.¶
(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.¶
(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.¶
(6) The director adopts, by reference, CDT 2023~~3~~4: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, 312-440-2500, or www.ada.org.¶
(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version ~~9~~11.0 7/2~~1~~3 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, or www.nucc.org.¶
(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 202~~2~~3 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606, 312-422-3000, or www.nubc.org.¶
(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 -5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or www.ncpdp.org.¶
(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2023~~3~~4, CPT® 2023~~3~~4, CPT® Assistant, HCPCS 2023~~3~~4, CDT 2023~~3~~,4. 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.¶
(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem, OR 97301.
Statutory/Other Authority: ORS 656.248, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

AMEND: 436-009-0010

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0010 updates references to CPT® 2024.

CHANGES TO RULE:

436-009-0010
Medical Billing and Payment ¶

(1) General.¶
(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim. Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner. Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.¶
(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.¶
(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may 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 who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.¶
(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.¶
(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.¶
(f) When rebilling, medical providers must indicate that the charges have been previously billed.¶
(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.¶
(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)¶
(a) Medical providers must bill within:¶
(A) 60 days of the date of service;¶
(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or¶
(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.¶
(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.¶
(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause.¶
(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.¶
(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.¶
(3) Billing Forms.¶
(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).¶
(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:¶
(A) Dental billings, which must be submitted on American Dental Association dental claim forms;¶
(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or¶

(C) Electronic billing transmissions of medical bills (see OAR 436-008).¶
(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.¶
(d) Medical providers may use computer-generated reproductions of the appropriate forms.¶
(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual. [See attached table.]¶
(4) Billing Codes.¶
(a) When billing for medical services, a medical provider must use codes listed in CPT® 2023~~3~~4, or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service. If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service. If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2023~~3~~4, or the appropriate unlisted HCPCS code, and provide a description of the service provided. A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.¶
(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.¶
(5) Modifiers.¶
(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2023~~3~~4, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.¶
(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:¶
(A) Unusually lengthy procedure;¶
(B) Excessive blood loss during the procedure;¶
(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);¶
(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;¶
(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or¶
(F) The services rendered are significantly more complex than described for the submitted CPT®.¶
(6) Physician Assistants and Nurse Practitioners. Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."¶
(7) Chart Notes.¶
(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.¶
(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.¶
(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.¶
(8) Challenging the Provider's Bill. For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.¶
(9) Billing the Patient and Patient Liability.¶
(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:¶
(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;¶
(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS

656.245 and OAR 436-010-0210;¶
(C) If the insurer notifies the patient that they are medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;¶
(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or¶
(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.¶
(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.¶
(c) A provider may bill a patient for a missed appointment under section (13) of this rule.¶
(10) Disputed Claim Settlement (DCS). The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.¶
(11) Payment Limitations.¶
(a) Insurers do not have to pay providers for the following:¶
(A) Completing forms 827 and 4909;¶
(B) Providing chart notes with the original bill;¶
(C) Preparing a written treatment plan;¶
(D) Supplying progress notes that document the services billed;¶
(E) Completing a work release form or completion of a PCE form, when no tests are performed;¶
(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or¶
(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.¶
(b) 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. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.¶
(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.¶
(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.¶
(12) Excluded Treatment. The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:¶
(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;¶
(b) Intradiscal electrothermal therapy (IDET);¶
(c) Surface electromyography (EMG) tests;¶
(d) Rolfing;¶
(e) Prolotherapy;¶
(f) Thermography;¶
(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:¶
(A) The single level artificial disc replacement is between L3 and S1;¶
(B) The patient is 16 to 60 years old;¶
(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and¶
(D) The procedure is not found inappropriate under OAR 436-010-0230;¶
(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and¶
(i) Platelet rich plasma (PRP) injections.¶
(13) Missed Appointment (No Show).¶
(a) In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.¶

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:¶
(A) The provider has a written missed-appointment policy that applies not only to workers' compensation patients, but to all patients;¶
(B) The provider routinely notifies all patients of the missed-appointment policy;¶
(C) The provider's written missed-appointment policy shows the cost to the patient; and¶
(D) The patient has signed the missed-appointment policy.¶
(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.
Statutory/Other Authority: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

436-009-0010 Medical Billing and Payment ****

(3) Billing Forms. ****

(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2024; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2024 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the nonshaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

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AMEND: 436-009-0012

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0012 updates references to CPT® 2024.

CHANGES TO RULE:

436-009-0012
Telehealth
(1) Definitions.¶
(a) For the purpose of this rule, "telehealth" means providing healthcare remotely by means of telecommunications technology, including but not limited to telemedicine and telephonic or online digital services.¶
(b) For the purpose of this rule, "telemedicine" means synchronous medical services provided via a real-time interactive audio and video telecommunications system between a patient at an originating site and a provider at a distant site.¶
(c) "Distant site" means the place where the provider providing medical services to a patient through telehealth is located.¶
(d) "Originating site" means the place where the patient receiving medical services through telehealth is located.¶
(2) Scope of services.¶
(a) All services must be appropriate, and the form of communication must be appropriate for the service provided.¶
(b) Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT 2023~~3~~4.¶
(3) Distant site provider billing.¶
(a) When billing for telemedicine services, the distant site provider must:¶
(A) Use the place of service (POS) code "02" (Telehealth Provided Other than in Patient's Home) or "10" (Telehealth Provided in Patient's Home); and¶
(B) Use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.¶
(b) When billing for telehealth services other than telemedicine services, the distant site provider:¶
(A) Must use the POS code "02" (Telehealth Provided Other than in Patient's Home) or "10" (Telehealth Provided in Patient's Home); and¶
(B) May not use modifier 95.¶
(4) Originating site billing. When billing for telehealth services, the originating site may charge a facility fee using HCPCS code Q3014, if the site is:¶
(a) The office of a physician or practitioner; or¶
(b) A health care facility including but not limited to a hospital, rural health clinic, skilled nursing facility, or community mental health center.¶
(5) Payment.¶
(a) Insurers must pay distant site providers at the non-facility rate.¶
(b) Equipment or supplies at the distant site are not separately payable.¶
(c) The payment amount for code Q3014 is $35.70 per unit or the provider's usual fee, whichever is lower. In calculating the units of time, 15 minutes, or any portion of 15 minutes, equals one unit.¶
(d) Professional fees of supporting providers at the originating site are not separately payable.¶
(e) Insurers are not required to pay a telehealth transmission fee (HCPCS code T1014).
Statutory/Other Authority: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

AMEND: 436-009-0023

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0023's ambulatory surgery center fee schedules, Appendices C and D, include new billing codes for 2024. While some maximum payment amounts are higher or lower, the overall reimbursement is not projected to change.

CHANGES TO RULE:

436-009-0023
Ambulatory Surgery Center (ASC) ¶

(1) Billing Form.¶
(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.¶
(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.¶
(2) ASC Facility Fee.¶
(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:¶
(A) Nursing, technical, and related services;¶
(B) Use of the facility where the surgical procedure is performed;¶
(C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;¶
(D) Radiology services designated as packaged in Appendix D;¶
(E) Administrative, record-keeping, and housekeeping items and services;¶
(F) Materials for anesthesia;¶
(G) Supervision of the services of an anesthetist by the operating surgeon; and¶
(H) Packaged services identified in Appendix C or D.¶
(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.¶
(3) ASC Billing.¶
(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says "packaged" in Appendices C or D.¶
(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.¶
(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC's cost for an implant is $100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.¶
(4) ASC Payment.¶
(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.¶
(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:¶
(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or¶
(B) The ASC's usual fee for surgical procedures and ancillary services.¶
(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly. The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.¶
(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead. [See attached table.]¶
(e) When the ASC's cost of an implant is $100 or more, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.¶
(f) When the ASC's cost of an implant is less than $100, insurers are not required to pay separately for the implant. An implant may consist of several separately billable components, some of which may cost less than $100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total

amount to calculate payment for the implant.¶
(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:¶
(A) The ASC is not a contracted facility for the MCO;¶
(B) The MCO has not pre-certified the service provided; or¶
(C) The surgeon is not an MCO panel provider.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.248, ORS 656.252

436-009-0023 Ambulatory Surgery Center (ASC)****

(4) ASC Payment. ****

(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.

CPT® Code	Maximum Payment Amount		CPT® Code	Maximum Payment Amount
23350	$235.12		36410	$19.94
25246	$220.99		36416	80% of billed
27093	$304.90		36620	80% of billed
27648	$274.16		62284	$282.47
36000	$39.05		62290	$417.89

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AMEND: 436-009-0025

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0025 includes revised language and formatting of a notice of right to administrative review, effective October 1, 2024. The updated language and formatting is intended to make the notice easier to comprehend.

CHANGES TO RULE:

436-009-0025
Worker Reimbursement ¶

(1) General.¶
(a) When the insurer accepts the claim the insurer must notify the worker in writing that:¶
(A) The insurer will reimburse claim-related services paid by the worker; and¶
(B) The worker has two years to request reimbursement.¶
(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use Form 3921 - Request for Reimbursement of Expenses.¶
(c) Insurers must date stamp requests for reimbursement on the date received.¶
(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.¶
(e) The explanation to the worker must be in 10 point size font or larger and must include:¶
(A) The amount of reimbursement for each type of out-of-pocket expense requested.¶
(B) The specific reason for nonpayment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;¶
(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within two days, excluding Saturdays, Sundays, and legal holidays;¶
(D) The following notice, Web link, and phone number:¶
"To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit wcd.oregon.gov or call 503-947-7606.";¶
(E) Space for the worker's signature and date; and¶
(F) A notice of right to administrative review as follows:¶
"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."¶
(G) Effective no later than October 1, 2024, the notice listed under paragraph (F) of this subsection must be replaced with the following notice in bold text and formatted as follows:¶
If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:¶
- Submit your request within 90 days of the mailing date of this explanation¶
- Sign and date this explanation in the space provided¶
- Explain why you think the payment is incorrect¶
- Attach required supporting documentation of your expense¶
- Send the documents to:¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405¶
Or¶
Fax your request to the Medical Resolution Team at 503-947-7629¶

- Send a copy of your request to the insurer¶
Keep a copy of this document for your records.¶
(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(4), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.¶
(2) Timeframes.¶
(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:¶
(A) Two years from the date the costs were incurred or¶
(B) Two years from the date the claim or medical condition is finally determined compensable.¶
(b) The insurer may disapprove the reimbursement request if the worker requests reimbursement after two years as listed in subsection (a).¶
(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.¶
(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request.¶
(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement or disapprove the request.¶
(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, the insurer must, within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.¶
(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later.¶
(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day or 14-day time frame for the insurer to issue reimbursement or disapprove the request.¶
(e) When any action, other than those listed in subsections (c) and (d) of this section, causes the reimbursement request to be payable, the insurer must reimburse the worker within 14 days of the action.¶
(f) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.¶
(g) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.¶
(3) Meal and Lodging Reimbursement.¶
(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.¶
(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.¶
(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location. The reimbursement rates for meals and lodging expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).¶
(4) Travel Reimbursement.¶
(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.¶
(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker. The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker. The insurer must inform the worker that the worker may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.¶
(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.¶
(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.¶
(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The

mileage reimbursement is limited to the rate published in Bulletin 112. The reimbursement rates for mileage expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).¶
(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.¶
(5) Other Reimbursements.¶
(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.¶
(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.¶
(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.¶
(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.¶
(6) Advancement Request. If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.
Statutory/Other Authority: ORS 656.245, ORS 656.325, ORS 656.704, ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.704, ORS 656.726(4)

AMEND: 436-009-0030

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0030

-Includes revised language and formatting of a notice of right to administrative review, effective October 1, 2024. The updated language and formatting is intended to make the notice easier to comprehend.

-Updates the name of the “Oregon Consumer Identity Theft Protection Act” to “Oregon Consumer Information Protection Act.”

CHANGES TO RULE:

436-009-0030
Insurers Duties and Responsibilities ¶

(1) General.¶
(a) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.¶
(b) 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 under OAR 436-009-0060. If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.¶
(c) The insurer must 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 must be continuous and must include no fewer than 10 percent of medical bills. The insurer must provide upon the director's request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.¶
(2) Bill Processing.¶
(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b), (3), and (7) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill. The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.¶
(b) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(1)(b) and (3)(b), and insurer action, for any nonpayment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.¶
(c) Any service billed with a code number commanding a higher fee than the services provided must be returned to the medical provider for correction or paid at the value of the service provided.¶
(3) Payment Requirements.¶
(a) Insurers must pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the bill is submitted in proper form according to OAR 436-009-0010(1)(b), (3)(a) through (7)(c), and clearly shows that the treatment is related to the accepted compensable injury or disease.¶
(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied within 45 days of receipt of the bill. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).¶
(c) The written EOB must be in 10 point size font or larger. Electronic and written explanations must include:¶
(A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;¶
(B) The specific reason for nonpayment, reduced payment, or discounted payment for each service billed;¶
(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or

its representative must respond to a medical provider's payment question within two days, excluding Saturdays, Sundays, and legal holidays;¶
(D) The following notice, Web link, and phone number:¶
"To access information about Oregon's Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.";¶
(E) Space for the provider's signature and date; and¶
(F) A notice of right to administrative review as follows:¶
"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."¶
(G) Effective no later than October 1, 2024, the notice listed under paragraph (F) of this subsection must be replaced with the following notice in bold text and formatted as follows:¶
If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:¶
- Submit your request within 90 days of the mailing date of this explanation¶
- Sign and date this explanation in the space provided¶
- Explain why you think the payment is incorrect¶
- Attach required supporting documentation of your expense¶
- Send the documents to:¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405¶
Or¶
Fax your request to the Medical Resolution Team at 503-947-7629¶
- Send a copy of your request to the insurer¶
Keep a copy of this document for your records.¶
(d) 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.¶
(e) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily applies such a service charge to the general public.¶
(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment or reduction of each medical service code.¶
(g) 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 within 45 days of receipt by the insurer even if the claim is denied.¶
(h) If an insurer determines that it has made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.¶
(4) Electronic Payment.¶
(a) An insurer may pay a provider through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the provider voluntarily consents.¶
(A) The provider's consent must be obtained before initiating electronic payments.¶
(B) The consent may be written or verbal. The insurer must send the provider a written confirmation when consent is obtained verbally.¶
(C) The provider may discontinue receiving electronic payments by notifying the insurer in writing.¶
(b) Cardholder agreement for ATM or debit cards. The provider must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued before or at the time the initial electronic payment is made.¶
(c) Instrument of payment. The instrument of payment must be negotiable and payable to the provider for the full

amount of the benefit paid, without cost to the provider.¶
(5) Communication with Providers.¶
(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within two days, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.¶
(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer I~~dentity Theft~~nformation Protection Act under ORS 646A.600 to 646A.628 and federal law.¶
(6) EDI Reporting. For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.260, ORS 656.264, ORS 656.325

AMEND: 436-009-0040

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0040's physician fee schedule, Appendix B, includes new billing codes for 2024. While some maximum payment amounts are higher or lower, the overall reimbursement is not projected to change.

CHANGES TO RULE:

436-009-0040
Fee Schedule ¶

(1) Fee Schedule Table.¶
(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table: [See attached table.]¶
(b) The global period is listed in the column Global Days' of Appendix B.¶
(2) Anesthesia.¶
(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.¶
(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.¶
(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier NT' (no time) must be on the bill.¶
(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.¶
(e) 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.¶
(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $60.93. Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:¶
(A) The maximum allowable payment amount for anesthesia codes; or¶
(B) The provider's usual fee.¶
(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.¶
(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.¶
(3) Surgery. Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:¶
(a) One surgeon [See attached table.]¶
(b) Two or more surgeons [See attached table.]¶
(c) Assistant surgeons [See attached table.]¶
(d) Nurse practitioners or physician assistants [See attached table.]¶
(e) Self-employed surgical assistants who work under the direct control and supervision of a physician [See attached table.]¶
(f) When a surgeon performs surgery following severe trauma, 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. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.¶
(g) If the surgery is nonelective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.¶
(4) Radiology Services.¶
(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views. ¶
(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), then the technical component must be paid 100 percent for the first area examined and 75 percent for all

subsequent areas. These reductions do not apply to the professional component. The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.¶
(5) Pathology and Laboratory Services.¶
(a) The payment amounts in Appendix B apply only when there is direct physician involvement.¶
(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.¶
(6) Physical Medicine and Rehabilitation Services.¶
(a) Time-based CPT codes must be billed and paid per code according to this table: [See attached table.]¶
(b) Except for CPT codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT code does not count as a separate code. When a provider bills for more than three separate CPT-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.¶
(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.¶
(d) CPT codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.¶
(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.¶
(7) Reports.¶
(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.¶
(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.¶
(8) Nurse Practitioners and Physician Assistants. Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

436-009-0040 Fee Schedule

(1) Fee Schedule Table.

(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table:

Services	**Codes**	**Payment Amount:**	
Services billed with **CPT®** codes, **HCPCS** codes, or Oregon Specific Codes (**OSC**):	Listed in Appendix B and performed in medical service provider's office	Lesser of:	Amount in non-facility column in Appendix B, or
			Provider's usual fee
	Listed in Appendix B and **not** performed in medical service provider's office	Lesser of:	Amount in facility column in Appendix B*, or
			Provider's usual fee
Dental Services billed with dental procedure codes:	D0000 through D9999	90% of provider's usual fee	
Ambulance Services billed with HCPCS codes:	A0425, A0426, A0427, A0428, A0429, A0433, and A0434	100% of provider's usual fee	
Services billed with **HCPCS** codes:	Not listed in the fee schedule	80% of provider's usual fee	
Services not described above:		80% of provider's usual fee	
* However, for all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Non-Facility Maximum column.			

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(3) Surgery.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:

(a) One surgeon

Procedures	**Appendix B lists:**	**The payment amount is:**	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The billed amount
	80% of billed amount	80% of billed amount	
Any additional procedures* including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The billed amount
	80% of billed amount	40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(b) Two or more surgeons

Procedures	**Appendix B lists:**	**The payment amount for each surgeon is:**	
Each surgeon performs a principal procedure (and any additional procedures) Any additional procedures including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or
			The billed amount
	80% of billed amount	60% of the billed amount (and 30% of the billed amount for any additional procedures*) (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(c) Assistant surgeons

Procedures	**Appendix B lists:**	**The payment amount is:**	
One or more surgical procedures	A dollar amount	The lesser of:	20% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	20% of the surgeon(s) fee calculated in subsections (a) or (b)	

(d) Nurse practitioners or physician assistants

Procedures	**Appendix B lists:**	**The payment amount is:**	
One or more surgical procedures as the primary surgical provider, billed without modifier "81."	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	85% of the surgeon(s) fee calculated in subsections (a) or (b)	
One or more surgical procedures as the surgical assistant*	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	15% of the surgeon(s) fee calculated in subsections (a) or (b)	
*Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.			

(e) Self-employed surgical assistants who work under the direct control and supervision of a physician

Procedures	**Appendix B lists:**	**The payment amount is:**	
One or more surgical procedures	A dollar amount	The lesser of:	10% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	10% of the surgeon(s) fee calculated in subsections (a) or (b)	

****

(6) Physical Medicine and Rehabilitation Services.

(a) Time-based CPT® codes must be billed and paid per code according to this table:

Treatment Time Per Code	Bill and Pay As
0 to 7 minutes	0
8 to 22 minutes	1 unit
23 to 37 minutes	2 units
38 to 52 minutes	3 units
53 to 67 minutes	4 units
68 to 82 minutes	5 units

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AMEND: 436-009-0060

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0060:

-Adds a new Oregon Specific Code (OSC) for a level 4 arbiter exam—a very complex exam. The very complex exam will use OSC AR004.

-Changes the OSC used to address limited arbiter exams—exams that involve a newly accepted condition or a partial exam. These exams were previously billed with OSC AR004; they would now be billed with OSC AR005.

-Adds a new OSC for an arbiter exam (psychiatric and neuropsychological exam)—AR006—to cover the first hour of the exam.

-Adds a new OSC for an arbiter exam (psychiatric and neuropsychological exam)—AR007—to cover each additional 30 minutes of the exam.

-Adds a new OSC for a level 4 arbiter report—AR014.

CHANGES TO RULE:

436-009-0060
Oregon Specific Codes ¶

(1) Multidisciplinary Services.¶
(a) Services provided by multidisciplinary programs not otherwise described by CPT codes must be billed under Oregon specific codes.¶
(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:¶
(A) The type of service rendered,¶
(B) The medical provider who provided the service,¶
(C) Whether treatment was individualized or provided in a group session, and¶
(D) The amount of time treatment was rendered for each service billed.¶
(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.) [See attached table.]¶
(3) CARF / JCAHO Accredited Programs.¶
(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).¶
(b) Organizations that have applied for CARF accreditation, but have not yet received 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. The organizations may provide multidisciplinary services under this section for a period of up to six 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.¶
(c) Notwithstanding OAR 436-009-0010(4)(a), 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.¶
(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

436-009-0060 Oregon Specific Codes****

(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.)

Service	OSC
Addictionologist consultant services: Services requested by a managed care organization consisting of an extensive records review, a physical exam, reports, responses to letters, and urine drug screening.	D0091
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A complex exam that may have several complicating factors.	AR003
Arbiter exam - level 4: A very complex exam that may have several complicating factors or multiple body systems.	AR004
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR005
Arbiter exam – psychiatric and neuropsychological exam: First hour of the examination.	AR006
Arbiter exam – psychiatric and neuropsychological exam: Each additional 30 minutes of the examination. If an arbiter bills for a portion of 30 minutes, the insurer must round the time up to the next 30 minutes and pay one unit for the portion of time.	AR007
Arbiter file review - level 1: A file review of a limited record.	AR021
Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012

Service	OSC
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - level 4: A report that answers complex questions and addresses several complicating factors or multiple body systems.	AR014
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records provided on a disc or USB drive, uploaded to an insurer's secure website, or using secure email or e-fax, requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002
Director required medical exam: Services by a physician selected under ORS 656.327 to perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate for exam (P0001) and record review (P0002) up to six hours combined.	P0001
Director required file review time: Time spent by a physician selected under ORS 656.327 to review the record. Services must be paid at an hourly rate for record review (P0002) and exam (P0001) up to six hours combined.	P0002
Director required medical report: Preparation and submission of the report.	P0003

Service	OSC
Director required review - complex case fee: One time, flat fee pre-authorized by the director for an extensive review in a complex case.	P0004
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.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003
IME – review and response: Insurer-requested review and response by treating physician; document time spent.	D0019
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.	97655
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – provided by a noncertified interpreter, excluding American Sign Language	D0004
Interpreter services – American Sign Language	D0005
Interpreter services - provided by a health care interpreter certified by the Oregon Health Authority, excluding American Sign Language	D0006
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.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671

Service	OSC
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196
PCE - second level: This is a PCE 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 generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643

Service	OSC
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
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).	97654
Records review: Review of medical records on an MCO-enrolled claim by a nontreating physician requested by an insurer or a managed care organization.	RECRW
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Video Review: Review of video requested by an insurer or a managed care organization.	VIDEO
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
Vocational evaluation - each additional 15 minutes	97663

Service	OSC
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam and report.	W0001

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AMEND: 436-009-0080

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0080:

-Increases overall maximum payments by 1.3 percent for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule, Appendix E.

-Removes outdated rental rates for durable medical equipment: E0194, E0434, and E0971.

CHANGES TO RULE:

436-009-0080
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) ¶

(1) Durable medical equipment (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:¶
(a) Is primarily and customarily used to serve a medical purpose,¶
(b) Can withstand repeated use,¶
(c) Could normally be rented and used by successive patients,¶
(d) Is appropriate for use in the home, and¶
(e) Is not generally useful to a person in the absence of an illness or injury.¶
(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.¶
(3) An orthotic is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.¶
(4) Supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.¶
(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:¶
(a) NU for purchased, new equipment;¶
(b) UE for purchased, used equipment; and¶
(c) RR for rented equipment¶
(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table: [See attached table.]¶
(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes): [See attached table.]¶
(8) For items rented, unless otherwise provided by contract:¶
(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.¶
(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.¶
(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.¶
(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:¶
(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or¶
(b) The provider may offer a service agreement at an additional cost.¶
(10) Hearing aids must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner. Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999.

However, without approval from the insurer or director, the payment for hearing aids may not exceed $7000 for a pair of hearing aids, or $3500 for a single hearing aid. If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.¶
(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for vision services billed with HCPCS codes V0000 through V2999.¶
(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.¶
(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.¶
(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

436-009-0080 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) ****

(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table:

If DMEPOS is:	And HCPCS is:	Then payment amount is:	
New	Listed in Appendix E	The lesser of	Amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Used	Listed in Appendix E	The lesser of	75% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	
Rented (monthly rate)	Listed in Appendix E	The lesser of	10% of amount in Appendix E; or
			Provider's usual fee
	Not listed in Appendix E	80% of provider's usual fee	

(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes):

Code	Monthly Rate		Code	Monthly Rate
E0163	$26.33		E0849	$98.40
E0165	$30.24		E0900	$93.68
E0168	$27.28		E0935	$996.97
E0261	$259.66		E0940	$52.20
E0277	$1135.64		E0990	$25.52
E0441	$86.85		E1800	$262.29
E0650	$1423.50		E1815	$276.15
			E2402	$2487.86

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Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

The Workers' Compensation Division no longer adopts the Federal Register that publishes Centers for Medicare and Medicaid Services' (CMS) relative value units (RVUs). The division publishes the following Appendices to the division 009 of chapter 436.

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers. [Effective April 1, 2024]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective April 1, 2024]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective April 1, 2024]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, 2024]

Note: If the above links do not connect you to the division's website, click:
https://wcd.oregon.gov/medical/Pages/disclaimer.aspx
If you have questions, call the Workers' Compensation Division, 503-947-7606.

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright 2023 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

The responsibility for the content of Oregon Workers' Compensation Maximum Allowable Payment Tables is with State of Oregon and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Oregon Workers' Compensation Maximum Allowable Payment Tables. Fee schedules, relative value units, conversion factors and related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Oregon Workers' Compensation Maximum Allowable Payment Tables should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

Link to the Maximum Allowable Payment Tables: https://wcd.oregon.gov/medical/Pages/disclaimer.aspx

Or, contact the division for a paper copy, 971-286-0316

AMEND: 436-009-0110

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0110:

-Increases maximum payments for interpreter services by 9.2%.

-Includes revised language and formatting of a notice of right to administrative review, effective October 1, 2024. The updated language and formatting is intended to make the notice easier to comprehend.

-Updates the name of the “Oregon Consumer Identity Theft Protection Act” to “Oregon Consumer Information Protection Act.”

CHANGES TO RULE:

436-009-0110
Interpreters ¶

(1) Choosing an Interpreter.¶
(a) A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or an interpreter. However, for signed language interpretation services, the worker may only choose an interpreter who is a medical sign language interpreter licensed under Oregon Laws 2023, chapter 414, section 6. A representative of the worker's employer may not provide interpreter services. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.¶
(b) When a worker asks an insurer to arrange for interpreter services, the insurer must:¶
(A) For interpretation services, other than signed language interpretation services, use a certified or qualified health care interpreter listed on the Oregon Health Care Interpreter Registry of the Oregon Health Authority available at: http://www.oregon.gov/OHA/OEI/Pages/HCI-Program.aspx. The interpreter's certification or qualification must be in effect on the date the interpreter services are provided. If no certified or qualified health care interpreter is available, the insurer may schedule an interpreter of its choice subject to the limits in subsection (a) of this section.¶
(B) For signed language interpretation services, use a sign language interpreter licensed under Oregon Laws 2023, chapter 414.¶
(2) Billing.¶
(a) Interpreters must charge the usual fee they charge to the general public for the same service.¶
(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the worker.¶
(c) Interpreters may bill for interpreter services and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule, "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location and back to the interpreter's starting point.¶
(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:¶
(A) The worker fails to attend the appointment; or¶
(B) The provider has to cancel or reschedule the appointment.¶
(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the division at 503-947-7814. They may also access insurance policy information at http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm.¶
(3) Billing and Payment Limitations.¶
(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if the provider cancels or reschedules the appointment.¶
(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, an interpreter may bill a workers' compensation client if the client fails to attend the appointment and if:¶
(A) The interpreter has a written missed-appointment policy that applies not only to workers' compensation clients, but to all clients;¶
(B) The interpreter routinely notifies all clients of the missed-appointment policy;¶
(C) The interpreter's written missed-appointment policy shows the cost to the client; and¶

(D) The client has signed the missed-appointment policy.¶
(c) The implementation and enforcement of subsection (b) of this section is a matter between the interpreter and the client. The division is not responsible for the implementation or enforcement of the interpreter's policy.¶
(d) The insurer is not required to pay for interpreter services or mileage when the services are provided by:¶
(A) A family member or friend of the worker; or¶
(B) A medical provider's employee.¶
(4) Billing Timelines.¶
(a) Interpreters must bill within:¶
(A) 60 days of the date of service;¶
(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or¶
(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.¶
(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the interpreter may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.¶
(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause.¶
(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.¶
(5) Billing Form.¶
(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:¶
(A) D0004 for interpreter services, excluding American Sign Language interpreter services, provided by noncertified interpreters;¶
(B) D0005 for American Sign Language interpreter services;¶
(C) D0006 for interpreter services, excluding American Sign Language interpreter services, provided by a health care interpreter certified by the Oregon Health Authority; and¶
(D) D0041 for mileage.¶
(b) An interpreter's invoice must include:¶
(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;¶
(B) The worker's name;¶
(C) The worker's workers' compensation claim number, if known;¶
(D) The correct Oregon specific codes for the billed services (D0004, D0005, D0006, or D0041);¶
(E) The workers' compensation insurer's name and address;¶
(F) The date interpreter services were provided;¶
(G) The name and address of the medical provider that conducted the exam or provided treatment;¶
(H) The total amount of time interpreter services were provided; and¶
(I) The mileage, if the round trip was 15 or more miles.¶
(6) Payment Calculations.¶
(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.¶
(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters: [See attached table.]¶
(7) Payment Requirements.¶
(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.¶
(b) When the worker fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay the no-show fee and mileage if the round-trip mileage is 15 or more miles.¶
(c) The insurer must retain the invoice and pay the interpreter within:¶
(A) 14 days of the date of claim acceptance or any action causing the service to be payable, which includes receiving a bill for or chart note of the corresponding medical appointment, or 45 days of receiving the invoice, whichever is later; or¶
(B) 45 days of receiving the invoice for an exam required by the insurer or director.¶
(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.¶
(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.¶
(f) If the insurer does not receive all the information to process the invoice, other than a bill for or chart note of the corresponding medical appointment, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.¶

(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment or reduction of each service billed.¶
(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.¶
(i) Electronic and written explanations must include:¶
(A) The payment amount for each service billed. When the payment covers multiple workers, the explanation must clearly separate and identify payments for each worker;¶
(B) The specific reason for nonpayment, reduced payment, or discounted payment for each service billed;¶
(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within two days, excluding Saturdays, Sundays, and legal holidays;¶
(D) The following notice, Web link, and phone number:¶
"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";¶
(E) Space for a signature and date; and¶
(F) A notice of the right to administrative review as follows:¶
"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."¶
(G) Effective no later than October 1, 2024, the notice listed under paragraph (F) of this subsection must be replaced with the following notice in bold text and formatted as follows:¶
If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:¶
- Submit your request within 90 days of the mailing date of this explanation¶
- Sign and date this explanation in the space provided¶
- Explain why you think the payment is incorrect¶
- Attach required supporting documentation of your expense¶
- Send the documents to:¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405¶
Or¶
Fax your request to the Medical Resolution Team at 503-947-7629¶
- Send a copy of your request to the insurer¶
Keep a copy of this document for your records.¶
(j) The insurer or its representative must respond to an interpreter's inquiry about payment within two days, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.¶
(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer I~~dentity Theft~~nformation Protection Act under ORS 646A.600 to 646A.628 and federal law.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.248

436-009-0110 Interpreters ****

(6) Payment Calculations. ****

(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters:

For:	The maximum payment is:
Interpreter services provided by a noncertified interpreter of an hour or less	$71.00
Interpreter service of an hour or less provided by health care interpreters certified by the Oregon Health Authority[1]	$83.00
American sign language interpreter services of an hour or less	$83.00
Interpreter services provided by a noncertified interpreter of more than one hour	$17.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Interpreter service of more than one hour provided by health care interpreters certified by the Oregon Health Authority[1]	$20.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language interpreter services of more than one hour	$20.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	The private vehicle mileage rate published in Bulletin 112
An examination required by the director or insurer that the worker fails to attend or when the provider cancels or reschedules	$71.00 no-show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage
[1] A list of certified health care interpreters can be found online under the Health Care Interpreter Registry at http://www.oregon.gov/oha/oei/Pages/HCI-Program.aspx .	

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AMEND: 436-010-0220

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0220 incorporates a timeframe of 14 days for MCOs to provide a list of three providers willing to treat the worker within a reasonable period of time.

CHANGES TO RULE:

436-010-0220
Choosing and Changing Medical Providers ¶

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment the physician considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:¶
(a) Emergency services;¶
(b) Insurer or director requested examinations;¶
(c) A Worker Requested Medical Examination;¶
(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and¶
(e) Diagnostic studies provided by radiologists and pathologists upon referral.¶
(2) Changing Attending Physician or Authorized Nurse Practitioner. The worker may choose to change attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:¶
(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;¶
(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or¶
(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:¶
(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;¶
(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;¶
(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;¶
(D) When the period for treatment or services by a type B or type C attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");¶
(E) When the physician assistant or authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;¶
(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;¶
(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or¶
(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.¶
(3) Insurer Notice to the Worker. When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior

to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.¶
(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.¶
(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:¶
(A) Send the worker a written explanation of the reasons;¶
(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and¶
(C) Inform the worker that the worker may request director approval by sending Form 2332 to the director.¶
(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.¶
(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:¶
(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.¶
(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.¶
(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order.¶
(5) Managed Care Organization (MCO) Enrolled Workers.¶
(a) An MCO enrolled worker must choose:¶
(A) A panel provider unless the MCO approves a non-panel provider, or¶
(B) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.¶
(b) Notwithstanding subsection (a) of this section, if a worker is unable to find three providers that are willing to treat the worker in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's geographic service area (GSA), the worker may contact the MCO for a list of three providers who are willing to treat the worker. If the MCO, within ~~a reasonable period of time~~14 days, is unable to provide a list of three providers who are willing to treat the worker within a reasonable period of time, the worker may choose a non-panel provider in that category.¶
(c) Notwithstanding subsection (a) of this section, if the MCO has fewer than three providers in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's GSA, the worker may choose a non-panel provider in that category.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.252, ORS 656.260

AMEND: 436-010-0240

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0240:

-Clarifies “patients” as “workers.”

-Incorporates a timeframe in which insurers and providers must respond to a request from workers or their representations for medical and payment records

CHANGES TO RULE:

436-010-0240
Medical Records and Reporting Requirements for Medical Providers ¶

(1) Medical Records and Reports.¶
(a) Medical providers must maintain records necessary to document the extent of medical services provided.¶
(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.¶
(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.¶
(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).¶
(2) Diagnostic Studies. When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.¶
(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.¶
(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.¶
(3) Multidisciplinary Programs. When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.¶
(4) Release of Medical Records.¶
(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]¶
(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:¶
(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and¶
(B) HIV-related information protected by ORS 433.045.¶
(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.¶
(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.¶
(e) ~~Patient~~Workers or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. ~~Patient~~Workers or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. Insurers must respond to the workers' or their representatives' request within the timeframes provided in OAR 436-060-0017(5). Medical providers must respond within 14 days of receipt of a request from workers or their representatives for medical or payment records. A summary may substitute for the actual record only if the

~~patient~~worker agrees to the substitution. The following records may be withheld:¶
(A) Psychotherapy notes;¶
(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;¶
(C) Other reasons specified by federal regulation; and¶
(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.¶
(f) A medical provider may charge the patient or the patient's representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of the patient's medical records because of inability to pay.¶
(g) A medical provider is encouraged to discuss potential modified work duties with employers. However, a medical provider may not discuss medical treatments or diagnoses with employers, or release medical records other than work release documentation, to employer representatives who are not directly responsible for claims processing responsibilities. This subsection does not relieve a medical provider from the requirements outlined in subsections (a) through (d) of this section.¶
(5) Release to Return to Work.¶
(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.¶
(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.¶
(6) Temporary Disability and Medically Stationary.¶
(a) When temporary disability is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request. If the medical provider fails to provide information under this rule within 14 days of receiving a request sent by fax or certified mail, penalties under OAR 436-010-0340 may be imposed.¶
(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:¶
(A) The anticipated date of release to work;¶
(B) The anticipated date the patient will become medically stationary;¶
(C) The next appointment date; and¶
(D) The patient's medical limitations.¶
(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.¶
(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.¶
(7) Consultations. When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:¶
(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.¶
(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.252, ORS 656.254

AMEND: 436-010-0270

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0270:

-Requires the insurer to inform the worker, their representative, and the provider whether the insurer approves a surgery within 45 days from the date the MCO pre-certified the surgery as medically appropriate; and

-Establishes a timeframe of 90 days to appeal insurer's disapproval of the surgery and dictates language and formatting of a notice to workers, worker's attorney, and attending physician.

CHANGES TO RULE:

436-010-0270
Insurers Rights and Duties ¶

(1) Notifications.¶
(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.¶
(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.¶
(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).¶
(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.¶
(2) Medical Records Requests.¶
(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.¶
(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.¶
(3) Pre-authorization. Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.¶
(4) Insurer's Duties under MCO Contracts.¶
(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:¶
(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);¶
(B) How workers can receive compensable medical services within the MCO;¶
(C) How workers can receive compensable medical services by non-panel providers; and¶
(D) The geographical service area governed by the MCO.¶
(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.¶
(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the worker's attorney's name, mailing address, phone number, and, if known, fax number and email address to the MCO.¶
(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:¶
(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:¶

(i) Provide a telephone number the worker may call to ask for a written list; and¶
(ii) Tell the worker that they have seven days from the mailing date of the notice to request the list;¶
(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;¶
(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:¶
(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or¶
(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;¶
(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;¶
(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the workers with health care benefits even if a workers' compensation claim is denied; and¶
(F) Notify the worker of the worker's right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.¶
(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.¶
(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.¶
(g) The insurer may delegate to the MCO responsibility for issuing the enrollment notice required by ORS 656.245(4)(a) and these rules by express provision in the contract between those parties; however, the insurer remains liable for any deficiencies in the notice issued by the MCO.¶
(h) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0037(3).¶
(i) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:¶
(A) Send a copy of the dispute to the MCO; or¶
(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.¶
(j) The insurer must notify the MCO within seven days of receiving notification of the following:¶
(A) When the worker obtains representation by an attorney, the attorney's name, mailing address, phone number, and, if known, fax number and email address;¶
(B) Any changes to the worker's or worker's attorney's name, address, or telephone number;¶
(C) Any requests for medical services from the worker or the worker's medical provider; or¶
(D) Any request by the worker to continue treating with a "come-along" provider.¶
(k) When an MCO pre-certifies a surgical service as medically appropriate, the insurer must, within 45 days from the mailing date of the MCO decision, notify the worker, the worker's representative, the provider, and the MCO whether the insurer approves the surgery.¶
(A) If the insurer disapproves the surgery for reasons other than appropriateness or whether the surgery is excessive or ineffectual, the disapproval must include the following notice in bold text and formatted as follows:¶
Notice to worker, worker's attorney, and medical provider:¶
If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:¶
- Notify the Department of Consumer and Business Services (DCBS) in writing.¶
- Send your written request for review of the insurer's disapproval to:¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405¶
If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the insurer's decision.¶
For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a

benefit consultant.¶
(B) If the insurer disagrees with the appropriateness decision of the MCO, the insurer must appeal the decision to the MCO under OAR 436-015-0110(4).¶
(l) Insurers under contract with MCOs must maintain records including, but not limited to:¶
(A) A listing of all employers covered by MCO contracts;¶
(B) The employers' WCD employer numbers;¶
(C) The estimated number of employees governed by each MCO contract;¶
(D) A list of all workers enrolled in the MCO; and¶
(E) The effective dates of such enrollments.¶
(~~l~~m) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.¶
(~~m~~n) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.252, ORS 656.325, ORS 656.245, ORS 656.248, ORS 656.260, ORS 656.264

AMEND: 436-010-0290

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0290 includes revised language and formatting of a notice to workers, worker's attorney, and attending physician, effective October 1, 2024. The updated language and formatting are intended to make the notice easier to comprehend.

CHANGES TO RULE:

436-010-0290
Medical Care After Medically Stationary ¶

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:¶
(a) Palliative care under section (2) of this rule;¶
(b) Curative care under sections (3) and (4) of this rule;¶
(c) Provided to a worker who has been determined permanently and totally disabled;¶
(d) Prescription medications;¶
(e) Necessary to administer or monitor administration of prescription medications;¶
(f) Prosthetic devices, braces, or supports;¶
(g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;¶
(h) Provided under an accepted claim for aggravation;¶
(i) Provided under Board's Own Motion;¶
(j) Necessary to diagnose the worker's condition; or¶
(k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.¶
(2) Palliative Care.¶
(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:¶
(A) Describe any objective findings;¶
(B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;¶
(C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;¶
(D) Explain how the requested care is related to the compensable condition; and¶
(E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.¶
(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.¶
(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice approving or disapproving the request to the attending physician, the provider who will provide the care, the worker, and the worker's attorney. If the request is disapproved~~,~~ t: ¶
(A) The notice must include the following ~~paragraph~~, in bold text:¶
NOTICE TO WORKER, WORKER'S ATTORNEY, AND ATTENDING PHYSICIAN: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services in writing within 90 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.¶
(B) Effective no later than October 1, 2024, the notice listed under paragraph (A) of this subsection must be replaced with the following notice in bold text and formatted as follows:¶
Notice to worker, worker's attorney, and attending physician:¶
If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:¶

- Notify the Department of Consumer and Business Services (DCBS) in writing.¶
- Send your written request for review to:¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405¶
If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the decision.¶
For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.¶
(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:¶
(A) The palliative care services are not related to the compensable conditions;¶
(B) The palliative care services are excessive, inappropriate, or ineffectual; or¶
(C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.¶
(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:¶
(A) A copy of the original request to the insurer; and¶
(B) A copy of the insurer's response.¶
(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.¶
(g) Subsequent requests for palliative care are subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.¶
(3) Curative Care. Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.¶
(4) Advances in Medical Science. The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:¶
(a) Describe any objective findings;¶
(b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);¶
(c) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;¶
(d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and¶
(e) Describe why the care is otherwise justified by the circumstances of the claim.
Statutory/Other Authority: ORS 656.726
Statutes/Other Implemented: ORS 656.245

AMEND: 436-015-0030

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0030 incorporates a timeframe of 14 days for MCOs to provide a list of three providers within a category, three nurse practitioners, or three physician assistants willing to treat the workers within a reasonable amount of time.

CHANGES TO RULE:

436-015-0030
Applying for Certification ¶

(1) General. The MCO must establish one place of business in Oregon where it administers the plan and keeps membership and other records as required by OAR 436-015-0050.¶
(2) An applicant for MCO certification must submit the following to the director:¶
(a) One copy of the application;¶
(b) A nonrefundable fee of $1,500, payable to the Department of Consumer and Business Services, which will be deposited in the Consumer and Business Services Fund;¶
(c) Affidavits of each person identified in section (3) of this rule, certifying that the individuals have no interest in a non-qualifying employer under OAR 436-015-0009;¶
(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services under the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and¶
(e) A complete organizational chart.¶
(3) MCO Application. The application must include:¶
(a) The name of the MCO;¶
(b) The name of each person who will be a director of the MCO;¶
(c) The name of the person who will be the president of the MCO;¶
(d) The title and name of the person who will be the day-to-day administrator of the MCO;¶
(e) The title and name of the person who will be the administrator of the financial affairs of the MCO; and¶
(f) A proposed plan for the MCO, in which the applicant identifies how the MCO will meet the requirements of ORS 656.260 and these rules.¶
(4) MCO Plan - General. The plan must:¶
(a) Identify the initial GSAs in which the MCO intends to operate (For details regarding GSAs, see http://wcd.oregon.gov/Bulletins/bul_248.pdf);¶
(b) Describe the reimbursement procedures for all services provided;¶
(c) Include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service;¶
(d) Describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers and how workers can access those providers;¶
(e) Provide a procedure to identify those providers in the panel provider listings that only accept existing patients as workers' compensation patients. This procedure is not subject to the timeframe established in subsection (f) of this section;¶
(f) Provide a procedure for regular, periodic updating of all MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days; and¶
(g) Include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization under OAR 436-015-0040 and OAR 436-009.¶
(5) MCO Plan - Worker Rights. The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:¶
(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;¶
(b) Receive initial treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within 24 hours of the MCO's knowledge of the need or a request for treatment;¶
(c) Receive treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within five working days after the worker received treatment outside the MCO;¶
(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include:¶
(A) The worker's right to receive emergency or urgent care, and¶
(B) The MCO's regular hours of operation if the worker needs assistance selecting an attending physician or has

other questions.¶
(e) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;¶
(f) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographic service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if the provider agrees to the MCO's terms and conditions;¶
(g) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker;¶
(h) Receive specialized medical services the MCO is not able to provide;¶
(i) Receive treatment that is consistent with MCO treatment standards and protocols; and¶
(j) Remain eligible to receive authorized temporary disability benefits up to 14 days after the mailing date of a notice enrolling the worker's claim in an MCO under OAR 436-010-0270(4)(d).¶
(6) MCO Plan - Choice of Provider. The plan must provide all of the following:¶
(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers within a GSA or the MCO, within 14 days, is unable to provide a list of three providers willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(b) A process that allows workers to select an authorized nurse practitioner. If the MCO has fewer than three authorized nurse practitioners within a GSA or the MCO, within 14 days, is unable to provide a list of three authorized nurse practitioners willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from an authorized nurse practitioner, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners cannot be required to comply with the terms and conditions regarding services performed by the MCO. These authorized nurse practitioners are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(c) A process that allows workers to select a physician assistant. If the MCO has fewer than three physician assistants within a GSA or the MCO, within 14 days, is unable to provide a list of three physician assistants willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a physician assistant, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such physician assistants cannot be required to comply with the terms and conditions regarding services performed by the MCO. These physician assistants are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(d) A procedure that allows workers to receive compensable medical treatment from a come-along provider authorized under OAR 436-015-0070.¶
(7) MCO Plan - Provider Agreement. The plan must include:¶
(a) A copy of the standard provider agreement used by the MCO when a provider is credentialed as a panel provider. Variations from the standard provider agreement must be identified when the plan is submitted for director approval; and¶
(b) An initial list of the names, addresses, and specialties of the individuals who will provide services within the MCO. This list must indicate which medical service providers will act as attending physicians in each GSA.¶
(8) MCO Plan - Monitoring and Reviewing. The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including:¶
(a) A program of peer review and utilization review including the following:¶
(A) Pre-admission review of elective admissions to the hospital and elective surgeries;¶
(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;¶
(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, workers' temporary disability, and total number of visits in relation to care

provided by other physicians to patients with the same diagnosis. A physician's profile must not be released to anyone outside the MCO without the physician's specific written consent, except that the physician's profile must be released to the director without the necessity of obtaining such consent;¶
(D) Concurrent review programs that periodically review the care after treatment has begun, to determine if continued care is medically necessary;¶
(E) Retrospective review programs that examine care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and¶
(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.¶
(b) A quality assurance program that includes:¶
(A) A system for monitoring and resolving problems or complaints, including those identified by workers or medical service providers;¶
(B) Physician peer review, which must be conducted by a group designated by the MCO or the director. The group must include members of the same healing art as the peer-reviewed physician; and¶
(C) A standardized medical record system.¶
(c) A program that specifies the criteria for selection and termination of panel providers and the process for peer review. The processes for terminating a panel provider and peer review must provide adequate notice and hearing rights.¶
(d) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, or quality assurance.¶
(9) MCO Plan - Dispute Resolution. The plan must include:¶
(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers under OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing waiver of the 30-day period to appeal a decision to the MCO upon a showing of good cause; and¶
(b) A description of how the MCO will ensure workers continue to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process.¶
(10) MCO Plan - Treatment Standards, Protocols, and Guidelines. The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must describe:¶
(a) The medical expertise or specialties of the clinicians involved;¶
(b) The basis for protocols and guidelines;¶
(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines;¶
(d) The criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines;¶
(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and¶
(f) A process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.¶
(11) MCO Plan - Return to Work and Workplace Safety. The plan must provide other programs that meet the requirements of ORS 656.260(4), including:¶
(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers; and¶
(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must:¶
(A) Identify how the MCO will promote such services;¶
(B) Describe the method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer;¶
(C) Describe the method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001;¶
(D) Include a provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and¶
(E) Include a provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO.¶
(12) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA(s) of the MCO. If the certification is denied, the director will provide the applicant with the reason for the denial.¶

(13) The director will not certify an MCO if the plan does not meet the requirements of these rules.¶
(14) Communication Liaison. The MCO must designate an in-state communication liaison(s) to the director and the insurers at the MCO's established in-state location.
Statutory/Other Authority: ORS 656.260, 656.726(4)
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0110

NOTICE FILED DATE: 01/26/2024

RULE SUMMARY: Amended rule 0110 includes revised language and formatting of notices to workers and other parties, effective October 1, 2024. The updated language and formatting are intended to make the notices easier to comprehend.

CHANGES TO RULE:

436-015-0110
Dispute Resolution ¶

(1) Disputes which arise between any party and an MCO must first be processed through the dispute resolution process of the MCO. ¶
(2) The MCO must promptly provide a written summary of the MCO's dispute resolution process to anyone who requests it, or to any party or their representative disputing any action of the MCO or affected by a dispute. The written summary must include at least the following:¶
(a) The title, address, and telephone number of the contact person at the MCO who is responsible for the dispute resolution process;¶
(b) The types of issues the MCO will consider in its dispute resolution process;¶
(c) A description of the procedures and time frames for submission, processing, and decision at each level of the dispute resolution process including the right of an aggrieved party to request administrative review by the director if the party disagrees with the final decision of the MCO; and¶
(d) A statement that absent a showing of good cause, failure to timely appeal to the MCO shall preclude appeal to the director. ¶
(3) The MCO must notify the worker and the worker's attorney when the MCO: ¶
(a) Receives any complaint or dispute under this rule; or¶
(b) Issues any decision under this rule.¶
(4) Whenever an MCO denies a service, or a party otherwise disputes a decision of the MCO, the MCO must send written notice of its decision to all parties that can appeal the decision. If the MCO provides a dispute resolution process for the issue~~, t~~: ¶
(a) The notice must include the following ~~paragraph~~, in bold text:¶
NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify us in writing within 30 days of the mailing date of this notice. Send a written request for review to: {MCO name and address}. If you have questions, contact {MCO contact person and phone number}. Absent a showing of good cause, if you do not notify us in writing within 30 days, you will lose all rights to appeal the decision. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the director of the Department of Consumer and Business Services (DCBS) for further review. If you fail to seek dispute resolution through us, you will lose your right to appeal to the director of DCBS.¶
(b) Effective no later than October 1, 2024, the notice listed under subsection (a) of this section must be replaced with the following notice in bold text and formatted as follows:¶
Notice to the worker and all other parties: ¶
If you want to appeal this decision, you must:¶
- Notify us in writing within 30 days of the mailing date of this notice¶
- Send your written request for review to: ¶
{MCO name}¶
{MCO address}¶
If you have questions, contact {MCO contact person and phone number}.¶
If you do not notify us in writing within 30 days, you will lose all rights to appeal the decision, unless you show good cause. If you appeal within the 30-day timeframe, we will review the disputed decision and notify you of our final decision within 60 days of your request. After that, if you still disagree with our decision, you may appeal to the Department of Consumer and Business Services (DCBS) for further review. If you do not seek dispute resolution through us, you will lose your right to appeal to DCBS.¶
(5) If an MCO receives a complaint or dispute that is not included in the MCO dispute resolution process, the MCO must, within seven days from the date of receiving the complaint, notify the parties in writing of their right to request review by the director under OAR 436-015-0008.¶
(a) The notice must include the following paragraph, in bold text:¶
NOTICE TO THE WORKER AND ALL OTHER PARTIES: The issue you have raised is not a matter that we handle.

To pursue this issue, you must request administrative review of the issue by the director of the Department of Consumer and Business Services (DCBS). Send written requests for review to: DCBS, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days of the mailing date of this notice, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.¶
(b) Effective no later than October 1, 2024, the notice listed under subsection (a) of this section must be replaced with the following notice in bold text and formatted as follows:¶
Notice to the worker and all other parties:¶
{MCO name} does not have a process to review the type of issue you have raised. To pursue this issue you must request administrative review by the Department of Consumer and Business Services (DCBS) within 60 days of the mailing date of this notice.¶
¶
If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. ¶
Send your written request for review to: ¶
¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405 ¶
¶
For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.¶
(6) The time frame for resolution of the dispute by the MCO may not exceed 60 days from the date the MCO receives the dispute to the date it issues its final decision. After the MCO resolves a dispute under ORS 656.260(15), the MCO must notify all parties to the dispute in writing with an explanation of the reasons for the decision. If the worker's attorney has notified the insurer in writing of representation, the MCO must also send a copy of the explanation of the reasons for the decision to the attorney. This notice must inform the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008.¶
(a) The notice must include the following paragraph, in bold text: ¶
NOTICE TO THE WORKER AND ALL OTHER PARTIES: If you want to appeal this decision, you must notify the director of the Department of Consumer and Business Services (DCBS) in writing within 60 days of the mailing date of this notice. Send written requests for review to: Department of Consumer and Business Services, Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, PO Box 14480, Salem, OR 97309-0405. If you do not notify DCBS in writing within 60 days, you will lose all rights to appeal the decision. For assistance, you may call the Workers' Compensation Division's toll-free hotline at 1-800-452-0288 and ask to speak with a Benefit Consultant.¶
(b) Effective no later than October 1, 2024, the notice listed under subsection (a) of this section must be replaced with the following notice in bold text and formatted as follows:¶
Notice to the worker and all other parties: ¶
If you want to appeal this decision, you must do so within 60 days from the mailing date of this notice. ¶
If you do not notify the Department of Consumer and Business Services (DCBS) in writing within 60 days, you will lose all rights to appeal the decision.¶
Send your written request for review to:¶
DCBS Workers' Compensation Division¶
Medical Resolution Team¶
350 Winter Street NE¶
PO Box 14480¶
Salem OR 97309-0405 ¶
For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.¶
(7) If the MCO fails to issue a decision within 60 days, the MCO's initial decision is automatically deemed affirmed. The parties may immediately proceed as though the MCO had issued an order affirming the MCO decision. The MCO must notify the parties of the next step in the process, including the right of an aggrieved party to request administrative review by the director under OAR 436-015-0008 including the appeal rights provided in (6) of this rule.¶
(8) The director may assist in resolution of a dispute before the MCO. The director may issue an order to further

the dispute resolution process. Any of the parties also may request in writing that the director assist in resolution if the dispute cannot be resolved by the MCO.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260