

# Agenda

## Rulemaking Advisory Committee

Workers' Compensation Division Rules  
OAR chapter 436,  
Division 009, Oregon Medical Fee and Payment Rules  
Division 010, Medical Services

<b>Type of meeting:</b>	Rulemaking advisory committee
<b>Date, time, &amp; place:</b>	Nov. 9, 2015, 8:30 a.m. to 11:30 a.m.  Room 260, Labor and Industries Building, 350 Winter Street NE, Salem, Oregon Teleconference dial-in: 1-213-787-0529   Access code, 9221262#
<b>Facilitator:</b>	Fred Bruyns, Workers' Compensation Division
<b>8:30 to 8:45</b>	Welcome and introductions; meeting objectives
<b>8:45 to 10:00</b>	Request for new issues – discussion of new issues Discussion of issues on file
<b>10:00 to 10:15</b>	Break
<b>10:15 to 11:20</b>	Discussion of issues continued
<b>11:20 to 11:30</b>	Summing up – next steps  Thank you!

Attachment: [Issues document](#) [ [1](#) [2](#) [3](#) [4](#) [5](#) [6](#) [7](#) [8](#) [9](#) [10](#) [11](#) [12](#) [13](#) ]

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 1**

**Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2016)**

**Issue:** Should WCD issue a temporary rule, effective each January 1, in order to adopt the new CPT codes published each year and allow providers to use the same codes for work comp billing as they do for other types of billing? Should WCD assign maximum payment amounts to CPT and HCPCS codes in Appendices B – E, where possible?

**Background:**

- The American Medical Association publishes new CPT codes, effective January 1 that WCD does not adopt until April 1. This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if providers use new codes between January 1 and April 1.
- CMS publishes Medicare fee schedule amounts for these CPT codes as well as a new DMEPOS fee schedule, that may contain new HCPCS codes that take effect January 1.
- Between mid-Dec. and mid-Jan. each year, WCD publishes a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), that become effective April 1. This allows time for public input on proposed payment amounts.
- Using a temporary rule to adopt the new CPT and HCPCS codes would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid new codes. In addition, adopting temporary Appendices B-E would allow WCD to assign payment amounts to new codes prior to April 1.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD could update appendices B – E and assign maximum payment amounts using the 2015 conversion factors/multipliers.

**Options:**

- Adopt new CPT codes through a temporary rule, effective January 1, 2016 and update appendices B – E with payment amounts for new codes using the 2015 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 2**

**Rule: OAR 436-009**

**Issue:** Should insurers be required to respond to a request for a written statement confirming the verbal approval of proposed physical therapy frequency and modalities?

**Background:**

- This issue was raised by a stakeholder who stated that insurers approve a certain number of PT visits and modalities by phone, but then refuse to confirm the conversation in writing so that they later can deny payment.
- Currently, insurers don't have to pre-authorize PT, although nothing in rule or statute prohibits them from pre-authorizing PT, if they so choose.
- If a provider keeps a phone log, the Medical Review Team will consider that documentation in case of a dispute regarding payment of services.
- However, WCD is not able to make the insurer guarantee payment, because compensability, i.e., causal relationship between the service provided and the accepted claim, is not in WCD's jurisdiction.

**Options:**

- Add a rule that requires insurers to pre-authorize PT visits in writing if requested. Similar to the provision for diagnostics?
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 3**

**Rule: OAR 436-009-0004**

**Issue:** Should the division update standards to current versions in these rules?

**Background:**

- Each year the division reviews adopted standards listed in this rule to assure that we are requiring the correct standards.

**Options:**

- Change standards to the current versions.
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 4**

**Rules: OAR 436-009-0008(1)(a) and OAR 436-010-0008(1)(a)**

**Issue:** Should WCD make a rule change to clarify when medical disputes arise under .245/327 vs. .248?

**Background:**

- This issue was raised by a stakeholder stating that their concern is the availability of attorney fees in disputes in which claimants have an interest.
- ORS 656.385(1) provides that in all cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340, where a claimant finally prevails after a proceeding has commenced, the Director of the Department of Consumer and Business Services or the Administrative Law Judge shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney.
- ORS 656.245(6) states that subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the injured worker, insurer or self-insured employer may request administrative review by the director pursuant to ORS 656.260 or 656.327.
- ORS 656.248(12) provides that when a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of bills for compensable medical services, notwithstanding any other provision of this chapter, the injured worker, insurer, self-insured employer or medical service provider may request administrative review by the director. The decision of the director is subject to review under ORS 656.704.
- The stakeholder provided the following analysis:
  - The emphasized language of ORS 656.248(12) is where the WCD can best distinguish between disputes arising under ORS 656.245/.327 and those arising under ORS 656.248. As I read the statutes, .248 disputes arise between 1) a worker, an insurer, or an employer and 2) a medical provider, and therefore are identified first and foremost by the parties in interest. This makes sense, for several reasons:
    - 1) Providers are not required to pay attorney fees to claimants' attorneys. As noted, ORS 656.327 only provides for fees paid by employers and insurers. So, a dispute between claimant and a medical provider is not going to result in an attorney fee.
    - 2) Disputes between an insurer and a provider only do not implicate the worker's interest. That is, there is no justiciable controversy between a worker and an insurer when a dispute exists only between an insurer and provider.
    - 3) This appeared to be the intent behind ORS 656.248 disputes when enacted. It was meant to deal with disputes between the insurer and the provider only.

- Of course, disputes may arise between an insurer and medical provider in which a claimant intervenes. To determine what kind of dispute it is in these will depend on whether claimant has any direct interest in the dispute against the insurer. That is, whether or not a justiciable controversy exists between the insurer and the claimant.
- The stakeholder proposes to amend OAR 436-009-0008(1)(a) and 436-010-0008(1)(a) as follows:
  - (A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. All disputes in which a worker's interest is adverse to the insurer's interest are medical service or treatment disputes arising under ORS 656.245, 656.247, 656.260, 656.327 or 656.340.** Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.
  - (B) Disputes between an insurer and a medical provider, or between a worker and a medical provider, arise under ORS 656.248.**

**Options:**

- Amend OAR 436-009-0008(1)(a) and 436-010-0008(1)(a) as proposed above.
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 5**

**Rule: OAR 436-009-0008(5)(a) and 436-010-0008(6)**

**Issue:** Should WCD change the requirement in these rules from “mailed” to “received” to be more consistent with other rules and avoid possible misunderstanding of the time frame?

**Background:**

- 436-009-0008(5)(a) and 436-010-0008(6) state, in part,: “The director may on the director’s own motion reconsider or withdraw any order that .....the review. The director may grant or deny a request for reconsideration at the director’s sole discretion. A request must be **mailed** before the administrative order becomes final.”
- By stating that the request must be **mailed**, rather than **received**, before the order becomes final, this rule invites a scenario in which the request is mailed within the time frame specified, however received after WCD has already lost jurisdiction to abate and withdraw the order because the order is final by operation of law (in most cases, 30 days after the order is issued).
- This rule language creates a danger of misleading stakeholders as to how and when orders may be reconsidered by the division. For example:
  - A party mails a request for reconsideration of a 656.245 order on day 29 (within the time frame required by the rule) but WCD receives it on day 31 (after the 30 day appeal period has run, the order is final, and WCD can no longer abate and reconsider). In other words, WCD could not do anything in response to that request even though it was mailed within the time frame stated.

**Options:**

- Change the word “mailed” to “received” in these rules?
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 6**

**Rules: OAR 436-009-0010(3)**

**Issue:** Should WCD clarify when fields 32 (facility name and address) and 32a (facility NPI) for the CMS 1500 should be populated?

**Background:**

- The NUCC instructions for field 32 and 32a for the CMS 1500 are somewhat unclear.
- WCD expects providers to put a facility's name and address in box 32 if that name and address are different than the billing provider's name and address (field 33) because WCD wants to know where the service was provided.
- EDI medical bill reporting requires insurers to report a facility NPI if they report a facility name and address. Therefore it would be reasonable to require providers to report a facility NPI in field 32a even if that NPI is the same as the billing provider's NPI.

**Options:**

- Amend the table in 009-0010(3)(e).
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 7**

**Rules: OAR 436-009-0010(12)**

**Issue:** Should Platelet Rich Plasma (PRP) injections be considered a form of prolotherapy and, if not, should PRP injections be a compensable medical service?

**Background:**

- ORS 656.245(3) allows the director, by rule, upon the advice of the medical advisory committee (MAC) for the workers' compensation division, to exclude from compensability any treatment the director finds to be unscientific, unproven, outmoded, or experimental.
- Prolotherapy is excluded from compensability under OAR 436-009-0010(12).
- For the purpose of OAR 436-009-0010(12), PRP injections are currently considered a form of prolotherapy and are, therefore, excluded from compensability.
- The MAC formed a subcommittee to research and analyze whether PRP injections should be considered a form of prolotherapy and, if not, whether PRP injections should be a compensable medical service.
- After conducting a thorough literature review and determining the most persuasive studies, the subcommittee is making the following recommendation to the full MAC:
  - PRP injections are **not** a form of prolotherapy and
  - PRP injections should **not** be a compensable medical service because they are:
    - Unproven – the evidence does not demonstrate efficacy and
    - Experimental – there is insufficient evidence to reasonably assess outcome.
- The full MAC will discuss the subcommittee's recommendation at its November 13, 2015, meeting.
- John Shilts will review MAC's recommendations and WCD will propose rules based on John's decision.

**Options:**

- Clarify by rule that for the purpose of OAR 436-009-0010, PRP injections are not considered a form of prolotherapy.
- Add PRP injections to the list of non-compensable treatments under OAR 436-009-0010(12).
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 8**

**Rules: OAR 436-009-0025(1)(e)(C); 009-0030(3)(c)(C); 009-0030(4)(a); 009-0110(7)(i)(C); 009-0110(7)(j); 010-0265(10)(b); 436-008-0030 (and guide)**

**Issue:** Should WCD change certain rules for insurer action or response from the current requirement in hours to days to be more consistent with other rule requirements?

**Background:**

- The division heard from a stakeholder that, “using numbers of hours for responding or sending things is problematic, and is not consistent with other rules. Other statutes and rules reference time-frames in days.”
- In the Div. 009 rules, insurers are required to respond to payment inquiries within 48 hours, e.g., “.....insurer or its representative must respond to a worker’s reimbursement question within 48 hours, excluding weekends and legal holidays.”
- In the Div. 010 rules, “The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of the insurer’s receipt of the report.”
- Other requirements in both sets of these rules require insurer responses or actions within a set number of days rather than number of hours.
- ORS 656.252(1)(a) requires physicians to submit the first report of injury to the insurer within 72 hours, i.e., the statute establishes a reporting requirement in hours, not days.

**Options:**

- Change certain rules to require insurer response or action in a certain number of days rather than in hours?
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009**

**Issue # 9**

**Rule: OAR 436-009-0060(1)(b)**

**Issue:** Should WCD remove this rule?

**Background:**

- The current 436-009-0060(1)(b) states, “When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for a patient, he or she must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.”
- This same language, with slight revision, is contained in 436-010-0240(3), “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.”
- The Div. 009 rules are about billing and payment, and WCD believes that the rule language can be removed.

**Options:**

- Remove this rule?
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 10**

**Rule: OAR 436-009-0080(10)**

**Issue:** Should WCD increase the amount for hearing aids before the worker needs insurer or director approval.

**Background:**

- WCD heard from stakeholders (worker and provider) that the cost of hearing aids has increased since 2002 and therefore, the amount for the cost of hearing aids before insurer approval is required should also be increased.
- OAR 436-009-0080(10) provides that the cost of a hearing aid may not exceed \$2500 (\$5000 for a pair) without insurer approval. This amount has been established in 2002 and has not changed since then.
- WCD has not analyzed any bill and payment data regarding hearing aids, i.e. WCD does not know what the average cost of hearing aids is or what percentage of hearing aids are above \$2500.

**Options:**

- Raise the cost of a hearing aid from \$2500 to ??? before insurer or director approval is required.
- Analyze bill and payment data prior to considering a change in future rulemaking.
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 11**

**Rule: OAR 436-009-0080**

**Issue:** Should this rule contain a provision that allows a worker to pay the difference between a prosthetic appliance prescribed by their provider and an upgraded appliance that the worker wishes to acquire?

**Background:**

- Insurers are required to pay for medically necessary prosthetic appliances and repairs.
- In 2015, WCD introduced a provision in OAR 436-009-0080(2) that allows a worker to choose to upgrade a prosthetic appliance when replacing such an appliance, if the worker is willing to pay the difference in price.
- Current rules do not contain such a provision for new appliances.

**Options:**

- Add a provision to OAR 436-009-0080 that allows a worker to choose an upgraded new prosthetic appliance, if the worker is willing to pay the difference in price.
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 12**

**Rule: OAR 436-010-0241(2) and Form 827**

**Issue:** Should WCD revise Form 827 and remove the box “Request for acceptance of a new or omitted medical condition on an existing claim” from this form?

**Background:**

- A stakeholder reports that doctors and their staff members (including receptionists) have completed the worker’s portion of Form 827, then asked the worker to sign the form, even knowing the worker is represented.
- The stakeholder believes that requesting a new condition claim is not purely a medical decision. It is a medical/legal decision and should not be completed without consulting an attorney. It sets in motion many procedural matters, time limits, and potentially a denial that will have to be contested, where the burden is on the worker to prove that the new condition actually exists and is sufficiently causally related to the accepted injury or disease.
- The doctor or his staff is not going to have to prove these things at a hearing or even determine whether there is sufficient proof to persuade a judge. Some attorneys have had to beg (after the form has been completed without their okay and a denial issued) for the insurer to withdraw the denial if the worker withdraws the claim. Some attending physicians have misused the “new condition” claim as a means to obtain diagnostic tests, when merely ordering the test would do.
- March 2008: The OMA's Workers' Compensation Committee recommended the division streamline the acceptance or denial of new medical condition through modification or creation of a form.
- March 2009: Draft, revised Form 827 presented to the Medical Advisory Committee. The committee members voiced strong support for the addition of the new/omitted condition check box.
- Jan 1, 2010: The option for workers to file new/omitted medical condition claims was added to OAR 436-010-0240, eff. 1/1/2010. (Use of Form 827 is not required to file such a claim.)

**Options:**

- Revise Form 827 removing the box, “Request for acceptance of a new or omitted medical condition on an existing claim.”
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**

**Oregon Administrative Rule Revision  
Chapter 436, Division 009 and 010**

**Issue # 13**

**Rule: OAR 436-010-0330(2)**

**Issue:** Should the reference to ORS 656.260 be removed from this section?

**Background:**

- This section states that the director will establish and maintain a list of physician reviewers. The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245, 656.260, and 656.327.
- However, based on *Roger D. Houser*, 17 CCHR 323 (2012), the director changed policy and no longer uses this list of physician reviewers when appointing a physician or panel of physicians to review treatment under ORS 656.260. Instead, for disputes under ORS 656.260, the director appoints a physician or panel of physicians under ORS 656.325.

**Options:**

- Remove the reference to ORS 656.260 from this section.
- No change.
- Other?

**Fiscal Impacts, including cost of compliance for small business:**

**Recommendations:**