

Rulemaking Advisory Committee Minutes
Workers' Compensation Division Rules
OAR chapter 436,
Division 009, Oregon Medical Fee and Payment Rules
Division 010, Medical Services
Nov. 9, 2015, 8:30 a.m. to 11:30 a.m.
[Nov. 23, 2015, 8:30 to 11:30 a.m.](#)

Committee members attending:	Nov. 9	Nov. 23
Adam Fowler, Helios	X.....	X
Allison Morfitt, SAIF Corporation	X.....	X
Brian Allen, Helios	X.....	
Chris Murrell, SAIF Corporation.....	X.....	
Courtnei Dresser, Oregon Medical Association	X.....	X
Dale Johnson, Attorney.....	X.....	
Dan Miller DC, Oregon Chiropractic Association	X.....	
Dan Schmelling, SAIF Corporation.....	X.....	X
Genoa Ingram, Court Street Consulting, LLC	X.....	X
Helen Eby, Gaucha TI.....		X
Jaye Fraser, SAIF Corporation	X.....	X
Jennifer Flood, Ombudsman for Injured Workers	X.....	
Joe Martinez, Concentra Medical Centers.....	X.....	X
Kathy de Domingo, Progressive Rehabilitation Associates.....	X.....	X
Keith Semple, Johnson Johnson Larson & Schaller PC		X
Kevin Tribout, Helios	X.....	X
Larry Bishop, Sedgwick CMS.....	X.....	
Laurel Gunderson, Providence MCO.....	X.....	
Lisa Anne Forsythe, Coventry Workers' Comp Services.....	X.....	X
Pam Settle, Coventry Workers' Comp Services.....	X.....	
Randy Elmer, Randy M Elmer Atty at Law PC.....	X.....	X
Scot Frink, Salem Audiology Clinic	X.....	X
Scot Hurner, Liberty Mutual	X.....	
Sheila Hansen, CorVel Corporation.....	X.....	X
Sheri North, Mitchell International Inc.	X.....	
Steve Detert, Allstate Insurance Company	X.....	
Sue Cline-Quinones		X
Ted Heus, Lyons Lederer, LLP	X.....	
Virginia Walker, Davaco	X.....	X

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Agency Staff members attending:	Nov. 9	Nov. 23
Amy Wadsworth.....	X.....	X
Andrew Gawne.....		X
Cara Filsinger.....	X.....	
Daneka Karma.....	X	
Don Gallogly	X.....	X
Fred Bruyns.....	X.....	X
Juerg Kunz	X.....	X
Michelle Miranda	X.....	X
Myra Aichlmayr	X.....	X
Nanci Johnston.....	X.....	X
Stan Fields.....	X.....	X
Steve Passantino	X	

Fred welcomed the committee members, requested input on fiscal impacts of potential rule changes discussed, and asked members to present any new issues before the committee considers the prepared agenda.

Meeting minutes have been entered below in italicized text. The following is not a transcript, and some comments have been paraphrased for brevity.

New issues:

Speaker & Time **Committee comments:**

06:28
Kevin *We have seen the compounding issue arise as the physician-dispensing issue has been handled by the states, including Oregon. We are advocating the same thing on the compound side. Twenty-three other states have taken regulatory or legislative action concerning compounds. We have seen over utilization of compounds, not only from a clinical standpoint, but really high pricing. Clinically, compounds are used on a small percentage of claims, mostly in the elderly and in children, if a patient cannot swallow the medication or has a reaction to an ingredient. Compound utilization has started to spike, to a point where 9-10% of utilization is for topical compounds, greater than in the other health care fields. Although sometimes medically necessary, to put compounds on the same level playing field as retail pharmacy and physician dispensing, compounds should be billed at the ingredient level. (See written input.)*

11:38
Lisa Anne *We have also observed the trends that Kevin referred to. It would be very helpful for us from a billing and payment processing standpoint if there were to*

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be rules that identified and required billing of the underlying NDC and rules surrounding it.

12:10
Jaye *We concur if we are going the route of compounds there needs to be some control over it. There might be something in the rules that would talk about criteria for when you are going to use compounds. I heard from Helios that there are instances where we need to go that way because of patient needs e.g. not being able to swallow large pills, or inability to tolerate a certain ingredient – so there is actually a reason for going to the compound.*

12:52
Jennifer *It would be good to pave that way so that the expectation is clear for everyone. Workers would know what they are entitled to; adjusters would know what they should be paying for.*

Fred *Additional thoughts? Any thought on the level in Oregon on the compounding prescriptions?*

13:35
Chris *Utilization has gone up in the last few years. Concerns from a medical perspective would be the inability to regulate dosing, as well as pricing because there is high variability in the pricing.*

14:17
Courtnei *No one is really clear on the numbers. Courtnei requested that more data be obtained before any decisions are made.*

15:00
Kathy *From the Chronic Pain Clinic perspective, I can tell you that we are being marketed more and more by compounding pharmacies... I agree we need to have a clear rationale for what we do.*

16:16
Kevin *We do have some clinical pieces that we can share with the committee on the efficacy of compounds and how they work from a topical pain standpoint that might be helpful.*

16:47
Lisa Anne *We may be able to provide data for you.*

17:03
Jennifer *Has the Medical Advisory Committee had any discussions on compounds?*

17:10
Juerg *No, not really.*

17:30
Fred *Introduce next issue. Advice received from Joe Martinez.*

17:57
Joe *Introduced a topic for the division and committee to consider – The last two years the division has kept the providers more or less budget neutral. The cost of doing business increases every year. In addition, as primary treatment*

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providers we assume risk when we see patients, and claims can be denied or litigated which as a result we incur significant amounts of debt that we don't recover in many instances. We respectfully ask the division to consider a 3% increase based on the Medicare index over the last couple years. We feel that this will allow us to continue to operate and remain competitive in this arena of medical care.

19:11
Kathy *For my clinic specifically the issue is more about timely payment. We certainly support an increase in the fee schedule because there is no disputing the fact that treating injured workers is more complex and time consuming. To be reimbursed timely is significant. Some of our claims can be 6-9 months out before they are paid. When we are waiting 90-180 days to get reimbursed for services provided and that we paid providers to do, it just adds to our costs.*

20:12
Jaye *Is that for a claim in litigation?*

20:18
Kathy *Not necessarily. Certain insurers will do a number of things to stall claims.*

21:05
Joe *That's a cost of doing business. The receivables age, and does cost the provider to finance and carry those receivables.*

21:40
Allison *I would ask that the department look at what providers are being reimbursed in the market to factor in how the payment compares to other payers.*

22:06
Dr. Miller *In the event that there is a broad scope increase I know that the chiropractic codes were segregated a couple years ago to make sure that they were not adversely affected with averages on the physical medicine codes. I want to make sure that if there is a 3% increase that segregated chiropractic codes are included. Chiropractors will use this fee schedule to determine what they charge across the board because we do have a high population of cash paying patients. We can't be like a hospital or medical provider that charges \$100.00 and expects to get 50% from this carrier and another percent from another carrier – Chiropractors typically across the board say the fee schedule is the market value.*

23:36
Kathy *Common practice among medical providers regardless of disciplines is to take the highest fee schedule and set the fees accordingly. We are federally prohibited from discussing fees with other providers, so we only have the fee schedules that the insurers provide us.*

24:20
Fred *We have been warned about how much information we try to obtain in terms of what fee schedule you are using and how that compares with other fee schedules because it can get into anti trust issues.*

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- 24:43
Jaye *Oregon specifically does not tie itself to Medicare, so I would urge the department to not just jump to Medicare when it makes that assessment but to do it on a conscious basis.*
- 25:20
Joe *The point with Medicare is that it is what many fee schedules use as a metric for increases, in many states across the country. It's been a fair measure on how to increase the fees and not have it just be an arbitrary number. It's been a fair bench mark to look at in terms of potential increase.*
- 25:50
Fred *That's different from the medical index of the consumer price index?*
- 25:53
Jaye *Yes it is. From SAIF's perspective, we think Oregon does this differently for a reason and we would urge you to not just look at Medicare.*
- 26:12
Scot Frink *We bill based on our billable hour cost of operation because with Medicare they set what they reimburse on the average of what they pay not on what it actually costs for us to do the work. In all honesty Medicare reimburses about 40% of what it actually costs to do the work.*
- 27:14
Fred *Introduced new issue from Allison Morfitt, SAIF Corporation.*
- 27:20
Allison *In our contracts with our MCO's there are a few circumstances where the MCO will negotiate discount with their providers on their panel for a particular service. Right now there aren't enough specific CPT codes or OSCs (Oregon Specific Codes) to really describe the service the MCO is negotiating, so I would request the department to adopt additional, more specific codes. We can provide a list of those codes to use in the case of MCO's negotiating discounts.*
- 28:53
Fred *Do you have a sense of volume for these codes?*
- 28:55
Allison *It's maybe a dozen or so...*
- 29:01
Juerg *If you want to introduce more OSCs we need to know what those codes are and what they stand for.*
- 29:20
Allison *We can provide a list of what those are, or if there was just some ability for us to use internally some of those specific codes as long as we are cross-walking it back to a code the division recognizes.*
- 29:34
Juerg *If your use is purely internally that's fine, but if you use those codes and changed them and they get back to the provider then it's no longer just an internal process. If it was purely changed internally, the division would never*

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even know. The cleanest thing would be to adopt additional OSCs.

30:27
Fred *This would apply to everyone. If there is anything you would like me to share with the committee within the next week or two please send to me. I have to let you know that everything in terms of rule making is public record as soon as I receive it.*

30:58
Lisa Anne *From our perspective, we would just want to know what services we are talking about here. We would want to make sure that if any codes are added we would prefer that they have an assigned value to default to.*

31:34
Fred *So you were thinking of these as assigned values Allison?*

31:36
Allison *Not necessarily. These are contractual between the MCO and provider.*

31:43
Juerg *Often times a code doesn't describe the very specific service- time may differ or what it includes may differ – When that happens you really can't assign a fixed dollar amount.*

32:15
Nanci *A good description would be helpful.*

32:38
Dr. Miller *Asked question about possible ramifications of non-contracted providers that would perform a similar service as the MCO ... - are non-contracted providers going to have to use this Oregon Specific Code that they may not even know about?*

33:09
Juerg *If we do adopt an OSC that more specifically describes the service provided we would expect the provider to use that OSC. The code itself I don't think has too much to with if it's contracted or not. The code just basically describes some sort of service.*

34:09
Dr. Miller *Sounds like it would be possibly an abbreviation of an existing code... without specific examples it's really hard to make a judgment on this.*

34:46
Juerg *If we do get a list with codes, if we adopt them we would publish those first in the proposed rules. If it is suggested there is a payment amount with any code we would publish that also.*

35:15
Dr. Miller *I don't want to see providers that are not contracted with MCO being lumped into obligations for taking the reductions that contracted providers agreed to.*

35:31
Jaye *We are talking about a MCO contracted fee, and so it is the panel providers that are impacted by those codes.*

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- 35:58
Laurel *If the MCO has contracted with the provider for a discount, if an OSC is assigned to a service, then all providers that work for the workers' comp system will get paid for this, then only that provider would have the discount taken.*
- 36:09
Dr. Miller *So you don't think that Oregon Specific Codes will end up with a fee schedule with less than what is being used?*
- 36:36
Laurel *Not necessarily, a specific fee code is assigned to a service, then all providers that do that service within the workers comp system would get paid that fee schedule amount, unless they were an MCO contracted provider who had agreed to a fee discount below the schedule by contract. Only MCO providers are subject to MCO discounts.*
- 36:51
Dr. Miller *It sounds like the discount is based upon the existing code that may be more general than the specific code they are trying to create.*
- 37:18
Juerg *If an Oregon specific code replaced another code that already exists, then the code that already exists probably doesn't correctly describe the service that's being done, or it's a code that is so general the fee schedule doesn't have a fee. I think it's too early to talk specifics until we actually see what is suggested.*
- 38:29
Jaye *SAIF just wants to get this issue on the table publicly, but doesn't expect it to be resolved at this point.*
- 38:40
Laurel *There are so many by report codes that could be assigned ... more specific codes. I think that is what I would like to see – more specific codes to say this is what it's for. For example, we already have specific codes for brief narrative, or how many questions are asked, and that is specific to workers' compensation.*
- 39:54
Lisa Anne *Asked Allison question if this is sort of a red herring that just happens during MCO contracting and then there is not a great code for something so one is added?*
- 40:45
Allison *With some of the Opioid testing there is a lot of different codes... thousands of dollars in charges, so that is something that we have negotiated with the MCO to set a rate for that confirmatory testing... Basically something that has been created to work for all three parties involved.*
- 43:00
Fred *Introduced new topic.*
- 43:06
Allison *New topic asking the department to take a look at the reimbursement for rural hospitals. For most services right now they are paid at 100% of their charges. What is the relationship of the charges as it relates to cost? At times hospitals*

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are charging five times what their costs actually are, so we would like the department to look at that.

44:42 Will you provide us some data on that? I'm not sure where we will get that data
Nanci from.

44:57 Do you have access to their cost reports? Discussed instances of hospital cost
Allison inflation charges.

46:23 Are you more concerned about outpatient than inpatient?
Juerg

46:28 It more just looking at the over all charges and coming up with a methodology
Allison that is tied more in lines with the cost.

46:48 A different methodology than we use now for calculating cost to charge ratio?
Nanci Because that is how we do it now based on the reports they give us.

47:02 That is correct. Discussed methodology used to calculate cost to charge ratio
Don and what is exempt and that there are different methodologies used.

47:28 More discussion on cost to charge ratio...

Allison
47:45 Discussed the conversion factors that the division uses and applications.
Juerg Discussion on introducing new codes.

51:08 Handout from Dolores Russell from CareMark Comp MCO for written issues
Fred submitted to the department.

52:18 See issue #1 below.
Fred

01:49:55 (After break) Introduced new issue from Steve Detert.
Fred

01:50:10 The first issue is regarding reasonable market rates for the 97124 CPT code for
Steve Detert massage in Oregon. In my own research, the rates being billed and approved
for the work comp fee schedule in Oregon don't appear to be commensurate
with the actual market rates for that service. I would like the committee to look
at this. Question to committee on how much they pay for this service as a
consumer when they go out on the open market?

01:51:57 Resort facility in Cannon Beach 50 minute massage was a \$120.00 ten years
Dr. Miller ago. Also, there is an exercise facility that charges \$1.00 per minute – a 50
minute massage would be \$50.00. I've seen the ranges in this.

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- 01:53:01
Steve Detert *In my own research I have seen rates range from \$50 through \$80 on average. What stuck me is how far it is away from work comp fee schedule which is \$180.00 an hour. The second step of research in interviewing massage therapists that work at physical medicine, physical therapy, or chiropractic facilities. Some of them are paid as employees and the billing facility bills for the service – research finds many massage therapists that are providing the same services are being paid \$25 to \$35 an hour. This matches up well with the \$60 to \$80 range because it allows for the facility to hire someone to provide a service and allows for a 50% mark-up for profit and cost of doing business.*
- 01:55:38
Laurel *I had no idea the fee schedule was \$180 an hour.*
- 01:55:53
Jaye *I have never paid more than \$130-140 for a 90 minute massage.*
- 01:56:13
Dr. Miller *There are a couple of things I would like to address. First, you have to consider the level of service (spa type massage vs a medically necessary massage). The Oregon Chiropractic Association put out that massage needs to be specific to the injury. If you have a one-area injury then you should have a one-unit massage - a 15 minute massage. We do see abuse of massages in the system.*
- 01:59:01
Laurel *We don't approve more than two units initially. I have seen a lot of massage therapy bills but I haven't seen anyone bill that high.*
- 01:59:32
Fred *I think we have to look at data in terms of what we have.*
- 01:59:41
Dr. Miller *Physical therapist that can do massages vs a massage therapist.*
- 02:00:15
Kathy *If it's being delivered by a physical therapist chances are that singular code for massage therapy is not the only code that is going to be submitted in the claim. There is a difference between the education of a massage therapist and that of a physical therapist.*
- 02:00:45
Laurel *Massage therapists don't even do chart notes.*
- 02:00:50
Dr. Miller *I think that they would be required to under workers' comp. It boils down to whether the chart notes justify the treatment.*
- 02:01:21
Sheila *I just came back from an accreditation survey they did in Canada for occupational rehabilitation programs which include massage therapists in their programs. Their documentation has to be clear on what they are doing, their*

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modalities. They can't just self-refer either.

02:01:52
Dr. Miller *I don't want to downplay the education of the LMT, and they have limitations in that they can't refer or diagnose. I think the review process of this particular service is justifiable regardless of what the fee schedule is – is it justifiable that they did this type of service for that particular type of injury?*

02:02:29
Steve Detert *I think there are two different discussions going on here. One is if the rate is reasonable for the market or the code. Two, what are people actually doing when they provide these services. I think your expectation of what is required is accurate as far as the record keeping. I think what happens is when you take a good purpose, which is to set up a fee schedule to keep costs and prices accurate for the market -, if it's not done properly it's a higher number that everyone matches. What I see from my side in reviewing the codes from a large number of providers is once you set a fee code at a number that is the price, even though the statute says you can bill less than that, really no one is doing that.*

02:03:22
Laurel *Or to bill their normal fee...*

02:03:26
Steve Detert *What you see is the workers' comp fee schedule has approved this amount for this code – I'm providing this code so I'm billing that amount. I think that it has inflated the cost of the service above what the market rate really is... I think there is cause for a rate review on this code.*

02:04:51
Dr. Miller *Another thing to consider is these codes are not provider specific. For example, a physical therapist can do this, an MA can do it, a DC can do it, an acupuncturist can do it – if they can all use this code than maybe the intention was it was a physical medicine code that could be done as part of a rehabilitation program and it's now being utilized as a little more aggressively with a certain demographic.*

02:06:21
Steve Detert *The flip side to this is the reason I gave the second analysis, was when we take statements or depositions from massage therapists that are employed at these facilities, the amount they are being paid by the hour is more consistent with these numbers. If you are paying someone \$30 an hour and you are charging six times that amount for the service you are rendering, that seems to be unusual. The second reason why I'm focusing only on this one code is when you look at the medicine code billed within Oregon, the percentage of monies paid for this one code versus all others in physical medicine – this is the dominant code. If you do the research you'll see that 25-35% of the monies paid are massage coding. Because it's such a high number it's a cash cow and everyone is jumping on board, and it does lead to abuse.*

02:08:23 *The fee is determined by CMS RVU's (Relative Value Units) and our conversion*

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- Juerg factor. Medicare uses CMS RVU's and their conversion factor. We use one conversion factor for all physical medicine and rehab codes (97 codes). The work comp fee schedule is above the Medicare fee schedule. If our level of increase was the reason why this code is highly priced, then all the other codes in physical medicine rehabilitation category would also be highly priced. From what I'm hearing that is not the case, but it's this specific code. This indicates to me that CMS RVU's are too high for that code. That's kind of how we import that pricing into the work comp fee schedule, because we generally don't mess with the RVU's. If we want to discuss the fee schedule for this specific code that should be separated from the RVU's, then that would be the discussion. We would do something similar like we did with the chiropractic codes but in the other direction, but that's what this committee needs to discuss. It doesn't seem like the category of physical medicine is overpriced. We actually had a discussion about raising the work comp fee schedule by 3% across the board.*
- 02:11:21 You also don't want to punish other providers that are using this code. You
Dr. Miller could be like Providence where they have a policy that says we are not going to allow for more than two units per injury for that massage, but I don't think this is the jurisdiction to do that in.*
- 02:11:51 You made a good point before. Generally when we go privately we get a whole
Juerg body massage that last an hour. In work comp we have specific accepted conditions that are really focused on one area of the body. If you have an upper back or neck injury it's hard to justify an hour long massage just for a limited area. That is where some price control can come in and where the insurers will challenge the appropriateness of the treatment for the condition.*
- 02:12:41 It based on what CMS uses for the RVU's – that's very carefully to be
Kathy evaluated. What are the technical components that go into it, what are the practice expenses that go into it, what's the education level of the provider?*
- 02:13:52 RVU are a good measurement of the expenses involved and that is why we
Juerg adopted it. We have very few codes where we don't use the RVU's.*
- 02:14:18 Uniqueness about the massage code is it's one of the few services where there is
Steve Detert competition in the market place outside of the workers' comp where people are providing the service to compare. It's hard to compare the cash component and or the market rate for the other services, and so my focus hasn't got to this and I can't comment on the RVU's on the other codes. I'm coming from the other side – I'm looking at the market and coming back to the fee schedule and something does not look right. When I see what is being billed on the street from all these businesses and what is being paid by the work comp fee schedule, and it's not \$10.00 but triple the amount. The characterization of punishing them isn't correct. Punishing them would be not paying them. Paying them what the market rate should be is setting a price for the right number...*

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- 02:17:22
Laurel *Massage therapists use the same codes as physical therapists, and other providers that provide this service, but the level of training is different. Why wouldn't it be fair to set them apart and assign a different conversion factor for them?*
- 02:19:11
Sheila *97124 is the code for massage therapy. It's the only code a massage therapist can use in WA. If you are looking at the complexity of care that a physical therapist provides, they are billing many other codes in conjunction with 97124. I don't know that changing what an LMT does is the right way.*
- 02:19:34
Steve Detert *When the code 97124 is billed – no matter the chiropractor's are not doing the massage themselves – the chiropractor is doing the examination, adjustments, and other technical care that require more skill. The LMT rate for code 97124 and the LMT services being provided out in the market place are a good comparison... It's a time based code at 15 minute for one unit, primarily being provided by LMT.*
- 02:21:08
Kathy *When you think about it from the perspective of a physician, RN, LPN, the code gets billed for that office visit no matter who delivers the components. It's billed by the physician's office under the physicians NPI. If a physical therapist is directing the treatment, and then sends to the massage therapist, it is still billed under the physical therapists because it is being directed by the physical therapist.*
- 02:21:52
Scot Frink *Several years ago it used to be okay for audiologist to bill under an ENT if they were working for an ENT and bill under the ENT NPI number. As of 2010 they can no longer do this. If the audiologist is providing the service it has to be billed under the audiologist's NPI number.*
- 02:22:11
Juerg *On the line level it would identify the massage therapist. I don't know that we could make the statement in workers' comp that most 97124 codes are billed by massage therapists or performed by massage therapists. I don't know if that's a correct statement for workers' comp.*
- 02:22:54
Sheila *I can tell you our documentation is all the same. The only distinction we might make is if it's Medicare for outpatient therapy... it's a modifier that solves the problem.*
- 02:23:19
Steve Detert *I think when you do that research you will find it's the same or very similar. You are going to provide the work to the person that's qualified to do it at the level and not above. That is why you are not going to see medical providers doing massages because it doesn't make business sense.*

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NEXT

Discussion

02:24:12
Steve Detert *Within any one code, a specific code that is provided can be provided by multiple different licensed individuals. Would you pay the same amount to providers for the service based on levels of skill and ability? We don't see it on our side where it differentiates different levels of skills and abilities applying a modifier to that fee schedule maximum. Would you take a person that's a chiropractic assistant that has a very limited requirement currently – would you pay them the same amount you would pay a licensed massage therapist or physical therapist for that massage code?*

02:26:03
Juerg *The fee applies to any provider.*

02:26:10
Steve Detert *What happens with that process when you have a set fee, no matter who provides it, they're leveraging the people that they pay the least that can "still do the procedure." What we are seeing is a very large up-tick of chiropractic assistants providing the bulk of the physical medicine treatment within a chiropractic facility. You see the same in physical therapy with physical therapy aids providing the bulk of the care. Should it not be different; should there be some sort of a modifier for different licenses? This is a very complex issue that raises questions...*

02:27:43
Laurel *I completely agree with you. I see physical therapy assistants providing most of the treatment. The payment rate is the same, but the outcomes are not. It's frustrating and it's been increasing over the years. Especially in physical therapy the PTA are providing the bulk of the treatment.*

02:28:26
Dr. Miller *Going back to the market place driving the cost, the market place also drives the consumer. If you have a patient that comes into your physical therapy office and says they are not getting better after a few treatments because the physical therapist assistant isn't doing their job, the patient has the right to fire them or get a different provider when they want to. It's a legislative issue not a fee schedule issue. It's who's providing the service... you can not just have MD's doing all the services or DC's doing all the services – they have to have their assistants doing the services that are not harmful to the patient, that are allowed by the definition of the CPT codes. It shouldn't be paid less, because they have been trained to do it.*

02:30:35
Laurel *We we're paying NPs and PAs 85% of the fee schedule, and as long as we are doing that – how does a physical therapy assistant or chiropractor assistant rate 100%.*

02:30:56
Kathy *There is a difference...PA's can do a diagnosis and make treatment recommendations whereas a physical therapist assistant cannot diagnosis. They can administer a portion of the task, but they are completely at control of the*

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?

Speaker & Committee comments:

Time

52:18

Fred

Read issue #1

54:36

Lisa Anne

We are in favor of this proposal. It's more difficult for us to accommodate the one quarter delay that currently exists... for us it would be a lot easier. This would be a big plus.

55:16

I think it's a good idea, but I'm wondering how big a problem it is?

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Laurel

Several people answered yes. Someone said it creates a program problem too.

55:42

Juerg

I would expect it to be a problem for providers also.

56:07

Fred

It has been recommended that we just adopt the current schedule – whatever is current at the time – but we cannot because that would be prospective rulemaking.

56:41

Sheila

How reasonable is it to set rates for those new codes?

56:45

Juerg

Should be pretty reasonable. The idea is that we would use the same conversion factor that we already use and apply those to the RVU's of the new codes. Generally the conversion factor has not change much over the past few years. I don't expect it to cause any major financial impact. If we adopt new codes without assigning payment amounts then we would have no ceiling to cap it at, so it's crucial that we do add a ceiling to the new codes.

57:50

Sheila

In terms of problematic implementation would we have two loads – one for January one for April?

58:04

Juerg

Yes. Come January 1 we would add the new codes with payment amounts to the current fee schedule, and then April 1 we would calculate new conversion factors for all the active codes, We would delete the obsolete codes from the fee schedule, which for January 1 we wouldn't have deleted the old codes.

59:03

Juerg

Discussion of how it would be published.

59:27

Fred

Asked question of Sheila and that she mentioned having to load data twice.

59:38

Sheila

It's not a significant impact. Just want to understand what we would be required to do.

59:48

Kathy

I think we'd rather take the hit on the labor to adjust the fee than take the delays in payment for codes that are no longer used.

59:57

Sheila

As Lisa Anne explained, that's all year long... every state has its own schedule and basically I'm just adding a load.

01:00:15

Lisa Anne

I agree with previous comments. For us in terms of loading codes – we are doing it anyway. I was a little confused on the adding and not deleting ... so if CPT comes out with a bundle of recommendations are we proposing that we

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would only be adding the new ones and then deleting old ones in April ...

01:00:49
Juerg *Correct.*

01:00:53
Fred *That is how we envision it currently. Do you think that is not appropriate?*

01:00:58
Lisa Anne *I don't know... for us generally we just do whatever is included with that CPT update. I don't know how that is handled in other states.*

01:01:29
Sheila *This is the first that I've heard of a state making an adjustment. I was under the impression that Oregon did it because it's nice to have that window.*

01:01:50
Lisa Anne *Are any payers here familiar with an approach like that?*

01:01:59
Fred *Does anyone have input on whether having the split is unique to workers' compensation in Oregon? For states that have their fee schedules effective on January 1, it is going to be a clean cut-over. Even disregarding the old codes, there will be changes to the fees come April 1, so there will be a change.*

01:02:27
Sheila *There are lots of states that do interim releases not specifically for this reason.*

01:02:36
Fred *How problematic is it to have the old codes remain that overlap into 2016?*

01:02:48
Laurel *What's the purpose of it?*

01:02:50
Juerg *A temporary rule, sometimes we call it an emergency rule, should have the least amount of impact as possible – and that is why we want to change as little as possible. Because we basically don't allow the public to have input as opposed to regular rules ... In my opinion the smallest impact that the division can make is just adding the new codes with the payment amounts, but not adjusting the entire fee schedule. Come April 1 the payment amounts would still change.*

01:03:55
Jaye *There is a certain amount of public comment going on right now.*

01:04:02
Juerg *That is considered input, but you are not providing comment on what we actually propose.*

01:04:09
Jaye *I think the problem we are trying to solve is having two different sets of codes out there for providers to use and for us to work with. We don't like returning*

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bills back to providers that are essentially good but the codes are wrong. The provider has done what they are supposed to do and updated their codes, but it comes to us and we have to return it because the code is wrong.

01:04:40
Juerg *Again, if we keep the old codes and the temporary fee schedule this first time around – providers are used to using the old codes till April 1- for the first time doing this makes sense.*

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?

**Speaker &
Time**

Committee comments:

01:09:33
Kathy *It happens all the time with the larger insurers that do keep the phone logs – there's no problem, but there's a lot of 3rd parties that don't keep the phone logs and we see denial of payment all the time. Anything that will keep a claim moving as promised. We provided service to the injured worker - at minimum a verbal agreement that this was being approved. Every commercial insurer will say that prior authorization is no guarantee of payment, but we are acting in good faith.*

01:10:16
Dr. Miller *We should not limit this to PT because chiropractors are limited to the 60-day, 18-visit rule. Often times we may get a new prescription for additional*

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chiropractic from the attending physician, and it would be nice to have a written acceptance of authorization for that treatment as well.

01:10:39
Kathy *I agree. It's not just PT this happens to but ancillary services.*

01:10:46
Jaye *I guess I'm confused. We all acknowledge that there's a difference between preauthorization for a service and actual approval for service. If you have something in writing saying it's preauthorized but it's not approval for the service, I don't see how that solves a problem.*

01:11:11
Kathy *Prior authorizations don't guarantee a payment, insurers (commercial) will go back into their payment policies and look at it from a co-payment perspective, similar to the Oregon health plan, you have the diagnostic code and the CPT code – in their code pairings they say this isn't an approved service for that member even though we had that prior authorization, that is where we get into the prior authorization is no guarantee of payment. It doesn't happen when we have phone logs.*

01:12:21
Larry *Where does the denial come from?*

01:12:30
Kathy *They will say there is no evidence that we ever authorized services, so they won't pay.*

01:12:45
Larry *All we are saying is within the confines of the rules, reasonable and necessary treatment can be provided - if that happens and the claim is compensable, we will pay for that. We shouldn't have to send a letter for every treatment request. All we are going to say is if it's related, if it's reasonable, if it's necessary – and all the other components – it's going to get paid under the fee schedule. That's all we can say.*

01:13:30
Laurel *That's what we tell all our MCO providers is that if you feel it is related to the injury, it's reasonable, and it's necessary, there is no reason for you not to do the treatment because you will be paid. Sometimes they don't do it because they are afraid they will not be paid. I just don't know what the answer to that is.*

01:14:24
Kathy *I'm not the stakeholder that brought up this issue, but I agree with the stakeholder. It happens all the time or it wouldn't be an issue. I'm sure the stakeholder is asking for a solution that will work.*

01:15:50
Jennifer *I have some caution about this because I want to make sure it doesn't put up a barrier for treatment for the injured worker. For the insurers that are doing it the right way and getting that verbal authorization allows the worker to get the treatment. My concern is if we require it in writing all the time, I just want it taken into consideration the impact to the worker and the effect on the delivery*

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of the treatment.

Committee 01:16:20 Discussion on appeal process available to providers by committee members.

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?

**Speaker &
Time**

Committee comments:

01:20:22 Lisa Anne What standards are you referring to?

01:20:29 Juerg Like the CPT codes. Make sure that we have the latest version of the CPT and HCPCS codes, anesthesiologist codes, all these kinds of standards that we use. It's mainly billing related. We do that every year. If we do have the temporary rule in effect, we already use the new CPT codes. The interesting thing is when we adopt the April 1 rules we are not actually replacing the temporary rules, we are replacing the current rules.

01:21:35 Fred It's as though the temp rule never existed - it just goes away.

01:21:45 Lisa Anne Are we talking about not just the codes themselves but the CPT payment policy associated with the codes?

01:21:54 Fred Not the payment policies, no. Just the codes themselves, yes.

01:22:01 Adam Are you also talking about the billing form?

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01:22:13 *Yes. We update that rule as well.*
Fred & Juerg

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.

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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?

**Speaker &
Time**

Committee comments:

01:26:35
Randy

We are the stakeholder that proposed this administrative change. Provided background information on proposal.

01:29:57
Lisa Anne

For us payment disputes don't involve claimants attorney's and attorney's fees – and medical necessity. It seems like we're blurring the line between payment issues... This sounds like a cross-over thing. Ask for clarification on the distinction between the two disputes.

01:31:18
Ted

I think you understand this correctly. The rule was intended to draw more of a distinct line between those kinds of disputes. The dispute over the amount of payment for a CPT code should be handled between insurer and the provider – that doesn't concern the claimant at all. The problem arises when there is non-payment, and then the non-payment is a compensability argument. At that point the claimant does have an interest because they may be responsible for payment. ... Rather than craft a rule that draws the line based on the character

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of the dispute, it is easier, and based on statutory language, that divides those disputes by who has an interest. Does that clarify the situation?

01:32:52
Lisa Anne

This sort of clarifies the issue. I have some trepidation in removing the right of administrative agency to make the determination whether this is a fee dispute or a reasonableness/medical necessity dispute. . If something is blurry in this regard... I totally get what you are saying about the distinction between non-payment based on the dollars involved and non-payment based on medical necessity. But, this would be a perfect example of where an ALJ or administrative agency would get involved to make the determination of where it would fall into. I would think this would be an exception handling thing. If the objections are written clearly, it should be clear whether it is due to the dollars or medical necessity. When it is not clear, I think that would be an appropriate decision for the ALJ. ...

01:35:27
Ted

There is still some judgment involved. I just think that determining whether the claim has an interest, a justiciable controversy, a direct interest in the litigation – I think there is some discretion, but also some criteria for making the determination. I have a question too. Are there disputes where you think the claimant does have a direct interest in that an attorney would intervene in against the insurer that don't need an attorney or if the attorney presents they shouldn't get paid?

01:35:30
Lisa Anne

We have situations with unrepresented claimants. In California that is handled through IMR. There is a separate process for that regardless of whether the claimant is represented or unrepresented. ...

01:36:18
Jaye

I recall we had this conversation at a prior advisory committee meeting around the implementation of the House Bill. What I recall (and I was not in the room; Julie Masters was present) is that the Workers' Compensation Division said they weren't aware this was a problem and they asked for some specific examples of where things had been mischaracterized. I thought you were going to go and get some. Were you able to find some examples? From SAIF Corporation's perspective, we think the statute is clear. We think the department is doing its job in looking at whether it is a .245 or .248 situation. We don't think there is a need for a rule. ...

01:37:33
Randy

We did provide a number of administrative decisions to John (John Shilts, administrator) and there is a split among those decisions. In nearly identical disputes, one decision maker relied upon .248 and provided no fee, while another said this is clearly a .245 dispute and provided a fee. There is language in both .245 and .248 that allows jurisdiction in the department over, quote, fee disputes. There is no real clarification on what type of fee dispute .248 really covers and .245 covers. The purpose of the rule is to clarify this so that these folks [Medical Resolution Team (MRT)] have a bright line to distinguish these types of disputes.

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01:38:35
Steve
Passantino

We got the examples, the Talavera case ([Dennis E. Talavera, 20 CCHR 31 \(2015\)](#)) and the Peterson case ([Gerald P. Peterson, 17 CCHR 299 \(2012\)](#)) In Peterson, the MRT set it up as treatment. The case was changed to contested case level and it ended up being processed as a medical fee case. In the Talavera case, I believe in 2010, we processed as a .248. ... The criteria we use right now is the final order on Jeffery Kuehn ([Jeffrey E. Kuehn, 19 CCHR 46 \(2014\)](#)) and Safeway v. Cornell ([H95-161; CA A93608](#)), which was specifically about an attorney fee – it was about reimbursement to the worker, there was no question of entitlement, we set it up as .248, and the Court of Appeals said that was the correct process. Currently, we don't do it based on the party that submits the dispute. The question is entitlement. If there is any question that the worker was entitled to the service and the denial is in the record, we process those as .245. ...

01:40:42
Jaye

Two cases. It sounds to me like they are doing what they are supposed to be doing. When I look at this rule, I think this language is overly broad. SAIF Corporation doesn't believe that we need it.

01:41:06
Randy

Steve put his finger right on it. It is subjective right now, almost. In the example saying, "I'm not getting my reimbursements," someone requests my assistance and I bring it to dispute resolution. They decide it is not about compensability. He is entitled to it. He has gone through this administrative nightmare to get it paid. But, I'm not going to pay his attorney for helping him, even though that was resolved for the worker – we should get paid for doing that. The clarification we are making is that if the worker is the one who has to come over here to get paid, regardless of the reason behind it, the lawyer shouldn't be deprived of a fee because the adjuster says "I just didn't get it downloaded"?

01:42:05
Jaye

I hear you, but what you are suggesting – the statute that separates the different kinds of bills, 245 and .248, they are two different kinds of disputes – that the administrative process should be different from what the statute says? If the insurer is just bad about how they reimburse the worker, but they are getting reimbursed, then it's a different dispute than if the insurer says it shouldn't be providing that.

01:42:43
Steve
Passantino

There seems to be a lack of knowledge in those cases that there is a remedy – like for instance the download problem [where insurer overlooked some received documents]. We are probably going to process that as a .248. A remedy exists because there is a delayed compensation to the worker. Under 656.262(11) there is an opportunity for penalties and attorney fees. To me work is work, so I do understand that concept. That being said, this rule, if we were to go this route, I think we are going to have to look at Safeway v. Cornell and the Kuehn order and see if it would be going against a Court of Appeals decision. MRT doesn't really care, we are neutral. We are looking for clear

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direction.

01:43:58
Jennifer *In this example you are processing as .248. The attorney has gone through the process of getting it in. No attorney fee. But then you turn around and ask for .262 penalty?*

01:44:12
Steve
Passantino *When MRT gets them – different attorneys practice differently. Some attorneys are judicious as to how they ask for penalties. For other attorneys, that is always part of the dispute. In this particular case, there is also a request for penalties and attorney fees. When we issue the order, we will ship a copy over to the Sanctions unit. When we are done, the Sanctions unit begins its review.*

01:44:57
Randy *We are going full circle here. I imagine what you are saying and what SAIF is suggesting here is that next session we ask the Legislature to add .245 to .385(1), which is what we proposed, but what we heard from Kevin Willingham and John Shilts is we think it's an internal matter. We agree with you. .248 is CPT codes and relative values – there was language added that was jurisdictional language that said, "a claimant, a medical provider, etc." can seek director review. Somehow this department has latched onto that language to start pulling in the disputes that were traditionally .245, which is nonpayment of medical services because it's not reasonable, not necessary ... or just failure to pay. Okay.*

01:45:38
Jaye *Perhaps the remedy is rather than this language – is when there is a dispute that is mischaracterized as a .248, and it is really a .245, that there would be a way to go to the department and say wait a minute – this is really a .245, you should treat it as a .245, and then you get your fees.*

01:46:02
Randy *We've been doing that, and that is where we've reached a loggerhead. I might add, I think it is a red herring to inject .262(11) into this at all. ... Even if it is reasonableness and necessity, but the worker was never deprived of medical services – "Randy, why should you get a fee for getting that paid under .245. Couldn't you go get a .262(11) fee?" A .262(11) fee is [for] the unreasonable resistance to the payment of compensation. It raises the bar for what we have to prove. We have to prove unreasonable behavior. That is an additional fee if that additional bad behavior exists. The underlying thing we want to get paid for is getting those medical services paid for, whether we can prove unreasonableness or not.*

01:47:00
Steve
Passantino *I don't disagree with you necessarily. I'm just saying that based on Safeway v. Cornell, that's the way case law has been interpreted I personally think that this case ignored who the disputes are between. ... It said that if the dispute involves non-payment or reduced payment, it fell under .248.*

01:47:52
Randy *In Safeway, the Court had to look at whether this department's reading of the rule was a reasonable interpretation – if you were given more guidance by rule,*

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I'm sure we would see a different result.

01:48:14 *I just want to add that this solution was based directly on the statutory
Ted language. That sort of defines who the parties are in a .248 dispute, as far as I
can tell verbatim from .248(12). ...*

01:49:55 *(Break) Please see new issues above.*

Nov. 23, 2015 Meeting Minutes:

Fred welcomed the committee members, requested input on fiscal impacts of potential rule changes discussed, and asked members to present any new issues before the committee considers the prepared agenda.

Meeting minutes have been entered below in italicized text. The following is not a transcript, and some comments have been paraphrased for brevity.

Note: Discussion begins with issue #7. The following minutes follow the order of the original agenda. Audio recording times show the sequence.

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

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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?

Speaker & Time	Committee comments:
10:30	<i>No comments.</i>

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?

Speaker & Time	Committee comments:
13:47 Lisa Anne	<i>Would support the division being very clear on the billing requirements... to help us on the back end for reporting purposes.</i>
14:03 Kathy	<i>I think it would be reasonable to have that expectation.</i>
14:29 Jaye	<i>I don’t know if it will be an issue for us, but I’ll find out and send to the department.</i>
14:48 Fred	<i>This would be a good time to tell everyone that if you have additional advice for us it would be good if it came in fairly soon, such as the next week or so. Feel free to send me an email; it doesn’t have to be a formal letter.</i>

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- 15:03
Juerg *On the CMS 1500, at the bottom, there are three boxes to the left of the signature, in the middle is the facility name and address, and on the right is the billing provider's name and address. The instructions are weird. What the division wants from the provider is that if you fill in the address where the services were provided, we want you to put in the NPI even if that is the same as the billing provider. So basically it would be a requirement for the provider to populate that field with the NPI that we currently don't have. Right now the instructions say you only have to put the NPI there if it's different from the billing, and we want to say if you put the address there you have to put in the NPI no matter what – even if it's the same.*
- 16:40
Jaye *The thing that I always worry about is if there's another data field with additional data coming in. On the flip side of that would be what we are reporting.*
- 16:57
Juerg *Going to make it easier for you, and EDI requires it to be there, but the providers don't necessarily put it there.*
- 17:13
Kathy *It helps justify the differences in the fees. For example doing an injection that needs to be done in the hospital setting, that's going to fall under the facility fee schedule as opposed to in-office.*
- 17:34
Nanci *It's not a new requirement for EDI reporting.*

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:

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- 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?

**Speaker &
Time**

Committee comments:

03:47

Advisory Committee Meeting started with issue #7

06:11

Juerg

The MAC committee has not voted on this or made an actual recommendation, but we expect that MAC will adopt the recommendation of the subcommittee. At some point – it’s speculation – but we expect that MAC will recommend to the administrator that PRP injections are not a form of prolotherapy, and should not be compensable because they are unproven. Currently, it’s excluded. If this was adopted and put in rule they would still not be compensable.

07:49

Jaye

SAIF Corporation supports the department.

09:28

Lisa Anne

We were not advocating either way.

10:06

Fred

Next issue #5.

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?

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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?

**Speaker &
Time**

Committee comments:

19:46
Sheila

In our training for provider relations, we wrote it as two business days, so I would support that change.

19:57
Jaye

Unless there is a reason for it, consistency is always better.

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

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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?

**Speaker & Committee comments:
Time**

21:12 *No concerns from SAIF.*
Jaye

21:37 *Next issue discussed is #11.*

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?

**Speaker & Committee comments:
Time**

29:39 *Whatever maximum amount is established by rule should be reflective of what's*

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Randy *going on in the marketplace. When it's stagnant for a long period of time it is really not assisting the worker in getting the rehabilitation for his hearing loss. It should be at least tied to an inflation rate or something like that. Some market survey of what hearing aids are actually costing the general public.*

30:14
Juerg *One thing to consider with hearing aids is that it is basically an electronic device. The history of electronic devices ... prices have actually come down. However, that's one thing that I don't really know because we haven't done any analysis. Question is if this is something that happens with hearing aids?*

Committee
(several
members) *No.*

31:14
Randy *I think it would be more appropriate if it was tied to some general market survey. What is available and what it is costing at the current time.*

31:24
Genoa *I did discuss this with several audiologists and it is not their experience that prices are coming down. Actually, it's just the opposite. Costs are increasing. What is covered now does not always address the issues that the patient is experiencing. They may need a higher end device to address the particular issues. It not workable right now at the \$2500.00 range.*

33:09
Scot Frink *Yes it is **an electronic device, but just as cell phone technology has changed, what we** are looking at in hearing aids is a computer, a computer in or at somebody's ear. The cost of that technology is substantial. It's also not just the technology itself it's the ongoing service that's required to maintain the hearing aids. There is a lot of overhead with this as well. There is a lot more to hearing aid than just the electronic device itself. There is ongoing care of the device, and counseling of the patient. This is more akin to physical therapy. Discussion on pricing of hearing aids and history of the last time the amount was increased. The overall cost of services has increased significantly. Previously what worker could get for \$5000 was top level technology. Now on a scale of 1 to 10 you can get a device that rates around a six or seven. This has limited their access to better technology. Similarly, there has been a restriction when it comes to accessories. Remote controls were one of the most significant things out there. We are restricted when it comes to what is deemed medically necessary. Now, hearing aids have Bluetooth technology. They can connect to your cell phone or iPad. I have gotten approval for accessories in excess of the \$5000 in circumstances where it's deemed medically necessary based on an individual circumstance for one's work or something like that. I honestly I would suggest that they start allowing for inclusion of those devices, because I have had some people who don't have a home phone anymore. They rely on their cell phone. I suggest that the accessories are included in the \$7500. Just increase the dollar amount appropriately.*

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- 37:00
Sue *I would like the department to do analysis before considering a change. I just did a search on AARP and it shows that the average price for a pair of mid level hearing aids is \$4400. I have no interest in increasing over the \$5000 amount without supporting documentation.*
- 37:36
Scot Frink *If the average price range per pair is \$4400, that proves my point which is used for midrange technology.*
- 37:53
Jaye *SAIF did go back and look to see what the cost of hearings aids has averaged over the last year. We had 157 hearing aids last year which averaged \$4500 a pair. I don't think that the workers compensation system is about always providing top of the line product. There may be instances where such device is necessary. I guess what we would suggest is there are instances where there is enough of a necessity for someone to have a more expensive prosthesis. We wouldn't object to putting something in the rule with standards around this. We would urge that the department leave the \$5000, which is absolutely adequate for what we are seeing right now.*
- 39:13
Scot Frink *Is the \$4500 you are talking about there because that is what was adequate for the client or is it there because of the cap that's in place which is keeping it down?*
- 39:28
Unknown *It's less than the cap.*
- 39:31
Unknown *I would say if we could define an outlier ...*
- 39:35
Scot Frink *When I have a workers' comp client coming in, I know there is a \$5000 limit there, so I recommend based on the limit knowing I can't exceed that. That is one reason I don't go for a higher. It's too much hassle to get anything approved over the amount of the \$5000.*
- 39:57
Fred *This would also mean that the department data actually reflects the cap as well. In other words, any data that we have on the actual amounts paid for hearing aids would be with that cap in place. It may not reflect the market.*
- 40:13
Jaye *It sounds like when you sell a set of hearing aids the price is inclusive of cleaning and maintenance.*
- 40:40
Scot Frink *It's called bundle servicing. Just the fitting itself costs \$600 to \$800, which is just the time put into it. Going beyond that every time they come back in it is increasing our cost to see that patient.*
- 41:18
Sheila *Perhaps it would be helpful to gather data from other states where the cap does not exist. Maybe this could at least help us make a more informed decision.*

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- 41:30 *On the flip side there are places where there are no caps ...*
Scot Frink
- 42:35 *Is there cap on other prosthetic devices?*
Kathy
- 42:42 *In the L codes. There's a fee schedule.*
Unknown
- 42:47 *I would say if the \$5000 cap isn't increased, 10-15 years from now they will be getting entry level technology.*
Scot Frink
- 43:05 *We can provide data from our system if that's helpful. We can run our data against other data and data from other states. As long as we know the CPT's you are looking at we can run a report and give you some information if that is helpful. Also, it's not quite an accurate assumption to say is something cost X then it would cost Y today. As technology is adopted more widely the cost can come down, for instance MRI. I think you have to factor both things into consideration.*
Lisa Anne
- 44:21 *Not just cost of product but also the cost of our operations that have increased. When we look at employee wages, for instance a while back we hired an audiologist assistant in 1995 at \$14.00 an hour, now someone straight out of school is making about \$32.00 an hour. Wages as you know is the largest cost of any operation.*
Scot Frink
- 44:58 *Are you saying that the \$5000 includes all the follow-up costs?*
Nanci
- 45:11 *Labor oriented services. If the hearing aid has a 2-4 year warranty, and if there's an out-of-warranty repair we charge for it. An ear mold or a behind-the-ear instrument that needs to be replaced is about \$89.00, because we pay someone else to acquire that.*
Scot Frink
- 46:03 *I would suggest that some of the obvious things like subject to audit, and it has to be usual and customary amount ... when we are looking at the best care for the patient we need to look at that as well. Nothing replaces human hearing, and the higher the level of technology the closer we can get to that.*
Scot Frink
- 46:36 *I just want to make sure that when we are looking at costs that this is all included in it?*
Nanci
- 46:44 *HCPCS code you use? Is this something that you could provide the division a list of?*
Juerg

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46:50 *Not off the top of my head, no. I can provide these for you. Discussion on Scot Frink analog hearing aids being obsolete so the codes may be obsolete as well.*

48:56 *Next issue discussed Issue #12.*

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?

**Speaker &
Time**

Committee comments:

22:31
Randy *I would urge you to adopt that rule. I see no difference in the policy underlying the reason for allowing the worker to upgrade as opposed to getting a new one. There's really no policy difference. Let us let them get something that's good and works.*

22:50
Kathy *It's also somewhat related to issue 10. If you place a level of \$5,000 on hearing aids, certainly there are more expensive hearing aids. But the baseline of \$5000 will get you what you need.*

23:09
Jaye *It is difficult to make a decent public policy issue about why the system would turn it's back on a worker who is saying – I think this prosthesis will work better for me because of x, y, or z reason. I'm tempted to suggest there be some sort of process in place, but that would add to the bureaucracy of the system. I don't think we would object to it.*

24:11
Kathy *Hearing aid example. If there are replacement costs in the future do you go back to the baseline of what was approved, however the worker chose to*

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purchase more expensive item and then you go with what they went with.

24:53
Jaye *That's the only thing that makes us hesitate.*

25:04
Kathy *I can think about it from the injured worker's side. Let's say I need a particular brace or I've lost an arm and my job requires more dexterity than I'm capable of. Is there a process to justify the expense? I'm just trying to think about it in the layers.*

Fred *It's important to actually see what the effect of a rule is over time. There is always potential to address it in the future.*

Kathy *Going back to the injured worker perspective again saying I've gotten used to this prosthesis but it's broken, now who is going to pay for this?*

26:31
Fred *That is a good point.*

26:43 *Skip to issue number 13.*

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.

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- 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?

Speaker & Time

51:57

Randy

Committee comments:

Speaking for myself and on behalf of Oregon Trial Lawyers Association it's a very controversial subject, but in our mind it was an experiment that went awry. I think we need to go back and re-examine if it's appropriate to let the doctor use the 827 form over the worker's signature to present new or omitted conditions. I think a misunderstanding amongst some medical providers is that they don't understand that the statute says that only the worker/the worker's attorney may make a new or omitted medical condition. The reason for that is because it's going to be a legal decision whether that claim becomes a compensable condition and it will ultimately end up in a hearing. What we have also seen through this misunderstanding of the doctor's believing that somehow they have the right to make those claims is that from what I understand, they think that if they put a new or omitted medical condition claim on the 827 form or list the ICD number for that condition, they will somehow go into the computer data base of the insurer. If they are billing for something that is beyond the accepted medical condition because it has this new ICD code in the computer it's going to somehow get them paid for something that is going beyond what has been accepted. This is obviously not the intended use. What has resulted for us is that we see these new or omitted medical claims being made, and then there is a denial. Then the worker brings us these denials. They have already appealed the denial and are waiting for hearing, or they ask me to appeal it. I have to go back to the physician that put in the code number or condition on the 827 to ask them to provide me with a narrative report that explains based on the history of the case that the work injury is the major contributing cause of this new or omitted condition. Time and time again I'm getting the response "No way, I can't say that... I wasn't intending to say that. I just wanted to get paid." Now for the worker there is a condition that could have been made anytime because there is no time limit on it. Until we have the medical support for this, it's really not legally appropriate to be taking this kind of approach. When it gets thrown out like that my client has lost all opportunity for the life of this claim to ever get that condition put on there again due to the misuse of the 827 form. Maybe an alternative would be to add language to the 827 that states the physician is certifying that they believe this to be a

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compensable condition. We are not opposed to some middle ground. For the time being it is our recommendation that it be removed.

55:43
Jaye *SAIF Corporation actually agrees that the box needs to be removed.*

56:12
Keith *We did have a discussion and came to the decision that we would like to see that part of the form removed. There seems to be a consensus among stakeholders on all sides that this is an issue that needs to be addressed.*

56:56
Courtnei *In speaking to our providers I'm still not certain I understand all of the concerns. Their goal is not to step into a legal battle or override the patient's request. My understanding when we first brought this forward 8 years ago we were looking at this issue of a claim being filed in urgent care or ER for example. The presenting injury may be a strain and then after a claim is filed it was something else after further review. So the strain was actually a tear. That was the concept of adding this omitted claim. It's not necessarily a new claim. This system is both for providers and patients. It would be great to get some data as I haven't seen any real language on how often this is happening and what the problem we are trying to deal with is. Any data would be great as we are trying to figure out how big a problem this could be. Instead of removing this, could something else be put in its place? Leaving it as it is right now and just continuing this discussion would be our hope, instead of removing it right off the bat.*

59:19
Dan *One thing we train to is along the lines of the example of the "strain turning into something else." We train to adjust our acceptance when you have something like a knee strain that turns into a meniscal tear. We will adjust our acceptance if we have already accepted the claim. What we do see a couple times a month are the new or omitted claims that we are talking about that come in on the 827 form. When we speak with the worker about it they often say I didn't know I was filing a new condition or omitted condition. We have to go through the process because we have the 827 signed by the worker saying "I'm making the claim." So, can we measure the problem? No, we don't track the new or omitted conditions that come in on the 827. Is this an ongoing problem? Yes.*

01:01:36
Randy *I'd like to add one thing to Courtnei's comments. OTLA is not unsympathetic to OMA's desire to be able to play a part in the role of advancing new condition claims, but there is lack of education on the part of OMA and its physicians as to when and how to use the box on the 827. As far as trying to measure the problem, I don't think that if even one worker is harmed greatly because a doctor puts a herniated disk on an 827 for an already accepted strain case, then the herniated disk is denied and the worker is now paying for surgery out of his own pocket. Then the doctor says I'm not supporting the disk is compensable, I'm now convinced that it's degenerative. Now the worker is deprived of having*

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that surgery paid for under workers' compensation. Later down the road, if a new attending physician disagrees with the initial diagnosis and supports that the injury was compensable and caused by the original injury, it is too late. The claim has been thrown out, denied, and litigated and the worker is stuck paying for the injury. I don't know if we need more than one or two of these to justify what we are talking about here.

01:03:07
Fred *I was around when they added this to the 827. Do you think there is a potential for workers to be blind to the option of filing a new condition claim if they don't see it as an option on the 827?*

01:03:51
Randy *I think that a vast majority of workers are ignorant of their options or exercise even if they are told they have the right. What a worker will tend to do is list the body part or symptom which is also not allowed under the statute under a new condition claim, but they don't understand really how to use it. I've had worker's that have complained to their adjuster that they have a back strain, but they looked at their MRI report which has numerous findings. The worker will say I've been advised by my adjuster to just list what is on the MRI report and they'll deal with it. Now they are on the table, they are denied. If I were representing that person I would recommend not to be baited into putting a bunch of stuff out there where you will get denied. As you can tell, it's a legal strategic decision whether you put a new or omitted condition claim out. Unless someone is fairly sophisticated in how that process works, then it's easily misused.*

01:05:03
Dan *I believe on the notice of acceptance it talks about filing a claim for a new or omitted condition. Disabling claims are supposed to receive "What Happens if I'm Injured on the Job" brochure. It's covered in there. The non-disabling claims should get a brochure that also talks about it. I'm not saying they read it, but it is provided multiple times throughout the claim. But I agree, it is a claims decision whether or not to file.*

01:05:42
Randy *I wish there were any easier way to address this right now. ...*

01:06:28
Courtney *Again, I would appreciate having further conversations about this before the department automatically removes that. It would be beneficial to have this conversation with more of the front line providers.*

01:07:25
Joe *I agree with that. It becomes a complex issue for us at the provider level when the patient has for example a lumbar strain and then complains of something additional beyond that. We are required by the 827 to fill in the box to see if the new medical condition can be accepted or not as part of the original compensable injury. We are caught in the middle between providing care the patient needs and the administrative side of our business and doing the right thing in correctly executing paperwork. This needs more attention and clarity*

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before we move forward on it.

01:09:13
Kathy *I'm thinking of it from the perspective of the provider...*

01:09:37
Joe *The diagnosis may change during the course of treatment.*

01:10:13
Randy *The new conditions can be made at any time but the statutes and the legislators decided that these should be made by the worker or the worker's attorney. Because it's distributed universally on an 827 form it puts that opportunity in front of medical providers that are not sophisticated enough to understand how the process really works. Frankly, any medical provider could have a blank sheet of paper that they can list out conditions on and have the worker sign which can be turned in with the 827.*

01:11:20
Jaye *The issue is that we are asking medical providers to draw legal conclusions. The reason that the statute says it is up to the worker or the worker's attorney to make those claims is because there are legal definitions associated with new or omitted conditions. Myself as a lawyer find it confusing. Our adjusters struggle with it. I have sympathy for providers that want to get paid, but I'm not sure that completing the box on the 827 is accomplishing this. Maybe there is another way to do this. But I think the box needs to come off.*

01:12:22
Courtnei *I would like to just remind everyone that it's not just filling out something to be paid, but to make sure that it is an appropriate course of treatment for the diagnosis.*

01:13:05
Jaye *SAIF Corporation agrees.*

01:13:12
Joe *I can't speak for all providers, but I can speak for my providers – We are there to provide medical care and the best medical care we can. We are challenged with processing the paperwork, but our primary concern has always been patient care.*

01:13:59
Virginia *As a company we want our employees to get the best possible care. It's been my experience that if a provider thinks the diagnosis is not correct they are going to complete the necessary diagnostic tests to support their decision. Or adjusters are going to accept that information, so I don't understand why there is the importance of having a box to check when they have the ability to prove that additional treatment is needed based on the diagnostic tests.*

01:14:52
Keith *One of the challenges, contrary to workers not knowing that they may need to request a new or omitted condition, folks are constantly told that they need to request a new or omitted condition, if the patient has any questions about the*

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relationship to the conditions already accepted. With the new cases that have been decided, Brown being one of the significant ones, there is a question of whether you have to claim new conditions, especially in terms of diagnostic tests. Often the test is necessary to determine the extent of the condition already accepted, but folks will be told that if they are looking for this or they think it is a disk herniation, then you have to claim that. It is unfortunate when folks are unrepresented and don't know there is another potential strategy. One of the problems is over requesting, every single condition that might be at play, and requesting conditions are a part of a differential diagnosis that are not borne out yet to where the doctor can even say the condition exists. ... We suspect that this is not really helping medical providers move forward with the treatment as often as it provides one more thing for us all to fight over.

01:17:53 *Introduced discussion of new issues submitted since last meeting.*
Fred

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?

Speaker & Time **Committee comments:**

27:51 *No comments*
Next issue discussed is issue number 10.

11/23/15 New issues; open discussion following issue #11

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**Speaker &
Time**

Committee comments:

01:18:17
Jaye

SAIF mentioned some specific codes that we have that we use due to our negotiations with MCO's. I guess we were concerned that those codes were going to be available for other folks to use. I think what we would prefer is – sometimes you have to fit the MCO process into the rest of the rules and processes. The MCO contracts allow us to negotiate. Those contracts are reviewed and approved by the division. To take negotiated codes and put them out there with the rest of the codes is like mixing apples and oranges. ... Basically, that is a specific agreement between a panel of doctors and an MCO – and between SAIF Corporation and the MCO. Rather than discussing it in this arena what we would rather do is have additional discussion at another time with the department. We really think these are MCO-specific issues. Our codes should not be available to anyone else.

01:20:54
Sheila:
Discussion
on charges
for closing
exams and
reports

We did finally pull some data on the closing exam and closing report codes. Of most concern to CorVel was that we do see these miscoded and when we thought we were doing the right thing by requesting a correction we found that was to our detriment because the bills would come back with a higher fee. That would be understandable occasionally. A couple were \$300 to \$400 different. The only other thing I would say is clarification of when the closing report code is ... why it is important for us to require these codes.

01:22:00
Fred

Those were the high and low charges you were seeing and then an average.

01:22:27
Juerg

The data you provided highlights the problem we are facing. If you look at these charges it's not just because one doctor charges more than another, but because what they actually did varied quite a bit. That's the problem we are having trying to assign some sort of fee schedule amount. It's not possible to have one closing exam go with one fee schedule amount because it can involve a wide spectrum. I think that we would have to break it up into two or three different codes similar to office visits. The question becomes what would be the criteria used to describe these codes.

01:23:53
Sheila

Drilling down into the data helps. I looked at a sampling of the really high and the really low, and there wasn't real consistency across the board in the complexity of the claims. If you could tell me exactly what you would need there it would help us maybe define what that criteria would look like and how many codes we would need to break it out.

01:24:36
Juerg

I agree it's up to the committee. The department doesn't have any agenda. The idea when we actually produce these codes was that eventually we could produce a fee schedule. We were hoping that we would be able to better analyze the data. This hasn't been the case. One other problem is the CPT code 99213 definitely is not an accurate code to describe a closing exam.

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- 01:25:20
Sheila *Most commonly used code for miscoding.*
- 01:25:28
Allison *I guess the question is how does the nature of the closing exam really differ from a regular office visit. There may be some opportunity to cross-walk back to some of those office visit codes.*
- 01:25:50
Sheila *I agree. The providers are telling us that – by miscoding it as an office visit. The report to me also helps define the complexity. What I see a lot of times is the report code isn't billed. If the report is a page or two, it doesn't really seem to warrant a separate activity... it's when the report becomes three or more pages. Maybe that is what warrants the extra... separately reimbursable charge.*
- 01:26:41
Kathy *The worker's exam encompasses some measurements and things like that.*
- 01:27:44
Scot Frink *My understanding is the codes are not necessarily the length of the report but the comprehensiveness of the evaluation. It's really how much they are doing in the actual exam.*
- 01:28:27
Sheila *They are timed codes, which makes them ideal for use in this case.*
- 01:28:30
Juerg *You are saying you should use time as criteria?*
- 01:28:38
Allison *Well maybe.... It is a closing exam ... time involved makes sense.*
- 01:29:10
Juerg *What kind of time frames are we looking at?*
- 01:29:13
Discussion on 99231 and other codes' time frames.
- 01:29:46
Scot Frink *Time is a general guideline but it's also how much is done. They may be looking at every single body system. So, it what's in the report as well as the time.*
- 01:29:29
Juerg *Are we talking about the exam, the report, or both?*
- 01:30:07
Sheila *What is the purpose of gathering data on the reports? How or when should that be a separately reimbursable code? That is why I was asking the question what the origin of the two separate codes was for. Was it because the closing report is something that is required by workers' comp? Are we talking about something that is like a 99080 which isn't warranted unless you have substantial amount of*

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documentation.

01:30:47
Juerg *When we do an OSC [Oregon Specific Code], we make that code whatever – we could say this code includes the exam and the report. We have this for other services also that include both. Or we can continue to have it separate. Again, what does the committee recommending to us?*

01:31:17
Kathy *Time and report will say per hour.*

01:31:20
Sheila *I don't know why the CR was put into play. I don't have an opinion either way on that. It could be included if it's not important to document. If you are getting a bill for a closing exam you got a report. Some providers are billing for that because they know they can, but others are not. Maybe combining it into one code actually makes it more straight forward.*

01:32:03
Dan *Just looking at closing report/closing exam there's probably instances where the insurer is setting up a closing exam and sending what could be a multiple question letter asking in addition to your fiscal closing exam we want you to address these questions and then generate a report. Whereas, other times it's just a closing exam, the worker is medically stationary, the claim evolves and closes, and they're providing a closing exam without a specific report.*

01:32:39
Sheila *If we called it an insurer requested closing report, would that help differentiate when it's payable?*

01:32:48
Dan *That's a good question to ask. Provided some examples on different scenarios.*

01:33:47
Sheila *It's almost like it's an addendum to the closing exam notes, if or when an insurer needs additional information.*

01:33:48
Kathy *If a provider has also been asked to comment on job analysis – that's complex medical decision making.*

01:33:54
Allison *I don't think it's bad to have separate code for closing exam in insurer requested closing reports, but just for the exam piece at least the fee schedule can be cross-walked into some already existing codes.*

01:34:40
Juerg *Since we are talking time, how long do these closing exams take?*

01:34:56
Allison *Just go back to the definitions for the E&M codes use time as a factor which is appropriate in some case and you can use complexity of medical decision making and all those other factors for determining the level of an E&M visit. I guess I would hesitate trying to come up with a new definition.*

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01:35:22
Sheila *We could do a reality check on this by looking to see what the AP was charging on the average office visit. Do we expect them to be spending more or less time on the closing exam?*

01:35:37
Kathy *If they've gone to a multidisciplinary program they've been given a lot of information.*

01:35:45
Sheila *It is like a record review for them.*

01:36:06
Joe *A level of closing exam related to level of EM would be appropriate; looking at maybe this is not as complex a case and may be a 990213 or 990214 depending on what is being asked. Maybe we could look at levels of closing exams to give flexibility in terms of complexity. A closing exam on a back might be significantly different than a closing exam on an ankle. You could use an appropriate E&M for level of service and cross-walk it back to something like that along with the report, which would be necessary in that case.*

01:36:55
Scot Frink *How about creating a modifier code? There are modifiers for more or less services, where the modifier could designate it as the closing exam.*

01:37:27
Sheila *I'd have to think about that one in terms of state-specific codes. It gets more complicated when you start looking at that.*

01:37:40
Joe *We don't want to make it any more complicated. I do see where people need to have some type of level of service because closing a case is different in a lot of situations.*

01:38:18
Sheila *Without having delved into the data it sounds like we all could agree that two codes for a simpler or higher level complexity would be reasonable for a closing exam. I can actually drill down and look at what's the difference between the monetary amounts. Would you want diagnosis or diagnoses? What would be helpful to this group?*

01:38:56
Juerg *I don't think that diagnosis would help much. We can put something together, but not maybe for this upcoming rule.*

Break

01:44:47
Fred *Discussion on hearing aids.*

01:44:53
Scot Frink *Discussion on hearing*
Hearing aids is not a life threatening issue but it is about quality of life. When we are looking at this reimbursement aspect of referring back to 2000-2004 – if you look around the room you can visually see laptops and computer pads. Kind of like comparing cell phones from 2002 to today's phones (2015). If you got the

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aids *best technology in 2002 would you still be using it today? Hopefully, this will help put it into a better frame when thinking about it. Earlier it was noted that the cost of technology goes down, but that doesn't mean you keep getting the old technology. You want to be able to provide the best technology to solve the person's problem at that time. More discussion on billing costs, access, Medicaid, and reimbursement... Final recommendation is to do a cost analysis on cost of living changes since 2002 at minimum and go from there. Make a provision for cost of living adjustments annually; otherwise you will be looking at this question again 5-10 years from now. Put a provision in there. Just like minimum wage that goes up every year with cost of living.*

01:50:35 *Is there any additional thought or input on what we discussed two weeks ago?*
Fred

01:50:51 *Some of the members wanted to know what is the deadline for submitting written comments on 245 vs 248 issue. They wanted to send in some case examples.*
Randy

01:51:05 *No formal legal deadline. It's not like testimony where if it comes in a day late we are not allowed to accept it. Advice is more informal.*
Fred

01:51:24 *About a week?*
Juerg

01:51:31 *What is your plan for filing proposed rules?*
Jaye

01:51:36 *Mid December may not be practically possible. More likely middle of January for a February hearing. Meaning we would publish permanent rules in March for April 1 effective date. There is really not a lot of flexibility in that timeframe.*
Fred

01:52:30 *Introduced new issue from Helen.*
Fred

01:52:47 *Certification Requirement: ... There is no excuse for not requiring certification for languages that have certification for the medical field.*
Helen:

Interpreting issues

Other issues: Record manipulation when doctor's employee helps to fill out medical paperwork for the patient. A professional interpreter should always be interpreting for the patient. ...

Next: Choice of interpreter. The certification number, name and expiration date of the interpreter should be on the medical record.

02:04:55 *Before we continue we need to have a discussion. The whole point of having an advisory committee is to get input. You have raised a question of requiring certification. This is an important point, and one that we should get input from*
Fred

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the committee members on.

02:05:08 *Does certification make sense to you?*
Helen

02:05:10 *We use certified interpreters' services. I can only speak for my clinic. We do validate that the people we do use are certified. Furthermore, because we are a particular type of practice we also cross-require that the interpreters that work with us also understand our culture.*

02:05:29 *I would not be certain that a language company always sends certified interpreters. In the law it says that the patients brother, sister, family member, can interpret for them. But I think that the law should require that (certification).*

02:06:16 *Right now the worker can come in with their interpreter already picked out, which could be a family member or any one of the firms around the state of Oregon which don't necessarily require certified staff.*

02:06:36 *That was MLAC [Management-Labor Advisory Committee] that recommended that we allow the worker to choose the interpreter, not the provider, and not the insurer. It was something that was important to MLAC.*

02:07:03 *That is what we do kind of across the board. The only difference is the training or certification. When you take regional dialects into account I think that a family member may be most effective in some cases.*

02:07:17 *From our perspective I don't have an objection to having certified interpreters, but would hate to see it mandated just because ... for example, you go in for a medical exam and you have an interpreter coming with you who you don't know – and maybe the medical exam is particularly sensitive – and you would rather have a family member. The system imposes enough upon workers.*

02:07:58 *Recommendations through CMS say not to use a family member...*
Kathy

02:08:10 *If you are going to hire an interpreter they will be certified right?*
Sheila

02:08:17 *The rules don't require that.*
Allison

02:08:20 *We always ask the worker that we've been working with if they have an interpreter they have been using for a while because we want to honor their choice. They already have an established relationship.*

02:08:56 *Speaking to the trusted family member/trusted friend issue. As an interpreter*

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- Helen trainer, I've trained a lot of people who have been in this role and interpreted for the family member and they have found it to be very stressful. I always tell people that are ready to interpret and are defensive, I say how about you do what you do best and be a family member and I'll do what I do best which is interpret. If you find that I need support or am interpreting incorrectly just let me know. They find themselves much more relaxed in that setting. I don't think that it would actually be a problem for the workers to work with a certified interpreter.*
- 02:10:23 We don't generally select the interpreter. The injured worker selects the
Jaye interpreter. We want the best for the worker. We want the best information for the claim.*
- 02:10:43 Question for Helen...introduced cultural implications of using a family member
Randy for interpreting.*
- 02:11:38 In many cultures the family member is in an awkward position. Interpreters that
Helen have come to my class to be trained have said it's been uncomfortable. ... When I suggest they not interpret for their family anymore, they breathe a sigh of relief.*
- 02:11:57 The point is, whatever is being spoken through the interpreter to the worker
Randy needs to be accurate. The responses need to be interpreted accurately so we have an accurate medical record. As an attorney I fully support that we use certified interpreters when a worker is in a medical office. I wish it was required and we could have the insurers pay for them in our offices.*
- 02:12:59 Doctor is writing his diagnosis based on an accurate and complete version of
Helen what the worker is saying, but he can't do it when he doesn't have an accurate and complete version.*
- 02:13:13 On the provider's side, workers' compensations does cover the cost of
Kathy interpretation. In a provider's office we are most likely to use a certified interpreter for a worker. Where it is going to fall down is most likely where it is not covered – where the provider has to absorb the cost.*
- 02:13:36 If it were mandated it would be a certified interpreter?
Randy*
- 02:13:41 If we had a non-injured worker who needs an interpreter we use the same
Kathy interpreter service who knows us well, so we are still using a certified interpreter.*
- 02:13:52 Outside of workers' comp who pays for that?
Randy*

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- 02:13:54 *We do.*
Kathy
- 02:14:00 *Going back to the family member being the interpreter, I'll say it can go either way.*
Scot Frink
- 02:14:43 *It depends on the professionalism of the interpreter. This is when interpreters need to be trained on professionalism, and not just on vocabulary. Unfortunately, a lot of training programs only train on vocabulary but very little on how to manage the interaction. My training program focuses on the interaction, the ethics... but these are issues that need to be addressed at another time. At the very least, you need to verify that the interpreter knows both languages. At least you have a 40% chance of getting the message across.*
Helen
- 02:15:33 *I would say we all agree that if we are going to help the injured worker find an interpreter they would be certified. But we don't want to take away the right of the worker on their ability to choose their interpreter.*
Sheila
- 02:15:50 *It's an important issue and we can look at our own practices ... we can do anecdotal research.*
Jaye
- 02:16:21 *A year or two ago when we looked into certified medical providers in Oregon, there were very few. Workers' comp patients are not just in Portland.*
Juerg
- 02:16:50 *That is why I'm proposing levels. . . . when you can't get a certified interpreter there is a simple language proficiency test to determine that they are proficient in both languages. They can take this test and have its results sent to workers' compensation, so a registry of provisionally certified interpreters can be established. At least you know that you are getting someone that can speak English well enough at the interpreting session.*
Helen
- 02:17:36 *Does OHA do something like this?*
Fred
- 02:17:38 *OHA does not have such a list. They only have people that have demonstrated the language proficiency and the training.*
Helen
- 02:17:46 *They have both certified and qualified?*
Fred
- 02:17:48 *Yes, but qualified is after training. Until you have completed training they don't register anyone.*
Helen
- 02:17:54 *The list says it's a certified court interpreter roster.*
Nanci

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- 02:17:56
Helen *That's court interpreter. Oregon Health Authority has a different list. This list exists but a lot of people are not on it yet. OHA is delayed on registering people. I'm just saying a list of people that are language proficient in both languages, but who may not have completed training. You are just looking for language proficiency in language A and in language B. All you are asking them to do is take a language proficiency test in A and B at the level that the national board requires being able to register for the certification exam.*
- 02:19:42
Randy *Does your rule proposal, which I'm not clear about – does it eliminate the option to use a family member/friend or employee of the medical provider in addition to interpreter?*
- 02:20:00
Helen *I believe if the medical provider has someone that is certified then that person would be okay. I'd be hesitant for the manipulation of the medical record issues. You would have to establish boundaries.*
- 02:20:22
Randy *So is your answer yes to propose to eliminate the other alternatives?*
- 02:20:24
Helen *I would be hesitant.*
- 02:20:26
Randy *In the rush to get medical treatment, it may delay that if the worker can't find a certified interpreter.*
- 02:20:33
Helen *You have to put down on the record that this was done by a person that works for the medical provider so you know who interpreted that day. So you would know who the interpreter was that day.*
- 02:20:44
Randy *There may not be one there or available.*
- 02:20:48
Helen *Recording who did that is important for your records so you know who provided the service.*
- 02:20:54
Randy *I was talking in the real world.*
- 02:20:58
Helen *In the real world where the rubber hits the road, you have to do what you have to do. So, sure use that person, but for example, Tuality Hospital is training people to be certified interpreters.*
- 02:21:25
Randy *I'm just trying to understand your proposal.*
- 02:22:05
Another issue with this law is in billing - Proving that the interpreter was there.

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- Helen* *I'm proposing that the interpreter be able to submit a billing form that has a sign in/out sheet to submit what is on list (5)(b) [OAR 436-009-0110(5)(b)] (Name, certification number, expiration date, and other criteria) and that's all. Some companies are asking for the interpreter to provide information on the worker's return to work status. The interpreter is not a doctor, and that is HIPAA protected information and not part of our job to record... we should be able to get paid without waiting for the process to get filed or whatever it's waiting on. All the stipulations, denials, failure to document that an interpreter was there, things we have no control over, delays or denies interpreters' payments. If the interpreter's payment can be completely separated, or somehow made independent, that would be important. Interpreters cannot be dependent on the ability for providers to ensure good record keeping.*
- 02:24:33* *So you are proposing a standard form?*
Fred
- 02:24:35* *I'm proposing a standard form that the interpreter could turn in or something that is independent of the doctor's record keeping. The doctor's record keeping is unreliable.*
Helen
- 02:24:50* *Does the committee have advice on this subject to the standardized form that we did talk about a couple of years ago? At that time there were two sides but no consensus on what to do.*
Fred
- 02:25:02* *Denied payments for unreliable record keeping, or insurance companies are coming back and asking the interpreters for information that is inappropriate to give because its HIPAA protected or confidential information.*
Helen
- 02:25:33* *Just for my own interest, is it workers' compensation insurers that are coming back to the interpreter? That would be a problem... it's not coming from SAIF.*
Dan
- 02:25:41* *Yes. It's not coming from SAIF. It's other companies that have very poor business practices. I think if Oregon took the lead and said these are the only questions that interpreters can be asked, then those companies would not be able to take a foothold in Oregon.*
Helen
- 02:26:45* *Do we know what OHA rules around interpreters say?*
Jaye
- 02:26:51* *We looked at this a couple years ago.*
Nanci
- 02:27:15* *Are there rules around practices for OHA? Where can we find out where we can get one immediately.*
Jaye
- 02:27:40* *The Oregon Health Authority rides on the National Council Ethics and*

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- Helen Standards of Practice.*
- 02:27:50 Nanci We are looking for something we can use for a mirror or if we wanted to use OHA interpretation list. Kind of like if you are in a doctor's office that has no interpreter, they need to be able to find out where to get one.*
- 02:28:06 Helen I can give you the link to that.*
- 02:28:09 Nanci But would that be available immediately so the worker can get treatment?*
- 02:28:21 Jaye I think Helen's point is well taken. The interpreters should not be asked questions about the substance of medical exams. I don't think that SAIF would object to any of those kinds of rules. It makes good sense to me. We would object to not having something in the doctor's record that there was an interpreter there. We like the idea of something that says this is where the interpreter was for record keeping. I think that is good documentation that should be there. This is a bigger conversation.*
- 02:29:23 Helen The Oregon law on health care interpreter refers back to the National Council for interpreting ethics and standards of practice.*
- 02:29:54 Jaye Normally the Department of Justice looks very askance anytime when you are adding into a rule a separate standard – that they said no you cannot do that. That is why I was looking for the actual rules.*
- 02:30:11 Helen If you just referred to the National Council of Standards – which is actually quoted from the Oregon Health Authority law – I can provide a link to that later. Basically, it says that everything said in the appointment will be kept confidential and will not be repeated outside of the appointment with anyone. The advocacy involved is also very limited. A lot of this is simplifying how the billing is happening. Discussion on payments and calculations which is on page 8 of the handout.*
- 02:33:31 Fred In terms of tying the mileage rate – so what we do for workers right now is tied to the federal rates paid to federal employees.*
- 02:33:40 Helen Almost everybody ties mileage to the federal rate; if you tied mileage to the federal rate everyone would know what you are talking about.*
- 02:33:52 Jaye This runs into the same issue of the responsibility that the agency has to develop its own rules. When you tie yourself to something that someone else is doing - I think it runs afoul too.*
- 02:34:09 Would that be true for what we do with workers in terms of related....*

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Fred

02:34:13 *I would say it is. I would say that every time the Feds change it change it you
Jaye need to change your rule.*

02:34:49 *On page 9 it says the interpreter service of more than one hour gets paid \$15.00
Helen for 15 minutes... which is basically 25% of each hour. Discussion on changing
the language so that it is simpler... "The only person in Oregon" line needs to
be rewritten. There is no such thing as the only person in Oregon.*

02:36:00 *There is a rule that says if the only person you can get is the only interpreter for
Fred this in the entire state, then you can charge an additional fee.*

02:36:07 *You are saying that doesn't exist?
Nanci*

02:36:09 *That doesn't exist. I'm thinking that if you just say 25% for the hourly rate...
Helen simplifies things.*

02:36:47 *I see a proposal for travel time of \$5.00 per quarter hour on page 2.
Fred*

02:37:05 *California has travel time included, and I recommend that you consider that for
Helen people that are driving long distances. I don't think it's an issue for short
distances. When interpreters submit their invoices ... as soon as the clock ticks
into the next quarter of an hour you pay for that quarter of an hour, it makes
more sense than saying you pay when you hit minute 8. Nobody in the United
States goes by this rule.*

02:38:51 *All the medical billing is according to this structure. The division has mirrored
Juerg the medical model and adopted that. This is where it comes from.*

02:39:01 *Okay. I've never heard of that before. I thought that is just the strangest thing
Helen I've ever heard of.*

02:29:11 *It meets with great resistance when it comes to depositions.
Randy*

02:39:51 *I'm seeing a 14-day turn around on payment of bills requirement.
Fred*

02:39:57 *You are tying it to so many things that the bills can be denied. There are so many
Helen reasons that a bill can be denied e.g. doctor forgot to turn in his bill, doctor
forgot to file paperwork. We never get paid. That's what interpreters tell me that
work for workers' compensation is that they never get paid. We submit our
paperwork, we showed up, we did our job, we should get paid. We are not*

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responsible for the doctor not turning in his paperwork. Can we please be separated from this?

02:41:02
Fred *The one thing that would be very difficult to separate is the 45 days that the insurance company has to accept or deny any medical bill which includes other types of services such as interpreters. That's why they have 45 days, and if it turns out the claim is being litigated and it turns out to be a compensable claim, they have 14 days after that.*

02:41:24
Helen *Can we at least be separated from the doctor turning in his paperwork?*

02:41:29
Jaye *No. The insurance company is not going to pay for the interpreter if the condition is denied.*

02:41:37
Helen *Once the interpreter turns in their paperwork can you chase the doctor to turn in their paperwork? We have no recourse to get paid, we have no control over that. It's a really big problem.*

02:41:42
Jaye *If the doctor wants to get paid they will turn their paperwork in.*

02:41:48
Helen *We don't have a way to chase a doctor for that. If we are tied to the doctor for turning in his paperwork can we at least require seeing the doctor's paperwork. You have the story... you get paid after I do, but then we never know what's going on with the paperwork. It is a really big problem. This means that no one wants to do workers' compensation work.*

02:42:18
Fred *It is a problem that we have heard about.*

02:42:52
Lisa Anne *I'm going to send over a link to the committee with the FAQ's on how they have handled this in California... one thing I will say when you have an urgent situation... in California they created a provisional certification that addresses this.*

02:44:22
Helen *In Oregon there is no provisional process. The worker can choose who they want, there are no requirements here.*

02:44:39
Fred *End of discussion.*