

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of:) SUMMARY OF
OAR 436-009, Oregon Medical Fee and Payment Rules) TESTIMONY AND
) AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency’s conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated February, 2015. On Feb. 23, 2015, a public rulemaking hearing was held as announced at 9 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record will be held open for written comment through Feb. 23, 2015.

Two people testified at the public rulemaking hearing, recorded below as exhibit 9. The public submitted 11 written documents as testimony.

Testimony list:

Exhibit	Testifying
<u>1</u>	Proposed OAR 436-009
<u>2</u>	Mercedes Hudgins, Mitchell
<u>3</u>	Kristie Griffin, Express Scripts
<u>4</u>	Kevin Tribout, Helios
<u>5</u>	Kevin Tribout, Helios
<u>6</u>	Aida Vrooman, Alexandra Jones, D’Andria Ornee, A and R Enterprises Inc.
<u>7</u>	Aida Vrooman, Alexandra Jones, D’Andria Ornee, A and R Enterprises Inc.
<u>8</u>	Ron Vrooman, consultant for A and R Enterprises Inc.
<u>9</u>	Hearing Transcript: a) Don Emerson, SAIF Corporation b) Scott Anderson, SAIF Corporation
<u>10</u>	Allison Morfitt, SAIF Corporation
<u>11</u>	Sue Ann Thompson, National Council for Prescription Drug Programs
<u>12</u>	Sue Ann Thompson, National Council for Prescription Drug Programs
<u>13</u>	Karen Ritchie, Mitchell

Testimony: OAR 436-009

Exhibit 4

“Helios supports the Division's proposed language in various parts of the rules to do all of the following: update CPT coding, reference only the 02/12 version of the CMS-1500, and provide for use of ICD-10 coding on and after October 1, 2015. All of these changes will align Oregon workers' compensation requirements with practices within the health care industry across the country. Such alignment eases the compliance burden for providers and other entities within the state workers' compensation system also operating in other healthcare markets and jurisdictions.”

Response: Thank you for your testimony. The division will implement the rule as proposed.

Testimony: OAR 436-009-0004(7), 436-009-0010(3)(b)

Exhibit 10

“SAIF supports the proposed rule eliminating the 08/05 version of the CMS form since this form is outdated and does not contain all the fields needed for EDI reporting.”

Response: Thank you for your testimony. The division will implement the rule as proposed.

Testimony: OAR 436-009-0004

Exhibit 11, 12

“* * * We appreciate your decision to adopt both the NCPDP Telecommunication Standard Version D.0 and the NCPDP WC/PC UCF under the Oregon workers' compensation rules for billing of pharmacy transactions. * * *”

Response: Thank you for your testimony. The division will implement the rule as proposed.

Testimony: OAR 436-009-0008(2)(d)(B)

Exhibit 10

“SAIF is concerned about adding language that allows a provider to request administrative review within 90 days of the mailing date of the most recent explanation of benefits. The proposed language is inconsistent with WCD's statement at its November 24, 2014 Rule Making Advisory Meeting where WCD staff indicated it did not intend to give providers a new 90 day administrative review period for each subsequent EOB issued. SAIF regularly receives provider rebills of the same bill multiple times, sometimes years after the original bill and EOB. With every rebill a new EOB is issued. SAIF recommends that the rule clarify that a rebill with an accompanying EOB for the same services does not extend the 90-day review period when subsequent EOB's are issued.”

Response: Thank you for your testimony. The division changed this rule to address this issue.

Testimony: OAR 436-009-0010 & 0020

Exhibit 9.a., 10

“* * * nowhere does it specify that a bill cannot have both ICD-9 and ICD-10 codes. And from some correspondence that has gone through I understand that it is the case that you should never have a bill with both codes.

“SAIF notes that OAR 436-009 does not state that a bill cannot have mixed ICD-9 and ICD-10 codes. SAIF interprets this to mean that service dates before 10/1/15 must be billed separately from service dates after 10/1/15.

“We also note that CMS MM7492 describes exception bill types allowing bill service dates that begin before 10/1/15, but end after 10/1/2015 (Table A; <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1408.pdf>).

SAIF understand that these exceptions would utilize the service through date to determine if ICD-9 or ICD-10 codes should be utilized.”

Response: Thank you for your testimony. The division changed 0010(1)(b) to clarify that ICD-9 and ICD-10 codes cannot be combined.

Testimony: OAR 436-009-0010 & 0020

Exhibit 9.a.

“* * * according to the CMS documentation, there are certain bill types that allow ICD-9 codes to go up through the service through date versus the service from date. And I understand these are like inpatient hospital, swing beds, and those types of bill types, and the rules don’t address those at all. And, if we are staying consistent with the CMS rules, I would expect to see those.”

Response: Thank you for your testimony. The division will, if necessary, address this issue when the CMS UB-04 instructions are published in July 2015.

Testimony: OAR 436-009-0010 & 0020; OAR 436-160

Exhibit 9.b.

“* * * ICD-10 and the question about how the proposed rule changes will impact the EDI medical system, and whether there are any new or changing data or editing requirements expected in that system. * * * the rule doesn’t speak to the fact that you can’t intermix ICD-9 and 10 on the same bill. If it is actually a requirement will the EDI system be modified to enforce that requirement? I think there are already changes like that anticipated in the EDI system. The sooner we can know about it, the better so we can program to it.”

Response: Thank you for your testimony. The division changed 0010(1)(b) to clarify that ICD-9 and ICD-10 codes cannot be combined.

Testimony: OAR 436-009-0010 & 0020

Exhibit 9.b.

“And then one other question too about ICD-10 is whether the department has a position on the fact that we don’t really know if ICD-10 is going to implement October first or not. It’s like in the past, you know, what are the plans for dealing with that uncertainty? Is there some anticipated date certain that we could plan on, or – how that will be addressed in the rules?”

Response: Thank you for your testimony. The division will, if necessary, address this issue when the CMS UB-04 instructions are published in July 2015.

Testimony: OAR 436-009-0020

Exhibit 2

“* * * a recent correction to Bulletin 290 (Hospital Fee Schedule Cost to Charge Ratio) * * * states:”

“Hospitals that are licensed or authorized to be hospitals in another state have a cost-to-charge ratio of 1.000.”

“Should this be listed in the box above? Please note: there is no mention of this in the proposed 436-009-0020 section – The Out of state hospital section only mentions to pay as charged “in full”. Does not mention to apply Cost to charge ratio of 1.0. Your assistance in clarifying these issues is greatly appreciated.”

Response: Thank you for your testimony. The division changed rule 0020(2)(c) to clarify this issue.

Testimony: OAR 436-009-0020(1)(b)(A)
“Mitchell is proposing the following:”

Exhibit 13

For dates of discharge prior to Oct. 1, 2015, ICD-9-CM codes, and on or after Oct. 1, 2015, ICD-10-CM codes...

Response: Thank you for your testimony. The division will, if necessary, address this issue when the CMS UB-04 instructions are published in July 2015.

Testimony: OAR 436-009-0023, Appendix D, Ancillary Services Fee Schedule *Exhibit 10*
“The proposed fee schedule significantly increases reimbursement for ancillary ASC services which will result in unnecessary additional costs to policyholders. This proposed change was not discussed at the rule advisory meetings. SAIF is opposed to the estimated \$600,000 increase in costs to policyholders.”

Response: Thank you for your testimony. Although some fees for services may increase, others are expected to decrease, therefore, the division expects the overall fee schedule costs to remain neutral as it has been in previous years. The division will continue to monitor the fee schedule costs and will continue to make annual adjustments as needed.

Testimony: OAR 436-009-0025(5) & 0090(1)

Exhibit 3, 4, 5, 11, 12

Ex. 3 “Express Scripts comments focus on the proposed amendments to reimbursement for dispensed brand-name drugs when the injured worker has insisted on receiving the brand in lieu of a generic drug despite the prescriber not prohibiting substitution. * * * In order to provide greater efficiency within the system and to relieve the injured worker of the burden of paying the full cost of the brand drug, Express Scripts recommends the following change to the proposed language * * *.”

*436-009-0025(5)(b) * * * For prescription medications, the insurer must reimburse the worker based on actual cost; however, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must ~~pay the total cost of the brand name drug out of pocket, or~~ pay the difference between the cost of the brand-name drug and generic to the pharmacy. and request reimbursement from the insurer. ~~However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.~~*

** * * 436-009-0090(1)(b) * * * When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug ~~and pay the total cost of the brand name drug out of pocket or~~ pay the difference between the cost of the brand-name drug and generic to the pharmacy.*

Ex. 4, 5, 11, 12 We support the intent of the Division in adding clarification concerning injured worker and insurer liability given the existing generic dispensing requirement for pharmacies.

However, the proposed language appears to us to only focus on the process by which the injured worker would directly invoice the insurer for their applicable cost. We believe this continued burden on the injured worker may not necessarily be warranted given the capabilities of pharmacies and pharmacy benefit managers (PBMs) when utilizing the Division's adopted NCPDP pharmacy billing standards (either paper or electronic). In addition, following these standards should alleviate confusion on the part of the dispensing pharmacy and provide greater overall efficiency in the process.

Other jurisdictions which have adopted workers' compensation rules permitting the injured worker to request a brand-name drug also require the injured worker to pay the difference between the brand and generic. This can be processed in a point of sale transaction using the NCPDP Telecommunication Standard D.O with which the pharmacy bills identifying both the brand-name drug dispensed and the generic drug that would have been dispensed along with the associated pricing information for both. In the paid response transaction, the bill adjudicator (PBM/processor acting on behalf of the insurer) pays the pharmacy at the generic drug rate and communicates the difference as patient responsibility based on state regulations. The pharmacy may then collect the difference from the injured worker at the point of sale (prior to dispense). Even if the pharmacy does not proactively bill with the generic drug information, the same process enables the adjudicator to still pay the pharmacy at an equivalent generic rate and communicate the difference as patient responsibility based on state regulations. The same process is supported when billed on paper using the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF). The pharmacy identifies and calculates the difference in specific paper form fields designated for this purpose and collects the difference from the injured worker prior to dispensing. The worker is spared the need to pay for the full cost of the drug and can be provided with the billing information needed to request reimbursement of the brand-generic difference from the insurer.

In order to standardize the processing of these transactions, provide greater efficiency, and relieve the injured worker of the burden of paying the full cost of the brand drug and/or separately having to invoice the insurer, we recommend the following change to the proposed language:

*436-009-0025(5)(b) * * * For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket, or pay the difference between the cost of the brand-name drug and generic to the pharmacy, and request reimbursement, if permitted, from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse ~~the worker~~ the generic price of the drug.*

** * * 436-009-0090(1)(b) * * * When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.*

We believe these recommended changes would also align well with the Division's existing pharmaceutical fee schedule table under 436-009-0090(2), providing greater consistency and clarity in the rules. That table specifically states that a pharmacy should only be reimbursed based on the average AWP for the class of generic drugs when dispensing a brand-name drug with a generic equivalent and the prescribing provider has not prohibited substitution.

NCPDP has published guidance on how these DAW 2 transactions are to take place. To assist the Division in understanding the process, we have attached with our written comments a copy of NCPDP WG16's *Guidance For The Workers' Compensation Industry* (Version 2.1), which contains details related to this on pages 14 and 15.

Response: Thank you for your testimony. The division has made changes to address these issues.

Testimony: OAR 436-009-0040(3)(d)

Exhibit 13

“In reference to section 436-009-0040 Section (3) (d) Nurse Practitioners or physician assistants:

“When Nurse Practitioner or Physician assistants act as surgical assistants, they must apply modifier ‘81’. We are recommending/requesting the industry standard HCPCS Level II modifier ‘AS’ be applied. Modifier -81 is typically used by physicians when acting as an assistant at surgery. The modifier AS description reads:”

AS- Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery.

Response: Thank you for your testimony. This issue was discussed at the external advisory committee, and the committee agreed on the current proposed rule. The division will not make any further changes at this time.

Testimony: OAR 436-009-0040(4)

Exhibit 10

“WCD is proposing a significant increase in reimbursement for multiple radiological procedures. ORS 656.248 requires that fee schedules shall represent the reimbursement generally received for the services provided. During the rule advisory committee meeting there was no information provided by WCD about typical fees received by providers for these services. It is unclear whether the increase in costs to policyholders is justified.”

Response: Thank you for your testimony. The division disagrees and does not expect this to cause a significant increase in payment.

Testimony: OAR 436-009-0040(7)

Exhibit 10

“This proposed rule seems to allow medical providers to request another medical provider to prepare a report, or review records or reports and then bill insurers for this service. If this is WCD's intent, SAIF opposes a rule that allows a provider to bill for a service SAIF did not request. SAIF suspects that WCD intends that the party preparing a report should bill the party who requested the provider's services. SAIF recommends the proposed rule read as follows:”

(a) Except as otherwise provided in OAR 436-009-006, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the requesting party for their report or review of the records using CPT codes such as 99080. The bill should include

documentation of time spent reviewing the records or reports.

Response: Thank you for your testimony. When the division rewrote the 009 rules in 2014, we inadvertently made changes to this rule. These proposed rules add the language we inadvertently moved back into this section. We do not expect any changes from years prior with this rule.

Testimony: OAR 436-009-0090(2)

Exhibit 4, 11

Proposed 436-009-0090(2)(b) adds that bills from pharmacies must include either the prescribing provider's NPI or license number. However, the Division's adopted electronic billing requirements (specifically the table in 6.3 of the Division's Electronic Billing and Payment Companion Guide) requires submission of the prescribing provider's NPI as the only allowable provider identifier in an electronic bill from a pharmacy. We believe the proposed language should maintain consistency with those electronic billing requirements.

To achieve this, we recommend the following change to the proposed language in 436-009-0090(2)(b):

(b) All bills from pharmacies must include the prescribing provider's NPI ~~or license number~~.

Ex. 11 “If, however, it is the Division’s intent to allow either identifier, then the electronic guidance should be updated. If the intent is to allow the license number when the prescriber does not have an NPI (e.g.; the treatment occurs outside the U.S.), then the task group recommends this situational provision be clarified in these proposed rules and those governing electronic billing.”

Response: Thank you for your testimony. Currently, the rules do not require that any provider have an NPI. However, when they do have an NPI, they must use it on the bill and the insurer must report it. When the provider doesn’t have an NPI, and they provide a license number, the insurer can report all 9s.

Testimony: OAR 436-009-0110

Exhibit 6

“* * * for the past few years, qualified and certified has been an issue by the hospitals, clinics and the state for interpreters. To be qualified or certified is important and in the rules they leave out “interpreting services as a profession” and replaces everything with “an interpreter” Which means pretty much anyone who speaks the other language can be an interpreter. * * * Not true; bi-lingual is not interpreting * * * That doesn’t mean it’s a competent interpreter and can do a good job.

“This is why for many years hospitals decided to hire professional interpreters and didn’t want family members to insure that the patient was getting the best care. Interpreters are working hard to better themselves by taking classes, passing the required tests to be certified. Once they’re certified they ask the interpreting companies to pay them more and as an interpreting company, we have to honor that. I think that this rule should be more specific to meet and reflect the real requirements demanded by interpreting companies and most importantly, the clinics they serve.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110

Exhibit 6

“I am in charge of doing billing * * *. In October of last year, I was told by the MRT group (Worker’s Comp. Division) that I should go directly to SAIF Corporation management * * * to resolve any billing issues I had with our invoices and if * * * [SAIF] couldn’t resolve the problem, then I could escalate the issue to the MRT group. Most of billing issues with SAIF is that if an appt. goes more than one hour, they challenge the invoice and don’t want to pay for the remaining time (1/4 or 1/2 hour) Then I have to go to the SAIF website (SAIF Medical Provider) and send * * * an email requesting the rest of the payment. Which at that point it takes an extra few days to get a check. This happens very often and it’s extremely time consuming.”

Response: Thank you for your testimony.

Testimony: OAR 436-009-0110

Exhibit 8

“Several hassle factors that have been demonstrated to WCD many times over:

- “The invoice from A & R Enterprises Inc. is denied, the doctor’s invoice had a different amount of time.
- “The doctor is only billing for his/her time spent with the patient.
- “The interpreter bills for requested time of the appointment until he/she is discharged, which includes paper work, time with nurse, and any other provider he/she needs to see and waits for the time with the doctor.”

Response: Thank you for your testimony.

Testimony: OAR 436-009-0110(1)

Exhibit 7

“Choosing an interpreter. Add: The patient will be informed that if the interpreter does not meet their needs, they can change interpreters”

Response: Thank you for your testimony. The rule states that the worker may choose the interpreter and we feel this is sufficient.

Testimony: OAR 436-009-0110(2)

Exhibit 7

“Billing. (b) Therefore the insurer must pay as the general public pays 30 day net. The late payment penalties is \$30.00 for every 30 days late or portion of 30 days late.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(2)

Exhibit 7

“Billing. * * * (c) You cannot say “Round Trip” in one sentence and then not mention it on the next sentence. “For the purpose of this rule “mileage” means the number of miles traveling for the interpreter’s starting point to the exam or treatment location” What about return mileage?”

Response: Thank you for your testimony. The division agrees and clarified the rule accordingly.

Testimony: OAR 436-009-0110(5)(b)

Exhibit 7, 8

“(5) Billing Form. [Add new paragraph (J)] (J) When the provider staff and patient sign off on time/date on work order the time will not be challenged prior to payment. Patient, care giver and interpreter attesting to time is sufficient for total payment.”

“* * * Also the correct place, time and date are provided. Even if the caregiver’s and interpreter’s amount of time has a discrepancy on time the caregiver spent with patient versus the amount of time the interpreter spends at the clinic. Even if the invoices arrived on different days. Three signatures should be enough proof for the insurer to pay the invoice when received. Not 45 days later if they choose. If the insurer wishes to challenge the veracity of the three involved persons attesting to an invoice in writing with place, names, date and time the insurer should be penalized for deceitful business practices. Huge hassle factor!”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(6)

Exhibit 6, 7

“As a result of paying the interpreter more, I believe that * * * the amount allowed should be raised to \$70.00 an hour. We provide a good service * * *. As a result insurance companies get their money well spent and the treatment to the patient with good communication through patient and provider. I believe that diminishing the interpreting profession is not going to provide a good outcome.”

“* * * Compare the cost indexes since our payment was reduced to \$60.00 from \$65.00 per hour.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(6)

Exhibit 7

“(6) Payment Calculations. (b) * * * \$15.00 per 15 minute increment, change it back to per minute at the new rate of \$70.00 per hour or even if the old rate prevails.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(6)

Exhibit 7

“(6) Payment Calculations. (b) * * * Change to \$70.00 no show fee plus payment for mileage if 15 or more miles round trip.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(6)

Exhibit 7

“(6) Payment Calculations. (b) * * * An interpreter who is the only person in Oregon able to interpret a specific language. Ridiculous rule. The sky is not the limit. However, difficulty on exotic language should pay \$80.00.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(7)

Exhibit 7

“(7) Payment Requirements. (b) Any other medical appointment pay at least ½ fee.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(7)

Exhibit 7, 8

“(7) Payment Requirements. * * * (c)(A) Should be **30** days of receiving the invoice.

“(7) Payment Requirements. * * * (c)(B) Should be **30** days as is standard.

“* * * Thus begins the float. The insurer has 45 days to pay. Fred and John [Workers’ Compensation Division] told Alexandra and Ron [A & R Enterprises Inc.] that they would be looked into. 30 days seems to be the commercial and industrial standard. That was two years ago. As it is now 45 days before they are late.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(7)

Exhibit 7

“(7) Payment Requirements. * * * (i)(C) A statement that the insurer or its representative must respond to an interpreter’s payment questions within **24** hours, excluding weekends and legal holidays.”

Response: Thank you for your testimony. The rule currently provides for 48 hours for an insurer to respond to any medical provider’s inquiry and we feel this is a reasonable amount of time to respond.

Testimony: OAR 436-009-0110(7)

Exhibit 7, 8

“(7) Payment Requirements. * * * (i)(F) A notice of the right to administrative review as follows: Not necessary; they have the invoice. Sanctions should start immediately at due date.

“* * * When the insurer does not pay the invoice as is proper in the business community, the insurer will incur a penalty.”

Response: Thank you for your testimony. This issue wasn’t discussed at the external advisory committee so the division will not consider this suggestion at this time. Please feel free to raise this issue for discussion at the next external advisory committee meeting for these rules.

Testimony: OAR 436-009-0110(7)

Exhibit 7

“(7) Payment Requirements. * * * (j) Duplicate notification not necessary. They have the invoice.”

Response: Thank you for your testimony.

Testimony: OAR 436-009, Appendix B

Exhibit 13

“Regarding Appendix B – “Global Days”:

“- Currently Appendix B indicates global period of 0-10-90 days. Please advise the source for determining the global period. Is the global period as defined in Appendix B different than global days as published by CMS (Medicare).”

Response: Yes the 0-10-90 days global period comes from CMS. However, for CPT® code 29826, we changed the Global days from ZZZ to 090 because, unlike CMS, we don’t consider this an add-on code.

Dated this 12th day of March, 2015.
--



Oregon

John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter Street NE
P.O. Box 14480
Salem, Oregon 97309-0405
1-800-452-0288, 503-947-7810
www.wcd.oregon.gov

Jan. 15, 2015

Exhibit
"1"

Proposed Changes to Workers' Compensation Rules

The Workers' Compensation Division proposes changes to OAR 436-009, Oregon Medical Fee and Payment Rules.

Please review the attached documents for more information about proposed changes and possible fiscal impacts.

The department welcomes public comment on proposed changes and has scheduled a public rulemaking hearing.

When is the hearing?

Feb. 23, 2015, 9 a.m.

Where is the hearing?

Labor & Industries Building
350 Winter Street NE, Room F (basement)
Salem, Oregon 97301

How can I make a comment?

Come to the hearing and speak, send written comments, or do both. Send written comments to:
Email – fred.h.bruyns@state.or.us
Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Phone – 503-947-7717; Fax – 503-947-7514

The closing date for written comments is Feb. 26, 2015.

How can I get copies of the proposed rules?

On the Workers' Compensation Division's website –
www.wcd.oregon.gov/policy/rules/rules.html#proprules

Or call 503-947-7717 to get free paper copies

Questions?

Contact Fred Bruyns, 503-947-7717.

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*
A Statement of Need and Fiscal Impact accompanies this form

FILED 1-15-15 2:48 PM ARCHIVES DIVISION SECRETARY OF STATE
--

Department of Consumer and Business Services, Workers' Compensation Division Agency and Division	436 Administrative Rules Chapter Number
Fred Bruyns Rules Coordinator	(503) 947-7717 Telephone
Department of Consumer and Business Services, Workers' Compensation Division, PO Box 14480, Salem, OR 97309-0405 Address	

RULE CAPTION

Amendment of rules governing workers' compensation medical billing and payment

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
2-23-15	9:00 a.m.	Room F, Labor & Industries Bldg, 350 Winter St. NE, Salem, OR	Fred Bruyns

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:

436-009

REPEAL:

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:

ORS 656.248, 656.726(4)

Other Authority:

Statutes Implemented:

ORS ch. 656, primarily 656.245, 656.248, 656.252, 656.254

RULE SUMMARY

The public may also listen to the hearing or testify by telephone:
Dial-in number is 213-787-0529; Access code is 9221262#.

The agency proposes to amend OAR 436-009, "Oregon Medical Fee and Payment Rules," to:

- Adopt updated medical fee schedules (Appendices B, C, D, and E) and resources for the payment of health care providers;
- Add definitions of "date stamp" and "patient";
- Specify that a medical service provider who conducts independent medical exams may submit bills in any form or format agreed to by the insurer and the medical service provider;
- Explain time frames when medical providers must switch from using ICD-9-CM to ICD-10-CM codes for billing;
- Require that modifier "81" be used only to identify services of nurse practitioners and physician assistants who were surgical assistants during surgery;
- Make workers liable for payment of the difference in cost between a generic and a brand-name drug, if:
 - The prescribing provider has not prohibited substitution;
 - The insurer previously notified the worker about the liability; and
 - The worker insists on receiving a brand-name drug;
- Reduce the discounts on payment for certain diagnostic imaging procedures applied to multiple regions of the body;
- Require that the insurer replace a prosthetic appliance that is damaged when in use at the time of and in the course of employment with a comparable appliance, but the worker may choose to upgrade the appliance and pay the price difference; and
- Specify that all bills from pharmacies must include the prescribing provider's NPI (national provider identifier) or license number.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

02-26-2015 Close of Business	Fred Bruyns	fred.h.bruyns@state.or.us
Last Day (<i>m/d/yyyy</i>) and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT
A Notice of Proposed Rulemaking Hearing accompanies this form.

FILED
1-15-15 2:48 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division
Agency and Division

436
Administrative Rules Chapter Number

Amendment of rules governing workers' compensation medical billing and payment

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

Amendment of OAR 436-009, Oregon Medical Fee and Payment Rules

Statutory Authority:

ORS 656.248, 656.726(4)

Other Authority:

Statutes Implemented:

ORS ch. 656, primarily 656.245, 656.248, 656.252, 656.254

Need for the Rule(s):

The agency is proposing changes to update the medical fee schedules as required by ORS 656.248, and to make other changes consistent with the director's responsibilities under ORS 656.726(4).

Documents Relied Upon, and where they are available:

Advisory committee meeting records and written advice. These records are available for public inspection in the office of the Workers' Compensation Division of the Department of Consumer and Business Services, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday. Please call (503) 947-7717 to request copies.

Fiscal and Economic Impact:

The agency projects that proposed rule changes will have no positive or negative fiscal impacts on the agency. Possible economic effects on other state agencies, units of local government, and the public are described below under "Statement of Cost of Compliance."

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

- a. The agency estimates that proposed rule changes will have no significant effect on costs of state agencies.
- b. The agency projects proposed rule changes would have some impact on units of local government, such as cities and counties that are self-insured. The fiscal effect on cities and counties is included with the impacts on workers' compensation insurers - see "The public" below.
- c. The agency estimates that proposed rule changes will increase costs to the public as follows:
 - Reductions to the discounts on payment for certain diagnostic imaging procedures applied to multiple regions of the body will increase costs to insurers and self-insured employers, and produce a corresponding increase in payments to imaging providers. The agency does not have sufficient data to make a precise estimate of the impact, but projects that the system-wide effect will be less than \$150,000 per year.
 - Increases to the maximum fees payable for durable medical equipment, prosthetics, orthotics, and supplies (under the DMEPOS fee schedule) are projected to increase annual costs for insurers and self-insured employers by approximately \$128,000, and produce a corresponding increase in payments to DMEPOS providers.
 - Making workers, after notification by insurers, and under limited circumstances, liable for payment of the difference in cost between generic and brand-name drugs may result in costs to workers who insist on receiving the brand even when their prescribing provider does not require that the worker receive the brand rather than the generic drug.
 - The proposed rules would require health care providers to use ICD-10-CM codes starting Oct. 1, 2015 (the ICD-10 codes are already used outside the US). This coding standard is now being adopted throughout the United States, and required by CMS for all Medicare/Medicaid bills, and by health insurance companies. The agency projects that health care providers and insurers will incur some costs, such as training, during transition to the new standard. However, the agency projects that adopting ICD-10-CM will be more cost effective for health care providers and insurers than retaining a soon-to-be obsolete ICD-9-CM standard.
 - Additional proposed rule changes are not projected to have significant impacts on costs.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

The agency estimates that Oregon has at least 12,000 medical providers. Many of these businesses would be small businesses as defined by

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

- The proposed rules would require health care providers to use ICD-10-CM codes starting Oct. 1, 2015 (the ICD-10 codes are already used outside the US). This coding standard is now being adopted throughout the United States, and required by CMS for all Medicare/Medicaid bills, and by health insurance companies. The agency projects that health care providers and insurers will incur some costs, such as training, during transition to the new standard. However, the agency projects that adopting ICD-10-CM will be more cost effective for health care providers and insurers than retaining a soon-to-be obsolete ICD-9-CM standard.
- The agency projects that additional proposed rule changes would not significantly affect businesses' costs for reporting, recordkeeping, administration, or professional services.

c. Equipment, supplies, labor and increased administration required for compliance:

- The agency projects that proposed rule changes would not significantly affect businesses' costs for equipment, supplies, or labor/administration required for compliance.

How were small businesses involved in the development of this rule?

The agency sent invitations for advisory committee participation to more than three thousand stakeholders, including small businesses, and small business representatives served on the committee.

Administrative Rule Advisory Committee consulted?: Yes

If not, why?:

<u>02-26-2015 Close of Business</u>	<u>Fred Bruyns</u>	<u>fred.h.bruyns@state.or.us</u>
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address



Oregon Medical Fee and Payment Rules
Oregon Administrative Rules
Chapter 436, Division 009

Proposed

Table of Contents

436-009-0001	Administration of These Rules	1
	Authority for Rules	1
	Purpose	1
	Applicability of Rules.....	1
436-009-0004	Adoption of Standards	2
436-009-0005	Definitions	4
436-009-0008	Request for Review by the Director<u>before the Director</u>	10
	General	10
	Time Frames and Conditions	10
	Form and Required Information	12
	Dispute Resolution by Agreement (Alternative Dispute Resolution).....	13
	Director Order and Reconsideration	14
	Hearings	14
	Other Proceedings	15
436-009-0010	Medical Billing and Payment	16
	General	16
	Billing Timelines (For payment timelines see OAR 436-009-0030.).....	17
	Billing Forms	18
	Billing Codes	19
	Modifiers	20
	Physician Assistants and Nurse Practitioners	20
	Chart Notes	20
	Challenging the Provider's Bill	21
	Billing the Patient / Patient Liability	21
	Disputed Claim Settlement (DCS).....	22
	Payment Limitations.....	22
	Excluded Treatment	23
	Missed Appointment (No Show).....	24
436-009-0018	Discounts and Contracts	24

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Medical Service Providers and Medical Clinics.....	24
Discounts	24
Fee Discount Agreements.....	25
Fee Discount Agreement Modifications and Terminations.....	26
Other Medical Providers.....	26
436-009-0020 Hospitals	28
Inpatient	28
Outpatient	28
Specific Circumstances.....	29
Out-of-State Hospitals.....	29
Calculation of Cost to Charge Ratio Published in Bulletin 290.....	30
436-009-0023 Ambulatory Surgery Center (ASC)	33
Billing Form	33
ASC Facility Fee	33
ASC Billing	34
ASC Payment	34
436-009-0025 Worker Reimbursement.....	36
General	36
Timeframes	37
Meal and Lodging Reimbursement.....	38
Travel Reimbursement.....	39
Other Reimbursements.....	40
Advancement Request.....	40
436-009-0030 Insurer's Duties and Responsibilities.....	41
General	41
Bill Processing	41
Payment Requirements.....	42
Communication with Providers.....	44
EDI Reporting	44
436-009-0035 Interim Medical Benefits.....	45
436-009-0040 Fee Schedule	47
Fee Schedule Table	47
Anesthesia	48
Surgery	49
Radiology Services	52
Pathology and Laboratory Services.....	52
Physical Medicine and Rehabilitation Services.....	53
Reports	53
Nurse Practitioners and Physician Assistants.....	54

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

436-009-0060	Oregon Specific Codes	55
	Multidisciplinary Services.	55
	Table of all Oregon Specific Codes	55
	CARF / JCAHO Accredited Programs.	60
436-009-0080	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	61
436-009-0090	Pharmaceutical	65
	General	65
	Pharmaceutical Billing and Payment	65
	Clinical Justification Form 4909.....	66
	Dispensing by Medical Service Providers.	67
436-009-0110	Interpreters	67
	Billing	67
	Billing and Payment Limitations.	68
	Billing Timelines	69
	Billing Form	69
	Payment Calculations.....	70
	Payment Requirements.	70
436-009-0998	Sanctions and Civil Penalties	73
Appendix A	Oregon hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills under OAR 436-009-0020	74
Appendices B through E		75
Appendix B	(physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers. [Effective April 1, 2014⁵]	75
Appendix C	(ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective April 1, 2014⁵]	75
Appendix D	(ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective April 1, 2014⁵]	75
Appendix E	(durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, 2014⁵]	75
Appendix F	- Matrix for health care provider types	76

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Fee Schedule Tables (Please note that the Appendices are not attached to these rules.)

[Appendix A Oregon hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills under OAR 436-009-0020](#)

[Appendix B \(physician fee schedule\)](#)

| [Effective April 1, 2014~~5~~]

[Appendix C \(ambulatory surgery center fee schedule amounts for surgical procedures\)](#)

| [Effective April 1, 2014~~5~~]

[Appendix D \(ambulatory surgery center fee schedule amounts for ancillary services\)](#)

| [Effective April 1, 2014~~5~~]

[Appendix E \(durable medical equipment, prosthetics, orthotics, and supplies \(DMEPOS\)\)](#)

| [Effective April 1, 2014~~5~~]

[Appendix F \(matrix for health care provider types\)](#)

| [Effective April 1, 2014~~5~~]

HISTORY LINES: These rules include only the most recent “History” lines. The history line shows when the rule was last revised and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers’ Compensation Division, 503-947-7627, or visit the division’s website: <http://wcd.oregon.gov/policy/rules/history.html>

NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in

~~Deleted~~

Added text is underlined, as in

Added

The Workers' Compensation Division (WCD) adopts, by reference, the American Society of Anesthesiologists (ASA) Relative Value Guide and Current Procedural Terminology (CPT®). See OAR 436-009-0004 for details and updated citations.

To order the *ASA Relative Value Guide*, contact:

American Society of Anesthesiologists
520 N. Northwest Highway, Park Ridge, IL 60068-2573
Phone 847-825-5586
<http://www.asahq.org/>

| **Ask for:** 2014~~5~~ *Relative Value Guide*

| To order the **CPT®** 2014~~5~~ or the *CPT Assistant*, contact:

American Medical Association
515 North State Street, Chicago, IL 60610
Phone 800-621-8335
<http://www.ama-assn.org/ama>

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

To order the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.2, contact:

National Council for Prescription Drug Programs (NCPDP)
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
Phone: 480.477.1000
www.ncpdp.org

To order the **NUBC UB-04 Data Specifications Manual**, contact:

National Uniform Billing Committee
American Hospital Association
One North Franklin, 29th Floor, Chicago, IL 60606
Phone 312-422-3390
www.nubc.org

Ask to: Become a subscriber of the NUBC UB-04 Specifications Manual

To order the Healthcare Common Procedure Coding System, contact:

National Technical Information Service
Springfield, VA 22161
Phone 800-621- 8335
www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp

436-009-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and OAR chapter 436, are considered orders of the director.

(2) Authority for Rules.

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.248.

(3) Purpose.

The purpose of these rules is to establish uniform guidelines for administering the payment for medical benefits to workers within the workers' compensation system.

(4) Applicability of Rules.

(a) These rules apply to all services rendered on or after the effective date of these rules.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 3/8/01 as WCD Admin. Order 01-051, eff. 4/1/01
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

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

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2014⁵ as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2014⁵, contact the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, 847-825-5586, or on the Web at: <http://www.asahq.org>.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT[®] 2014⁵), Fourth Edition Revised, 2013⁴, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT[®] must be used as guides governing the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's CPT[®] Assistant, Volume 0, Issue 04 1990 through Volume 23⁴, Issue 12, 2013⁴. If there is a conflict between the CPT[®] manual and CPT[®] Assistant, the CPT[®] manual is the controlling resource.

(4) To get a copy of the CPT[®] 2014⁵ or the CPT[®] Assistant, contact the American Medical Association, 515 North State Street, Chicago, IL60610, 800-621-8335, or on the Web at: <http://www.ama-assn.org>.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT[®] codes or that provide more detail than a CPT[®] code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or on the Web at: www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

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

(6) The director adopts, by reference, CDT 2014~~5~~: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or on the Web at: www.ada.org.

(7) The director adopts, by reference, ~~the 08/05 and the 02/12 1500 Claim Forms and Version 9.0 7/13 (for the 08/05 form) and Version 1.1 06/13 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manuals published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, 515 N. State St., Chicago, IL 60654, or on the Web at: www.nucc.org.~~

(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2014~~5~~ Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, One North Franklin, 29th Floor, Chicago, IL 60606, 312-422-3390, or on the Web at: www.nubc.org.

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.3 and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – 5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or on the Web at: www.ncpdp.org.

(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2014~~5~~, CPT[®] 2014~~5~~, CPT[®] Assistant, HCPCS 2014~~5~~, CDT 2014~~5~~, Dental Procedure Codes, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem OR 97301, 503-947-7606.

Stat Auth: ORS 656.248, 656.726(4)
Stats Implemented: ORS 656.248
Hist: Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 11/12/13 as Admin. Order 13-058, eff. 1/1/14
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

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

436-009-0005 Definitions

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

(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

- (a) ANSI means the American National Standards Institute.
- (b) ASC means ambulatory surgery center.
- (c) CMS means Centers for Medicare & Medicaid Services.
- (d) CPT[®] means Current Procedural Terminology published by the American Medical Association.
- (e) DME means durable medical equipment.
- (f) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies
- (g) EDI means electronic data interchange.
- (h) HCPCS means Healthcare Common Procedure Coding System published by CMS.
- (i) IAIABC means International Association of Industrial Accident Boards and Commissions.
- (j) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.
- (k) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.
- (l) ICD-10-PCS means International Classification of Diseases, Tenth Revision, Procedure Coding System.
- (m) MCO means managed care organization certified by the director.
- (n) NPI means national provider identifier.
- (o) OSC means Oregon specific code.
- (p) PCE means physical capacity evaluation.
- (q) WCE means work capacity evaluation.

(3) “**Administrative Review**” means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(4) An “**ambulatory surgery center**” (ASC) means:

- (a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or

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

(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.

(5) **“Attending Physician”** has the same meaning as described in ORS 656.005(12)(b). See Appendix F, “Matrix for Health Care Provider Types” ~~Appendix F.~~

(6) **“Authorized nurse practitioner”** means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and has been assigned an authorized nurse practitioner number by the director.

(7) **“Board”** means the Workers' Compensation Board and includes its Hearings Division.

(8) **“Chart note”** means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(9) **“Clinic”** means a group practice in which several medical service providers work cooperatively.

(10) **“CMS form 2552”** (Hospital and Hospital Health Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(11) **“Current Procedural Terminology”** or **“CPT”**[®] means the Current Procedural Terminology codes and terminology ~~most recently~~ published by the American Medical Association unless otherwise specified in these rules.

(12) **“Days”** means calendar days.

(13) **“Date stamp”** means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

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

(134) “**Division**” means the Workers’ Compensation Division of the Department of Consumer and Business Services.

(145) “**Enrolled**” means an eligible worker who has received notification from the insurer that the worker is being required to receive treatment under the provisions of a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker’s primary residence is more than 100 miles outside the ~~managed care organization~~ MCO’s certified geographical service area.

(156) “**Fee Discount Agreement**” means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

(167) “**Hearings Division**” means the Hearings Division of the Workers’ Compensation Board.

(178) “**Hospital**” means an institution licensed by the State of Oregon as a hospital.

(a) “**Inpatient**” means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(b) “**Outpatient**” means a patient not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments ~~which~~ that do not result in admission are also considered outpatient services.

(189) “**Initial Claim**” means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the “initial claim” means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(1920) “**Insurer**” means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the

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

state; or, an employer or employer group that has been certified under ORS 656.430 ~~meeting and meets~~ the qualifications of a self-insured employer under ORS 656.407.

(201) ~~“Interim Mmedical Benefits”~~ means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002, that are not denied within 14 days of the employer’s notice of the claim.

(212) ~~“Interpreter”~~ means a person who:

(a) Provides oral or sign language translation; and

(b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider’s employee, or a family member or friend of the patient.

(223) ~~“Interpreter services”~~ means the act of orally translating between a medical provider and a patient who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the patient as well as reasonable time spent on necessary paperwork for the provider’s office.

(234) ~~“Mailed or Mailing Date,”~~ for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by facsimile or “fax” are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the Workers’ Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(245) ~~“Managed Care Organization”~~ or “MCO” means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(256) ~~“Medical Provider”~~ means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(267) ~~“Medical Service”~~ means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

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

(278) “**Medical Sservice Pprovider**” means a person duly licensed to practice one or more of the healing arts.

(289) “**Medical Ttreatment**” means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker’s condition through conservative care.

(30) “**Patient**” means the same as worker as defined in ORS 656.005(30).

(2931) “**Parties**” mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(3032) “**Physical Ccapacity Eevaluation**” means an objective, directly observed, measurement of a patient’s ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship’s Functional Capacity Evaluation, and Functional Capacity Assessment will be considered to have the same meaning as Physical Capacity Evaluation.

(3133) “**Provider network**” means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.

(3234) “**Report**” means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(3335) “**Residual Ffunctional Ccapacity**” means a patient’s remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

(3436) “**Specialist Pphysician**” means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or

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

authorized nurse practitioner to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.

(3537) “**Type A attending physician**” means an attending physician under ORS 656.005(12)(b)(A). See Appendix F, “Matrix for Health Care Provider types” ~~Appendix F~~.

(3638) “**Type B attending physician**” means an attending physician under ORS 656.005(12)(b)(B). See Appendix F, “Matrix for Health Care Provider types” ~~Appendix F~~.

(3739) “**Usual Fee**” means the medical provider's fee charged to the general public for a given service.

(3840) “**Work Capacity Evaluation**” means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening will be considered to have the same meaning as Work Capacity Evaluation.

(3941) “**Work Hardening**” means an individualized, medically prescribed and monitored, work oriented treatment process. The process involves the patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.000 et seq.; 656.005; 656.726(4)
Hist: Amended 11/1/07 as Admin. Order 07-057, eff. 1/2/08
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0008 Request for Review ~~by~~before the Director

(1) General.

(a) Administrative review before the director:

(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. 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 ~~by the director~~before the director.

(B) A party does not need to be represented to participate in the administrative review before the director.

(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(b) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

(2) Time Frames and Conditions.

(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(b) For ~~all~~ MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision absent a showing of good cause. When the aggrieved party is a represented

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

worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

(c) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review ~~by the director~~ before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must advise the medical provider or worker that they may request review ~~by the director~~ before the director.

(d) For claims not enrolled in an MCO, or for disputes ~~which~~ that do not involve an action or decision of an MCO; ~~the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due.~~

(A) A worker must request administrative review before the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services. If the worker is represented, and the worker's attorney has given notice of representation to the insurer, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.

(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee.

(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.

(D) For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

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

(e) Within 180 days of the date a bill is paid, an insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

(f) Medical provider bills for treatment or services that are under review ~~by the director~~ before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review ~~by the director~~ before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements.

(A) The requesting party must simultaneously notify all other interested parties of the dispute, and their representatives, if known, ~~as follows~~ The notice must:

- Identify the worker's name, date of injury, insurer, and claim number;
- Specify the issues in dispute and the relief sought; and
- Provide the specific dates of the unpaid disputed treatment or services.

(B) If the request for review is submitted by either the insurer or the medical provider, it must state specific code(s) of service(s) in dispute and include enough documentation to support the request, including copies of original bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to review the dispute. The insurer or medical provider requesting review must provide all involved parties a copy of:

- The request for review;
- Any attached supporting documentation; and
- If known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical

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

provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, the insurer must provide a record packet, without cost, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document ~~ten~~10 must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(B) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(C) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may ~~penalize or~~ sanction the insurer under OAR 436-010-0340.

(4) Dispute Resolution by Agreement (Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

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

(D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the ~~claimant~~worker's attorney.

(5) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed to the director before the administrative order becomes final.

(b) During any reconsideration of the administrative order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(c) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of its contentions and provide them with copies of all additional information presented.

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(6) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245(3) or 656.247, no new medical

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

evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Board as follows:

(A) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(B) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.

(C) The division will forward the request and other pertinent information to the board.

(7) Other Proceedings.

(a) Director's administrative review of other actions not covered under sections (1)(a) through (6)(b) of this rule: Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party, may request administrative review ~~by the director~~ before the director. Any party may request administrative review as follows:

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

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

Stat. Auth.: ORS 656.704, 656.726(4); Stats. Implemented: ORS 656.704
Hist: Amended 12/15/08 as Admin. Order 08-063, eff. 1/1/09
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0010 Medical Billing and Payment

(1) General.

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

Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner.

Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law ~~which~~that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

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

- (e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.
- (f) When rebilling, medical providers must indicate that the charges have been previously billed.
- (g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.
- (2) **Billing Timelines.** (For payment timelines see OAR 436-009-0030.)
- (a) Medical providers must bill within:
- (A) 60 days of the date of service;
 - (B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or
 - (C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.
- (b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.
- (c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.
- (d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.
- (e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

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

(3) Billing Forms.

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 form (~~Versions 08/05 or 02/12 for dates of service prior to Oct. 1, 2014; Version 02/12 for dates of service Oct. 1, 2014 or after~~) except for:

- (A) Dental billings, which must be submitted on American Dental Association dental claim forms;
- (B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or
- (C) Electronic billing transmissions of medical bills (see OAR 436-008).

(c) Notwithstanding subsection (3)(a) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.

(ed) Medical providers may use computer-generated reproductions of the appropriate forms.

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

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	<u>For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and on or after Oct. 1, 2015, use ICD-10-CM codes.</u>
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: <ul style="list-style-type: none"> • CPT® codes listed in CPT® 20145; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: <ul style="list-style-type: none"> • The provider should use an appropriate unlisted code from

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

	<p>CPT[®] 20145 (e.g., CPT[®] code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and</p> <ul style="list-style-type: none"> • The provider should describe the service provided. <p>Nurse practitioners and physician assistants must use modifier “81” to identify their services <u>when billing as the surgical assistant during surgery.</u></p>
24I (shaded area)	See under box 24J shaded area.
24J (non-shaded area)	The rendering provider’s NPI.
24J (shaded area)	<p>If the bill includes the rendering provider’s NPI in the non-shaded area of box 24J, the shaded area of box 24I and 24J may be left blank.</p> <p>If the rendering provider does not have an NPI, then include the rendering provider’s state license number and use the qualifier “0B” in box 24I.</p>

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT[®] 20145 or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

If there is no specific CPT[®] code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service.

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT[®] 20145 or the appropriate unlisted HCPCS code, and provide a description of the service provided.

A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

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

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

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT[®] 2014⁵, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

- (A) Unusually lengthy procedure;
- (B) Excessive blood loss during the procedure;
- (C) Presence of an excessively large surgical specimen (especially in abdominal surgery);
- (D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;
- (E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or
- (F) The services rendered are significantly more complex than described for the submitted CPT[®].

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must ~~bill using modifier "81" and document in the chart notes that they provided the medical service.~~ If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."

(7) Chart Notes.

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

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

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider's Bill.

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, and any extenuating circumstances.

(9) Billing the Patient / Patient Liability.

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. However, the patient may be liable, and the provider may bill the patient:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

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

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(10) Disputed Claim Settlement (DCS).

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) Payment Limitations.

(a) Insurers do not have to pay providers for the following:

- (A) Completing forms 827 and 4909;
- (B) Providing chart notes with the original bill;
- (C) Preparing a written treatment plan;
- (D) Supplying progress notes that document the services billed;
- (E) Completing a work release form or completion of a PCE form, when no tests are performed;
- (F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or
- (G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the

ORDER NO. 15-XXX

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

patient. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing.

(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) Excluded Treatment.

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

- (a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
- (b) Intradiscal electrothermal therapy (IDET);
- (c) Surface ~~EMG (electromyography)~~ (EMG) tests;
- (d) Roling;
- (e) Prolotherapy;
- (f) Thermography;
- (g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:
 - (A) The single level artificial disc replacement is between L3 and S1;
 - (B) The patient is 16 to 60 years old;
 - (C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and
 - (D) The procedure is not found inappropriate under OAR 436-010-0230~~(15)~~ or ~~(16)~~;
and
- (h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:
 - (A) The single level artificial disc replacement is between C3 and C7;
 - (B) The patient is 16 to 60 years old;
 - (C) The patient underwent unsuccessful conservative treatment;
 - (D) There is intraoperative visualization of the surgical implant level; and
 - (E) The procedure is not found inappropriate under OAR 436-010-0230~~(17)~~ or ~~(18)~~.

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

(13) Missed Appointment (No Show).

In general, the insurer does not have to pay for “no show” appointments. However, insurers must pay for “no show” appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

Stat. Auth.: ORS 656.245, 656.252, 656.254; Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 6/13/14 as Admin. Order 14-055, eff. 7/1/14

436-009-0018 Discounts and Contracts

(1) Medical Service Providers and Medical Clinics.

For the purpose of this rule, “Medical Service Provider” means persons duly licensed to practice one or more of the healing arts. “Clinic” means a group practice in which several medical service providers work cooperatively.

(2) Discounts.

(a) An insurer may only apply the following discounts to a medical service provider’s or clinic’s fee:

(A) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(B) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(b) If the insurer has multiple contracts with a medical service provider or clinic, and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO’s contract.

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

(c) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule amount.

(d) An insurer may not apply a fee discount until the medical service provider or clinic and the insurer have signed the fee discount agreement.

(3) Fee Discount Agreements.

(a) The fee discount agreement between the parties must be on the provider's letterhead and contain all the information listed on Form ~~440-3659~~. Bulletin 352 provides further information. The agreement must include the following:

- (A) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;
- (B) The effective and end dates of the agreement;
- (C) The discount rate or rates under the agreement;
- (D) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a patient receives;
- (E) A statement that the agreement only applies to patients who are being treated for Oregon workers' compensation claims;
- (F) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties.
- (G) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;
- (H) The name and address of the singular insurer or self-insured employer that will apply the discounts;
- (I) The national provider identifier (NPI) for the provider or clinic; and
- (J) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(b) Once the fee discount agreement has been signed by the insurer and medical service provider or clinic, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:

- (A) The insurer's name that will apply the discounts under the fee discount agreement;
- (B) The medical service provider's or clinic's name;

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

- (C) The effective date of the agreement;
- (D) The end date of the agreement;
- (E) The discount rate under the agreement and;
- (F) An indication that all the terms required under section (3)(a) of this rule are included in the signed fee discount agreement.

(4) Fee Discount Agreement Modifications and Terminations.

(a) When the medical service provider or clinic and the insurer agree to modify an existing fee discount agreement, the parties must enter into a new fee discount agreement.

(b) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice to the other party. The insurer must report the termination to the director prior to the termination taking effect by completing the director's online form. The following information must be reported:

- (A) The insurer's name;
- (B) The medical service provider's or clinic's name; and
- (C) The termination date of the agreement.

(5) Other Medical Providers.

(a) For the purpose of this rule, other "Medical Providers" means providers such as hospitals, ambulatory surgery centers, or vendors of medical services and does not include medical service providers or clinics.

(b) The insurer may apply a discount to the medical provider's fee if a written or verbal contract exists.

(c) If the insurer and the medical provider have multiple contracts, only one discount may be applied.

(d) If the insurer has multiple contracts with a provider and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

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

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Adopted 12/15/08 as WCD Admin. Order 08-063, eff. 1/1/09
Amended 5/21/09 as WCD Admin. Order 09-050, eff. 7/1/09
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0020 Hospitals

(1) Inpatient.

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

- (A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes; and on or after Oct. 1, 2015, ICD-10-CM codes;
- (B) When applicable, procedural codes;
- (C) The hospital's NPI; and
- (D) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.

(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio (See Bulletin 290). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.

(2) Outpatient.

(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient bills must, when applicable, include the following:

- (A) Revenue codes;
- (B) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes; and on or after Oct. 1, 2015, ICD-10-CM codes;
- (C) CPT[®] codes and HCPCS codes; and
- (D) The hospital's NPI.

(c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows:

ORDER NO. 15-XXX

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* OREGON MEDICAL FEE AND PAYMENT RULES**

Revenue Code	Pay Amount:	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or
		The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or
		The amount billed
All other revenue codes	<ul style="list-style-type: none"> • For hospitals listed in Bulletin 290, the amount billed multiplied by the cost-to-charge ratio. • For in-state hospitals not listed in Bulletin 290, 80% of the amount billed. 	

(3) Specific Circumstances.

When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital inpatient fee schedule.

(4) Out-of-State Hospitals.

(a) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.

(b) Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative.

(c) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.

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

(d) If the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(5) Calculation of Cost-to-Charge Ratio Published in Bulletin 290.

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

(b) The basic cost-to-charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

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

- (A) Provider-based physician adjustment;
- (B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and
- (C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost-to-charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.

(e) The basic cost-to-charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the

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

projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule will be added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost-to-charge ratio. In no event will the adjusted cost-to-charge ratio exceed 1.00.

(g) The adjusted cost-to-charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of their CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost-to-charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division shall determine an adjusted cost-to-charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.

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

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

(k) Notwithstanding sections (1)(c), (2)(b), and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital

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

Flexibility Program are automatically exempt from imposition of the adjusted cost-to-charge ratio.

Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248; 656.252; 656.256
Hist: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 6/13/14 as Admin. Order 14-055, eff. 7/1/14

436-009-0023 Ambulatory Surgery Center (ASC)

(1) Billing Form.

(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.

(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.

(2) ASC Facility Fee.

(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:

- (A) Nursing, technical, and related services;
- (B) Use of the facility where the surgical procedure is performed;
- (C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;
- (D) Radiology services designated as packaged in Appendix D;
- (E) Administrative, record-keeping, and housekeeping items and services;
- (F) Materials for anesthesia;
- (G) Supervision of the services of an anesthetist by the operating surgeon; and
- (H) Packaged services identified in Appendix C or D.

(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, ~~X~~X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.

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

(3) ASC Billing.

(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says “packaged” in Appendices C or D.

(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.

(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC’s cost for an implant is \$100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC’s cost of the implant.

(4) ASC Payment.

(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.

(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:

(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or

(B) The ASC’s usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee.

A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and should be paid accordingly.

The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an “N” in the “Subject to Multiple Procedure Discounting” column.

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

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

CPT® Code	Maximum Payment Amount		CPT® Code	Maximum Payment Amount
23350	\$235.12		36410	\$19.94
25246	\$220.99		36416	80% of billed
27093	\$304.90		36620	80% of billed
27370	\$290.78		62284	\$282.47
27648	\$274.16		62290	\$417.89
36000	\$39.05			

(e) When the ASC's cost of an implant is more than \$100, insurers must pay implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.

(f) When the ASC's cost of an implant is less than \$100, insurers are not required to pay separately for the implant.

An implant may consist of several separately billable components, some of which may have costs of less than \$100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.

(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:

- (A) The ASC is not a contracted facility for the MCO;
- (B) The MCO has not pre-certified the service provided; or
- (C) The surgeon is not an MCO panel provider.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245; 656.248; 656.252
Hist: Adopted 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0025 Worker Reimbursement

(1) General.

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

- (A) The insurer will reimburse claim-related services paid by the worker; and
- (B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as sales slip, receipt, or other evidence to support the request. The worker may use [Form 3921 – Request for Reimbursement of Expenses](#).

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

- (A) The amount of reimbursement for each type of out-of-pocket expense requested.
- (B) The specific reason for non-payment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;
- (C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within 48 hours, excluding weekends and legal holidays;
- (D) The following notice, Web link, and phone number:
“To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit www.oregonwcdoc.info or call 503-947-7606.”;
- (E) Space for the worker's signature and date; and
- (F) A notice of right to administrative review as follows:
“**If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the**

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

Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records.”

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(5)(f), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) Timeframes.

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

- (A) Two years from the date the costs were incurred or
- (B) Two years from the date the claim or medical condition is finally determined compensable.

(b) If the worker requests reimbursement after two years as listed in subsection (a), the insurer may disapprove the reimbursement request.

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request:

- (A) Reimburse the worker if the request shows the costs are related to the accepted claim;
- (B) Disapprove the request if unreasonable or if the costs are not related to the accepted claim; or
- (C) Request additional information from the worker to determine if costs are related to the accepted claim. If additional information is needed, the time needed to obtain the information is not counted in the 30 day time frame for the insurer to issue reimbursement.

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

(d) When the insurer receives a reimbursement request prior to claim acceptance, and the claim is ultimately accepted, by whichever date is later the insurer must:

(A) Within 30 days of receiving the reimbursement request:

- Reimburse the worker if the request shows the costs are related,
- Disapprove the request if unreasonable or if the costs are not related, or
- Request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 30 day time frame for the insurer to issue reimbursement; or

(B) Within 14 days of claim acceptance:

- Reimburse the worker if the request shows the costs are related,
- Disapprove the request if unreasonable or if the costs are not related, or
- Request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 14 day time frame for the insurer to issue reimbursement.

(e) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(f) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) Meal and Lodging Reimbursement.

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(4) Travel Reimbursement.

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer must inform the worker that he or she may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112.

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

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

(5) Other Reimbursements.

(a) The insurer must reimburse the worker for ~~prescriptions and~~ other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out of pocket, and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.

~~(b)~~ (c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) Advancement Request.

If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth: ORS 656.245, 656.325, 656.704, and 656.726(4)
Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0030 Insurer's Duties and Responsibilities

(1) General.

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

(b) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents under OAR 436-009-0060. If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(c) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills.

The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(2) Bill Processing.

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b) and (2) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill.

The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.

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

(b) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(1)(b) and (3)(a), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

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

(3) Payment Requirements.

(a) Insurers must pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the bill is submitted in proper form according to OAR 436-009-0010(1)(b), (3)(a) through (7)(c), and clearly shows that the treatment is related to the accepted compensable injury or disease.

(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an ~~explanation of benefits (EOB)~~ has the same meaning as an explanation of review (EOR).

(c) The written ~~explanation of benefits (EOB)~~ must be in 10 point size font or larger. Electronic and written explanations must include:

- (A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;
- (B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;
- (C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within 48 hours, excluding weekends and legal holidays;
- (D) The following notice, Web link, and phone number:

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

“To access information about Oregon’s Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.”;

(E) Space for the provider’s signature and date; and

(F) A notice of right to administrative review as follows:

“If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers’ Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records.”

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

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

(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code.

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

(h) If an insurer determines that they have made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.

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

(4) Communication with Providers.

(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within 48 hours, not including weekends or legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

(5) EDI Reporting.

For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0035 Interim Medical Benefits

(1) General.

(a) Interim medical benefits under ORS 656.247 only apply to initial claims when the patient has a health benefit plan(s), i.e., the patient's private health insurance(s). For the purpose of this rule the Oregon Health Plan is not a health benefit plan.

(b) Interim medical benefits are not due on claims:

(A) When the patient is enrolled in an MCO prior to claim acceptance or denial under ORS 656.245(4)(b)(B); or

(B) When the insurer denies the claim within 14 days of the employer's notice of the claim.

(c) Interim medical benefits cover services provided from the date of employer's notice or knowledge of the claim to the date the insurer accepts or denies the claim. Interim medical benefits do not include treatments excluded under OAR 436-009-0010(12).

(d) When billing for interim medical benefits, the medical provider must bill the workers' compensation insurer according to these rules, and the health benefit plan according to the plan's requirements. The provider may submit a pre-authorization request to the health benefit plan prior to claim acceptance or denial.

(e) If the medical provider knows that the patient filed a work-related claim, the medical provider may not collect any health benefit plan co-pay, co-insurance, or deductible from the patient during the interim period.

(2) Claim Acceptance.

If the insurer accepts the claim:

(a) The insurer must pay medical providers for services according to these rules; and

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

(b) The provider, after receiving payment from the insurer, must reimburse the worker and the health benefit plan for any medical expenses, co-pays, co-insurance, or deductibles, paid by the worker or the health benefit plan.

(3) Claim Denial.

If the insurer denies the claim:

(a) The insurer must notify the medical provider as provided in OAR 436-060-0140 that an initial claim has been denied; and

(b) The medical provider must bill the health benefit plan, unless the medical provider has previously billed the health benefit plan. The provider must forward a copy of the workers' compensation denial letter to the health benefit plan.

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.247
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 10/17/14 as Admin. Order 14-060, eff. 1/1/15

436-009-0040 Fee Schedule

(1) Fee Schedule Table.

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

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

(b) The global period is listed in the column 'Global Days' of Appendix B.

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

(2) Anesthesia.

(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.

(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia, and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.

(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier 'NT' (no time) must be on the bill.

(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.

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

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of \$58.00.

(A) Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

- The maximum allowable payment amount for anesthesia codes; or
- The provider's usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

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

(3) Surgery.

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

(a) One surgeon

Procedures	Appendix B lists:	The payment amount is:	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The <u>billed amount</u> -billed
	80% of billed <u>amount</u>	80% of billed <u>amount</u>	
Any additional procedures* including: <ul style="list-style-type: none"> • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure 	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The <u>billed amount</u> -billed
	80% of billed <u>amount</u>	40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of <i>ZZZ</i> .			

ORDER NO. 15-XXX

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* OREGON MEDICAL FEE AND PAYMENT RULES**

(b) Two or more surgeons

Procedures	Appendix B lists:	The payment amount for each surgeon is:	
Each surgeon performs a principal procedure (and any additional procedures) Any additional procedures including:	A dollar amount	The lesser of:	75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or
			The <u>billed amount</u> -billed
<ul style="list-style-type: none"> • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure 	80% of <u>billed amount</u>		60% of the billed amount (and 30% of the <u>billed amount</u> -billed for any additional procedures*) (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(c) Assistant surgeons

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

ORDER NO. 15-XXX

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed OREGON MEDICAL FEE AND PAYMENT RULES

(d) Nurse practitioners or physician assistants

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

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

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

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

(g) If the surgery is non-elective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.

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

(4) Radiology Services.

(a) Insurers only have to pay for ~~✕~~X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI); then the technical component must be paid 100 percent for the first area examined, and 50-75 percent for the second area, and 25 percent for all subsequent areas. These reductions do not apply to the professional component.

The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.

(5) Pathology and Laboratory Services.

(a) The payment amounts in Appendix B apply only when there is direct physician involvement.

(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.

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

(6) Physical Medicine and Rehabilitation Services.

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

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

(b) Except for CPT[®] codes 97001, 97002, 97003, or 97004, payment for modalities and therapeutic procedures is limited to a total of three separate CPT[®]-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT[®] code does not count as a separate code.

(c) CPT[®] codes 97032, 97033, 97034, 97035, 97036, and 97039 are time based codes and require constant attendance. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day or the amount of time spent providing the treatment.

(d) CPT[®] codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities ~~which~~that require constant attendance or knowledge and skill of the licensed medical provider.

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

(7) Reports.

(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill for their report or review of the

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

records using CPT[®] codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.

(8) Nurse Practitioners and Physician Assistants.

Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

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

436-009-0060 Oregon Specific Codes

(1) Multidisciplinary Services.

(a) Services provided by multidisciplinary programs not otherwise described by CPT[®] codes must be billed under Oregon specific codes.

(b) 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.

(c) Bills using the multidisciplinary codes must include copies of the treatment record ~~which~~that specifies:

- (A) The type of service rendered,
- (B) The medical provider who provided the service,
- (C) Whether treatment was individualized or provided in a group session, and
- (D) The amount of time treatment was rendered for each service billed.

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

Service	OSC
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR004
Arbiter file review - level 1: A file review of a limited record.	AR021

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

Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002

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

Director required medical exam or review time: Services by a physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate up to 6 hours for record review and exam.	P0001
Director required medical report: Preparation and submission of the report.	P0003
Director required review - complex case fee: Preauthorized fee by the director for an extensive review in a complex case.	P0004
Director required exam – failure to appear: Patient fails to appear for a director required exam.	P0005
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (Independent medical exam): Report, addendum to a report, a file review, or an exam.	D0003
IME – review and response: Insurer requested review and response by treating physician; document time spent.	D0019
Interdisciplinary Rehabilitation Conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits.	97655
Interdisciplinary Rehabilitation Conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits.	97656
Interdisciplinary Rehabilitation Conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits.	97657
Interdisciplinary Rehabilitation Conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference, up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – other than American Sign Language (ASL)	D0004
Interpreter services – American Sign Language (ASL)	D0005

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

Job site visit - 1 hour (includes travel): -Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status, and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (Physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE shall be paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.	99196

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

PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE must be paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
Professional Case Management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual - each additional 30 minutes	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Vocational evaluation - 30 minutes: Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options.	97662
Vocational evaluation - each additional 15 minutes	97663
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643

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

WCE (W<u>ork</u> capacity evaluation): This is a residual functional capacity evaluation, which <u>that</u> generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE must be paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: <ul style="list-style-type: none"> • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings. 	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (W<u>orker</u> requested medical exam): Exam and report.	W0001

(3) CARF / JCAHO Accredited Programs.

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program shall not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations ~~which~~that have applied for CARF accreditation, but have not yet received such accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to

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

the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

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

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

Stat. Auth.: ORS 656.726(4) Stats. Implemented: ORS 656.248
Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

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

(1) **Durable medical equipment (DME)** is equipment that:

- Is primarily and customarily used to serve a medical purpose,
- Can withstand repeated use,
- Could normally be rented and used by successive patients,
- Is appropriate for use in the home, and
- Is not generally useful to a person in the absence of an illness or injury.

Examples: Transcutaneous Electrical Nerve Stimulation (TENS), MicroCurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc.

(2) A **prosthetic** is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc.

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

The repair or replacement of a prosthetic appliance is a compensable medical expense, even if the worker received no other physical injury. The insurer must pay for the repair of prosthetic appliances damaged when in use at the time of and in the course of employment. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An **orthosis** is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.

(4) **Supplies** are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

- (a) NU for purchased, new equipment
- (b) UE for purchased, used equipment
- (c) RR for rented equipment

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

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

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

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

Code	Monthly Rate	Code	Monthly Rate
E0163	\$26.33	E0849	\$98.40
E0165	\$30.24	E0900	\$93.68
E0168	\$27.28	E0935	\$996.97
E0194	\$3643.05	E0940	\$52.20
E0261	\$259.66	E0971	\$5.68
E0277	\$1135.64	E0990	\$25.52
E0434	\$35.31	E1800	\$262.29
E0441	\$86.85	E1815	\$276.15
E0650	\$1423.50	E2402	\$2487.86

(8) For items rented, unless otherwise provided by contract:

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

- (a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.
- (b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.
- (c) The insurer may purchase a rental item anytime within the 13 month rental period, with 75 percent of the rental amount paid applied towards the purchase.

(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:

- (a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set up; or
- (b) The provider may offer a service agreement at an additional cost.

(10) **Hearing aids** must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist.

The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

Unless otherwise provided by contract, insurers must pay the provider's usual fee for **hearing services** billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed \$5000 for a pair of hearing aids, or \$2500 for a single hearing aid.

(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for **vision services** billed with HCPCS codes V0000 through V2999.

(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.

(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

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

(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0090 Pharmaceutical

(1) General.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and pay the total cost of the brand-name drug out of pocket.

(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.

(2) Pharmaceutical Billing and Payment.

(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed.

(b) All bills from pharmacies must include the prescribing provider's NPI or license number.

(bc) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

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

(ed) Unless directly purchased by the worker (see section 0025(5) of these rules), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

If the drug dispensed is:	Then the maximum allowable fee is:
A generic drug	83.5 % of the dispensed drug's AWP plus a \$2.00 dispensing fee
A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent	83.5 % of the dispensed drug's AWP plus a \$2.00 dispensing fee
A brand name drug with a generic equivalent and the prescribing provider has not prohibited substitution	83.5 % of the average AWP for the class of generic drugs plus a \$2.00 dispensing fee

(Note: "AWP" means the Average Wholesale Price effective on the date the drug was dispensed.)

(de) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., First DataBank, RED BOOK, or Medi-Span.

(3) Clinical Justification Form 4909.

(a) The prescribing provider must fill out Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, and submit it to the insurer when prescribing more than a five day supply of the following drugs:

- (A) Celebrex[®],
- (B) Cymbalta[®],
- (C) Fentora[®],
- (D) Kadian[®],
- (E) Lidoderm[®],
- (F) Lyrica[®], or
- (G) OxyContin[®].

(b) Insurers may not challenge the adequacy of the clinical justification. However, they can challenge whether or not the medication is excessive, inappropriate, or ineffectual under ORS 656.327.

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

(c) The prescribing provider is not required to fill out Form 4909 for refills of medications listed on that form.

(d) If a prescribing provider fails to submit Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, to the insurer, the insurer may file a complaint with the director.

(4) Dispensing by Medical Service Providers.

(a) Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the patient, up to a maximum of 10 days.

(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248, 656.252, 656.254
Hist: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0110 Interpreters

(1) Choosing an Interpreter.

A patient may choose a person to communicate with a medical provider when the patient and the medical provider speak different languages, including sign language. The patient may choose a family member, a friend, an employee of the medical provider, or an interpreter. The medical provider may disapprove of the patient's choice at any time the medical provider feels the interpreter services are not improving communication with the patient, or feels the interpretation is not complete or accurate.

(2) Billing.

(a) Interpreters must charge the usual fee they charge to the general public for the same service.

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

(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the patient.

(c) Interpreters may bill for interpreter services, and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location.

(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:

- (A) The patient fails to attend the appointment; or
- (B) The provider has to cancel or reschedule the appointment.

(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the Department of Consumer and Business Services' Workers' Compensation Division at 503-947-7814. They may also access insurance policy information at <http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm>.

(3) Billing and Payment Limitations.

(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if:

- (A) The patient fails to attend the appointment; or
- (B) The provider cancels or reschedules the appointment.

(b) The insurer is not required to pay for interpreter services or mileage when the services are provided by:

- (A) A family member or friend of the patient; or
- (B) A medical provider's employee.

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

(4) Billing Timelines.

(a) Interpreters must bill within:

- (A) 60 days of the date of service;
- (B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or
- (C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.

(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the interpreter.

(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.

(5) Billing Form.

(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:

- (A) D0004 for interpreter services except American Sign Language,
- (B) D0005 for American Sign Language interpreter services, and
- (C) D0041 for mileage.

(b) An interpreter's invoice must include:

- (A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;
- (B) The patient's name;
- (C) The patient's workers' compensation claim number, if known;
- (D) The correct Oregon specific codes for the billed services (D0004, D0005, or D0041);
- (E) The workers' compensation insurer's name and address;
- (F) The date interpreter services were provided;

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

- (G) The name and address of the medical provider that conducted the exam or provided treatment;
- (H) The total amount of time interpreter services were provided; and
- (I) The mileage, if the round trip was 15 or more miles.

(6) Payment Calculations.

(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.

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

For:	The maximum payment is:
Interpreter services of an hour or less	\$60.00
American sign language (ASL) interpreter services of an hour or less	\$70.00
Interpreter services of more than one hour	\$15.00 per 15 minute increment; a 15 minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language (ASL) interpreter services of more than one hour	\$17.50 per 15 minute increment; a 15 minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	\$0.50 per mile
An examination required by the director or insurer which <u>when</u> that the patient fails to attend or when the provider cancels or reschedules	\$60.00 no show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage

(7) Payment Requirements.

(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.

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

(b) When the patient fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay the no show fee and mileage if the round-trip mileage is 15 or more miles.

(c) The insurer must pay the interpreter within:

(A) 14 days of the date of claim acceptance or any action causing the service to be payable, or 45 days of receiving the invoice, whichever is later; or

(B) 45 days of receiving the invoice for an exam required by the insurer or director.

(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.

(f) If the insurer does not receive all the information to process the invoice, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.

(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each service billed.

(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.

(i) Electronic and written explanations must include:

(A) The payment amount for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

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

- (B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;
- (C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within 48 hours, excluding weekends and legal holidays;
- (D) The following notice, Web link, and phone number:
"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";
- (E) Space for a signature and date; and
- (F) A notice of the right to administrative review as follows:
"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(j) The insurer or its representative must respond to an interpreter's inquiry about payment within 48 hours, not including weekends or legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.

(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.248
Hist: Adopted 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0998 Sanctions and Civil Penalties

(1) The director may impose sanctions upon a medical provider or insurer for violation of these rules in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider's bill that is incorrect, the insurer must pay the provider's bill at the provider's usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty.

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS chapter 656.

~~(5) If a prescribing provider fails to submit Form 4009, Pharmaceutical Clinical Justification for Workers' Compensation, to the insurer, in accordance with OAR 436-009-0090(3)(a), the insurer may file a complaint with the director.~~

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist: Renumbered from 436-009-0100 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended and renumbered from 436-009-0199 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

ORDER NO. 15-XXX

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed OREGON MEDICAL FEE AND PAYMENT RULES

Appendix A

Oregon hospitals required to include Medicare Severity Diagnosis Related Group codes on hospital inpatient bills under OAR 436-009-0020

	HOSPITAL NAME	NPI	ALT NPI	SECOND ALT NPI
1	Adventist Medical Center	1801887658		
2	<u>Asante Ashland Community Hospital*</u>	1386644029	.	.
<u>3</u>	<u>Asante Rogue Regional Medical Center Hospital</u>	<u>1770587107</u>	<u>1427277086</u>	.
4	Asante Three Rivers Medical Center	1801891809	1598895690	.
<u>35</u>	Bay Area Hospital – Coos Bay	1225016561	.	.
<u>46</u>	Good Samaritan Regional Medical Center - Corvallis	1962453134	.	.
<u>57</u>	Holy Rosary Medical Center – Ontario*	1891891792	.	.
<u>68</u>	Kaiser Sunnyside Medical Center	1124182902	.	.
<u>79</u>	Kaiser Westside Medical Center	1891048807		
<u>810</u>	Legacy Emanuel Hospital & Health Medical Center	1831112358	1295756898	.
<u>911</u>	Legacy Good Samaritan Hospital & Medical Center	1780608216	.	.
<u>102</u>	Legacy Meridian Park Hospital Medical Center	1184647620	.	.
<u>143</u>	Legacy Mt. Hood Medical Center	1255354700	.	.
124	McKenzie-Willamette Medical Center – Springfield	1568413573	1528006301	.
<u>135</u>	Mercy Medical Center – Roseburg*	1477590198	1134161391	.
<u>146</u>	Mid Columbia Medical Center – The Dalles*	1306842752	.	.
<u>157</u>	Oregon Health & Science University Hospital	1609824010	1376873570	1548272511
<u>168</u>	Providence Medford Medical Center	1689755670	.	.
<u>179</u>	Providence Milwaukie Hospital Medical Center	1366536963	.	.
1820	Providence Newberg Hospital Medical Center*	1952482275	.	.
<u>1921</u>	Providence Portland Medical Center	1003991845	.	.
<u>202</u>	Providence St. Vincent Hospital & Medical Center	1114015971	1083866933	.
<u>23</u>	Providence Willamette Falls Medical Center	<u>1639108434</u>	.	.
24	Rogue Valley Medical Center – Medford	1770587107	1427277086	.
<u>224</u>	Sacred Heart Medical Center Riverbend – Springfield	1083888515	1881928067	.
<u>235</u>	Sacred Heart Medical Center University Dist. – Springfield	1346237971	1164595617	.
<u>246</u>	Salem Hospital	1265431829	1114197894	.
<u>257</u>	Samaritan Albany General Hospital	1154372340	.	.
<u>268</u>	Santiam Memorial Hospital – Stayton*	1154302214	.	.
<u>279</u>	Silverton Hospital	1669424354	.	.
2830	Sky Lakes Medical Center – Klamath Falls	1811130149	1659340370	.
<u>31</u>	<u>St. Alphonsus Medical Center – Ontario*</u>	<u>1891891792</u>	.	.
<u>2932</u>	St. Charles Medical Center – Bend	1982621447	1598839789	.
<u>303</u>	St. Charles Medical Center – Redmond*	1225056146	.	.
<u>31</u>	Three Rivers Community Hospital – Grants Pass*	1801891809	1598895690	.
<u>324</u>	Tuality Community Hospital – Hillsboro	1275591984	1336228659	.

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

33	Willamette Falls Hospital – Oregon City	1639108434	.	.
345	Willamette Valley Medical Center – McMinnville *	1346269982	.	.
*Denotes hospital as rural. All of the 25 OR Critical Access Hospitals are intentionally excluded from this list.				

Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

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

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers.

[Effective April 1, 20145]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective April 1, 20145]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective April 1, 20145]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, 20145]

Note: If the above links do not connect you to the department's website, click:

<http://www.cbs.state.or.us/external/wcd/policy/rules/disclaimer.html>

If you have questions, call the Workers' Compensation Division, 503-947-7606.

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright 20134 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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

CPT only copyright 20134 American Medical Association. All rights reserved.

Link to the Maximum Allowable Payment Tables: <http://www.cbs.state.or.us/wcd/policy/rules/disclaimer.html>

Or, contact the division for a paper copy, 503-947-7717

Appendix F - Matrix for health care provider types*

See OAR 436-009-0005

	Attending physician status (primarily responsible for treatment of a worker's injury <u>patient</u>)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the worker <u>patient</u> to work	Establish impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of Osteopathy Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic Pphysician Naturopathic Pphysician Physician Assistant	Yes, for a total of 60 consecutive days or 18 visits, from the date of the initial visit on the initial claim with any Type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency Room Pphysicians	No, if the physician refers the worker <u>patient</u> to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No, if worker <u>patient</u> referred to a primary care physician	Yes
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes, for 180 days from the date of the first visit on the initial claim.	No	No, unless authorized by the attending physician
"Other Health Care Providers" e.g. acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim- with any "Other Health Care" providers. Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by the attending physician and under a written treatment plan

* This matrix does not apply to Managed Care Organizations

BRUYNS Fred H * DCBS

From: Mercedes Hudgins <Mercedes.Hudgins@mitchell.com>
Sent: Tuesday, January 27, 2015 1:27 PM
To: KUNZ Juerg * DCBS
Cc: Karen Ritchie; Ryan Prades; Lisa Carton; Miriam Encarnacion; BRUYNS Fred H * DCBS
Subject: RE: Clarification - 436-009-0020 - Outpatient

Hello Juerg,

Sure... Please note, we are in the process of reviewing the proposed changes – You might be receiving more emails from me... But, yes, go ahead and use my question as testimony.

Thank you!
-Mercedes

From: KUNZ Juerg * DCBS [<mailto:Juerg.Kunz@oregon.gov>]
Sent: Tuesday, January 27, 2015 1:25 PM
To: Mercedes Hudgins
Cc: Karen Ritchie; Ryan Prades; Lisa Carton; Miriam Encarnacion; BRUYNS Fred H * DCBS
Subject: RE: Clarification - 436-009-0020 - Outpatient

Hi Mercedes,

In an email to me you included the following question/observation – see below. I wanted to ask you if you're ok if we used that as testimony.

Please let me know.

Thanks for your help.

Sincerely,

Juerg Kunz
Medical Policy Analyst
Oregon Workers' Compensation Division
503-947-7741 / FAX 503-947-7629
juerg.kunz@oregon.gov



Next, according to a recent correction to Bulletin 290 (Hospital Fee Schedule Cost to Charge Ratio) the correction states:

Hospitals that are licensed or authorized to be hospitals in another state have a cost-to-charge ratio of 1.000.

Should this be listed in the box above? Please note: there is no mention of this in the proposed 436-009-0020 section – The Out of state hospital section only mentions to pay as charged “in full”. Does not mention to apply Cost to charge ratio of 1.0.

Your assistance in clarifying these issues is greatly appreciated.

Thank you,

--
MERCEDES HUDGINS | Data Analyst, Auto Casualty Solutions
Mitchell | (o) 858.368.7042 | (e-fax) 858.408-7290 | mercedes.hudgins@mitchell.com | www.mitchell.com



This e-mail, including any attachments, may contain confidential, privileged or otherwise legally protected information. It is intended only for the addressee. If you received this e-mail in error or from someone who was not authorized to send it to you, do not disseminate, copy or otherwise use this e-mail or its attachments. Please notify the sender immediately by reply e-mail and delete the e-mail from your system. Thank you for your cooperation.

February 4, 2015

Express Scripts
One Express Way
St Louis, MO 63121

Fred Bruyns, Rules Coordinator
Workers' Compensation Division
350 Winter Street NE
Salem, OR 97309-0405
Email: fred.h.bruyns@state.or.us and fred.h.bruyns@oregon.gov

Cc: Nanci Johnston, Medical Policy Analyst
Email: nanci.j.johnston@oregon.gov

Re: Proposed amendments to OAR 436-009 Oregon Medical Fee and Payment Rules

Express Scripts appreciates the opportunity to provide the following comments regarding the proposed amendments to OAR 436-009 Oregon Medical Fee and Payment Rules.

Express Scripts, Inc. is one of the largest pharmacy benefit management (PBM) companies in North America, providing PBM services to thousands of client groups, including managed-care organizations, insurance carriers, employers, third-party administrators, public sector, workers' compensation, and union-sponsored benefit plans. Express Scripts takes a strategic approach to workers' compensation, structuring customized client solutions around best-in-class core services, which are supported by advanced trend-management and clinical-review programs, to ensure safety for injured workers, while aggressively controlling costs.

Express Scripts comments focus on the proposed amendments to reimbursement for dispensed brand-name drugs when the injured worker has insisted on receiving the brand in lieu of a generic drug despite the prescriber not prohibiting substitution. The proposed rule adds language to section 436-009-0025(5), see below:

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out of pocket, and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand name drug, the insurer only has to reimburse the worker the generic price of the drug.

In order to provide greater efficiency within the system and to relieve the injured worker of the burden of paying the full cost of the brand drug, Express Scripts recommends the following change to the proposed language in 436-009-0025(5)(b) (recommended deletions indicated with strikethrough; recommended additions underlined):

(b) For prescription medications, the insurer must reimburse the worker based on actual cost; however, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. ~~When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out of pocket, or pay the difference between the cost of the brand-name drug and generic to the pharmacy, and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.~~



In order to provide consistency throughout the rules we also recommend the following changes to 436-009-0090(1)(b) (recommended deletions indicated with strikethrough; recommended additions underlined):

(b) *When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug ~~and pay the total cost of the brand-name drug out of pocket~~ or pay the difference between the cost of the brand-name drug and generic to the pharmacy.*

Thank you for allowing the opportunity to provide feedback on the proposed amendments to OAR 436-009 Oregon Medical Fee and Payment Rules. We look forward to working with the Division on this and other rule-making matters. Feel free to contact us with any comments, questions, or concerns.

Sincerely,

Kristie Griffin
Compliance Manager, Workers' Compensation
Express Scripts, Inc.
904-683-4638
kgriffin@express-scripts.com



February 20, 2015

Fred Bruyns, rules coordinator
Workers' Compensation Division
350 Winter Street NE
Salem, OR 97309-0405
Email: fred.h.bruyns@state.or.us

Cc: Nanci Johnston, medical policy analyst
Email: nanci.j.johnston@oregon.gov

Re: Proposed Changes to OAR 436-009

Introduction

Helios appreciates this opportunity to provide comments on the Workers' Compensation Division's proposed changes to OAR 436-009, Oregon Medical Fee and Payment Rules. We were also very appreciative of the advisory committee meetings the Division held leading up to this rule-making and the ability of Helios to provide our input on proposed changes during those meetings – as well as the willingness of Division staff to speak with us further on specific language proposed. Helios largely supports the proposed changes but offers a few additional recommendations specific to pharmacy billing and processing based on our substantial experience processing pharmacy transactions in Oregon and the other 49 states, in addition to our involvement in standard-setting organizations like the National Council for Prescription Drug Programs (NCPDP).

Billing Code and Form Updates

Helios supports the Division's proposed language in various parts of the rules to do all of the following: update CPT coding, reference only the 02/12 version of the CMS-1500, and provide for use of ICD-10 coding on and after October 1, 2015. All of these changes will align Oregon workers' compensation requirements with practices within the healthcare industry across the country. Such alignment eases the compliance burden for providers and other entities within the state workers' compensation system also operating in other healthcare markets and jurisdictions.

Injured Worker Reimbursement for Brand-Name Drugs

Proposed 436-009-0025(5)(b) addresses injured worker reimbursement for prescription medication, including the liability of the insurer for the cost of a dispensed brand-name drug when the injured worker insists on receiving the brand-name drug despite the prescriber not prohibiting generic substitution. This particular scenario is referred to as "dispense as written" (DAW) code "DAW 2" within NCPDP transactions. Helios supports the intent of the Division in adding clarification concerning injured worker and insurer liability given the existing generic dispensing requirement for pharmacies. However, the proposed language appears to us to only focus on the process by which the injured worker would directly invoice the insurer for their applicable cost. Helios believes this continued burden on the injured worker may not necessarily be warranted given the capabilities of pharmacies and pharmacy benefit managers (PBMs) when utilizing the Division's adopted NCPDP pharmacy billing standards (either paper or electronic). In addition, following these standards should alleviate confusion on the part of the dispensing pharmacy and provide greater overall efficiency in the process.



Other jurisdictions which have adopted workers' compensation rules permitting the injured worker to request a brand-name drug also require the injured worker to pay the difference between the brand and generic. This can be processed in a point of sale transaction using the NCPDP Telecommunication Standard D.0 with which the pharmacy bills identifying both the brand-name drug dispensed and the generic drug that would have been dispensed along with the associated pricing information for both. In the paid response transaction, the bill adjudicator (PBM/processor acting on behalf of the insurer) pays the pharmacy at the generic drug rate and communicates the difference as patient responsibility based on state regulations. The pharmacy may then collect the difference from the injured worker at the point of sale (prior to dispense). Even if the pharmacy does not proactively bill with the generic drug information, the same process enables the adjudicator to still pay the pharmacy at an equivalent generic rate and communicate the difference as patient responsibility based on state regulations. The same process is supported when billed on paper using the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF). The pharmacy identifies and calculates the difference in specific paper form fields designated for this purpose and collects the difference from the injured worker prior to dispensing. The worker is spared the need to pay for the full cost of the drug and can be provided with the billing information needed to request reimbursement of the brand-generic difference from the insurer.

In order to standardize the processing of these transactions, provide greater efficiency, and relieve the injured worker of the burden of paying the full cost of the brand drug and/or separately having to invoice the insurer, Helios recommends the following change to the proposed language in 436-009-0025(5)(b) (recommended deletions indicated with strikethrough; recommended additions underlined):

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket; or pay the difference between the cost of the brand-name drug and generic to the pharmacy, and request reimbursement, if permitted, from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse ~~the worker~~ the generic price of the drug.

In order to provide consistency throughout the rules, we also recommend the following changes to 436-009-0090(1)(b):

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

We believe these recommended changes would also align well with the Division's existing pharmaceutical fee schedule table under 436-009-0090(2), providing greater consistency and clarity in the rules. That table specifically states that a pharmacy should only be reimbursed based on the average AWP for the class of generic drugs when dispensing a brand-name drug with a generic equivalent and the prescribing provider has not prohibited substitution.

NCPDP has published guidance on how these DAW 2 transactions are to take place for workers' compensation using their standards. To assist the Division in understanding the process, we have attached with our written comments a copy of NCPDP WG16's *Guidance For The Workers' Compensation Industry*, which contains details related to this on pages 14 and 15. Should the Division have any other questions related to this process and how it is typically conducted, please do not hesitate to reach out to us.

Prescriber ID

Proposed 436-009-0090(2)(b) adds that bills from pharmacies must include either the prescribing provider's NPI or license number. However, the Division's adopted electronic billing requirements (specifically the table in 6.3 of the Division's *Electronic Billing and Payment Companion Guide*) requires submission of the prescribing provider's NPI as the only allowable provider identifier in an electronic bill from a pharmacy. Helios believes the proposed language should maintain consistency with those electronic billing requirements.

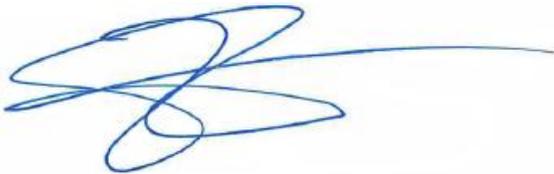
To achieve this, we recommend the following change to the proposed language in 436-009-0090(2)(b):

(b) All bills from pharmacies must include the prescribing provider's NPI ~~or license number~~.

Conclusion

Thank you for your consideration of our comments. Helios looks forward to a continued dialogue with the Division in this and other regulatory efforts. Should you have any questions, please feel free to contact us.

Sincerely,



Kevin C. Tribout
Executive Director of Government Affairs
Helios
Kevin.tribout@helioscomp.com



NCPDP Work Group 16 Property & Casualty/Workers' Compensation

**GUIDANCE FOR THE WORKERS' COMPENSATION
INDUSTRY**

VERSION 2.1

This document offers guidance to the Workers' Compensation industry on the use of NCPDP standards.

February 2015

National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260

Phone: (480) 477-1000
Fax: (480) 767-1042
E-mail: ncpdp@ncpdp.org
http: www.ncpdp.org



NCPDP Work Group 16 Property & Casualty/Workers' Compensation Guidance for the Workers' Compensation Industry

Version 2.1

This work is owned by National Council for Prescription Drug Programs, Inc., 9240 E. Raintree Drive, Scottsdale, AZ 85260, (480) 477-1000, ncdpd@ncdpd.org, and protected by the copyright laws of the United States. 17 U.S.C. §101, et. seq. Permission is given to Council members to copy and use the work or any part thereof in connection with the business purposes of the Council members. The work may not be changed or altered. The work may not be sold, used or exploited for commercial purposes. This permission may be revoked by National Council for Prescription Drug Programs, Inc., at any time. The National Council for Prescription Drugs Programs, Inc. is not responsible for any errors or damage as a result of the use of the work.

NCPDP recognizes the confidentiality of certain information exchanged electronically through the use of its standards. Users should be familiar with the federal, state, and local laws, regulations and codes requiring confidentiality of this information and should utilize the standards accordingly.

NOTICE: In addition, this NCPDP Standard contains certain data fields and elements that may be completed by users with the proprietary information of third parties. The use and distribution of third parties' proprietary information without such third parties' consent, or the execution of a license or other agreement with such third party, could subject the user to numerous legal claims. **All users are encouraged to contact such third parties to determine whether such information is proprietary and if necessary, to consult with legal counsel to make arrangements for the use and distribution of such proprietary information.**

Published by:
National Council for Prescription Drug Programs

Publication History:
Version 1.0 February 2010
Version 2.1 February 2015
Version 2.1
Copyright © 2015

All rights reserved.
Permission is hereby granted to any organization to copy and distribute this material as long as the copies are not sold.

National Council for Prescription Drug Programs
9240 E. Raintree Drive
Scottsdale, AZ 85260
(480) 477-1000
ncdpd@ncdpd.org

TABLE OF CONTENTS

I. PURPOSE AND SCOPE 5

A. IMPORTANT REFERENCE DOCUMENTS 6

B. DEFINITIONS 7

C. ACRONYMS 11

II. FREQUENTLY ASKED QUESTIONS..... 13

III. DETAILED GUIDANCE 14

A. WORKERS' COMPENSATION – BRAND/GENERIC SELECTION AND INVOICING WHEN BOTH THE BRAND AND GENERIC NDCS AND THEIR COSTS MUST BE PRESENT 14

 1. BACKGROUND 14

 2. PRICING THE PATIENT SELECTED BRANDED DRUG..... 14

B. ASSIGNMENT OF JURISDICTIONAL FIELDS..... 16

 1. WORK GROUP REVIEW OF THE REQUEST..... 16

 2. SOLUTION..... 16

 3. LONG TERM AND/OR ELECTRONIC SOLUTION..... 17

Disclaimer

This document is Copyright © 2015 by the National Council for Prescription Drug Programs (NCPDP). It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holders. This document is provided “as is” without any express or implied warranty.

While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice. If you require legal advice, you should consult with an attorney. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by NCPDP. The listing of an organization does not imply any sort of endorsement and the NCPDP takes no responsibility for the products or tools.

The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by the NCPDP.

The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

I. PURPOSE AND SCOPE

NCPDP Work Group 16 Property & Casualty/Workers' Compensation (WG16) has created this document as a resource to the industry on the use and application of NCPDP standards to meet the business requirements of the Workers' Compensation Insurance environment. The document contains two sets of information: Frequently Asked Questions (FAQ) and Detailed Guidance. Periodic additions and modifications are anticipated as new issues and business needs are brought forward. Questions and issues needing industry guidance should be submitted to the WG16 Co-Chairs or the assigned NCPDP staff liaison.

In the Workers' Compensation arena there is a growing trend among the states to move to the standard transactions and code sets adopted under the Health Insurance and Portability and Accountability Act (HIPAA) for the healthcare industry for the billing and reporting of healthcare products and services. The providers of the healthcare services are familiar with these transactions and code sets which makes the move advantageous both in terms of efficient work flow and administrative costs. The states derive benefit by having a greater ability to do comparative analysis of their services and costs with those in the general healthcare arena. Utilization of the electronic standards also saves the system administrative costs as electronic claims processing and adjudication is more cost effective than the processing of paper claims.

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

A. IMPORTANT REFERENCE DOCUMENTS

Users of this document should consult the NCPDP documents listed below for further information and clarification.

MANUAL CLAIM FORMS REFERENCE IMPLEMENTATION GUIDE

Intended to provide guidance information for completing and processing

- The NCPDP Universal Claim Form that aligns with NCPDP Telecommunication Standard Version D.Ø and above
- The NCPDP Workers' Compensation/Property and Casualty Universal Claim Form that aligns with NCPDP Telecommunication Standard Version D.Ø and above

The Manual Claim Forms Reference Implementation Guide is available with purchase or licenses of NCPDP claim forms.

TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE

Specifies transmission formats for claim submission and response. Refer to NCPDP *Telecommunication Standard Implementation Guide Version D.Ø* and above.

DATA DICTIONARY

Full reference to all fields used in NCPDP standards.

EXTERNAL CODE LIST

Full reference to all values used in NCPDP standards.

STANDARDS MATRIX

This document contains charts that list the Standards and Implementation Guides versions approved or under consideration by NCPDP, with reference to the Data Dictionary and External Code List documents appropriate for use.

EDITORIAL DOCUMENT

This document contains clarifications, corrections, examples, and questions/answers that were obtained after the publication of the NCPDP *Telecommunication Standard Implementation Guide*. It must be used as a reference between official publications of the implementation guide. This document may be updated as often as quarterly and new versions should be downloaded. It is available from the public and members only sections of the NCPDP website.

These documents are available with NCPDP membership; contact the NCPDP office at 48Ø-477-1ØØØ, or via e-mail at ncpdp@ncpdp.org. The documents are available in the "Members" section of the website at www.ncpdp.org.

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

B. DEFINITIONS

The following represent common terms used in the delivery of pharmacy care in the context of the workers' compensation market. The definitions provided are meant to be informational and general in nature. Individual jurisdictions may have specific definitions for these terms that govern.

Adjuster – The individual who handles the overall claims process for the insurance carrier (payer).

Apportionment – The process the Workers' Compensation Appeals Board (or other similar governmental entity) uses to determine what portion of a worker's injury or illness is legally attributable to the worker's industrial injury or illness and, consequently, to the employer.

Bill – The submitted request for payment for a medical or pharmaceutical product or service provided. In the context of workers' compensation the concepts "bill" and "claim" are not interchangeable.

Bill Review – The evaluation and adjudication of pharmaceutical services bills for appropriateness of reimbursement including, but not limited to, medical necessity and prevailing or mandated rates of reimbursement (fee schedules), duplication of charges, unbundling of charges, medical relatedness of services to compensable injury or illness, and any other prevailing adjudication criteria that may apply. Also referred to as bill screening or bill audit.

Claim – A claim in the workers' compensation context represents an injury or an illness arising out of a work related event. A claim covers: medical bills, loss of wages, and other expenses as a result of an injury/illness.

Claim Number – A number assigned by the insurance carrier, self-insured employer and/or jurisdiction (e.g., workers' compensation board or division) to identify a specific claim for an injury. A particular claim may have two claim numbers associated with it: one assigned by the payer and the other by the jurisdiction.

Claimant – Injured worker/employee (injured while at work) who has filed a workers' compensation claim.

Compensable – Eligible for, or subject to, compensation for a bodily injury or illness.

Compound – A pharmaceutical product that results from the combining, mixing, or altering of one or more ingredients, excluding flavorings, to create a customized medication (not typically produced by a manufacturer) for an individual patient in response to a licensed practitioner's prescription.

Controverted – A disputed workers' compensation claim.

Date of Injury (DOI) – The date the employee was injured or contracted an illness while on the job as identified in reports to the jurisdiction and confirmed by the insurer.

Denied Claim – A claim in which the insurance company believes the injury or illness is not covered by workers' compensation.

Denied Service – A service which is deemed non-compensable based on the nature of the claimant's injury or illness, or contradicted by established treatment protocols, or as permitted by the relevant jurisdiction's statutes or regulations.

Division/Department of Worker's Compensation (DWC) – Government entity that monitors and enforces the administration of workers' compensation claims, and provides administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers'

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

compensation benefits. May also be referred to as a Bureau, Board or other type of governmental body.

Eligibility – A determination by the carrier/payer that the individual is entitled to receive benefits based on a claim for a compensable injury/illness. Eligibility does not guarantee payment.

Explanation of Benefits (EOB) – A summary statement (paper or electronic) that explains medical bill payment, adjustment and/or the reason for denial of specific charges. May also be referred to as an Explanation of Review (EOR), Explanation of Bill Review (EOBR), Explanation of Medical Benefits (EOMB) or other similar term.

Fee Schedule – A defined table/set of allowable fees per service/item (usually a maximum) promulgated by law or the jurisdictional workers' compensation agency's rules.

Formulary – A list(s) of brand name and generic drugs chosen, often based on safety, medical effectiveness and/or cost effectiveness. Formularies in workers' compensation may be injury/illness-specific and/or established by jurisdictional rules. Drugs not included on a formulary typically require preauthorization or prospective utilization review by the payer.

FROI – First Report of Injury

Generic Mandate – A jurisdictional requirement for prescribers to prescribe and/or dispensers to dispense a therapeutically equivalent generic drug in place of a brand name drug, often for cost-containment purposes. Dependent on particular jurisdictional requirements, a brand name drug may at times still be permitted to be prescribed and/or dispensed based on medical necessity, specific direction from the prescriber, unavailability of the generic equivalent, or where permitted at the specific request of the claimant who will be responsible for paying the difference in cost between the brand and generic.

Jurisdiction – The governmental entity (federal or state) with legal authority over the workers' compensation claim.

Medical Necessity – A determination that certain services/items are medically necessary for the treatment of a specific condition or combination of conditions relative to a particular patient. Entails an individual assessment rather than a general determination of what works in the ordinary case.

Original/Underlying NDC – The original manufacturer/labeler's established national drug code for the drug actually used in a repackaged or compounded product.

Payer – An entity that assumes the risk of paying for medical treatments. This can be a self-insured employer, a workers' compensation insurance carrier, or another third party (health care plan or health maintenance organization) ultimately responsible for payment under given circumstances.

Pharmacy Benefit Manager (PBM) – An entity, other than a pharmacy, pharmacist, or third party biller that acts as an administrator or processor in connection with workers' compensation pharmacy benefits. PBM services may include any of the following: retail network administration; mail service pharmacy; or patient compliance, therapeutic intervention, and generic substitution programs. PBMs generally contract with both the pharmacy and the insurer (payer). Dependent on specific contractual agreements, transactional relationships, and business models, a PBM may be considered either a bill submitter or a bill receiver in a given transaction.

Physician Dispensing – Used for when a physician provides a patient, on an outpatient basis (not administered or in conjunction with an office or surgical procedure), a medication supply (other than a free sample) from their office.

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

Repackaged Drug – A drug that FDA-approved repackagers have purchased in bulk and repackaged (often into individual prescription sizes) and assigned a new NDC.

Return to Work (RTW) – Phrase used in relation to an injured or ill employee who has reached substantial medical improvement to be able to return to the position for which the employee was hired with either no workplace modifications or restrictions, or with permanent workplace modifications or restrictions that are not essential to the job function for which the employee was hired.

Statement of Medical Necessity – A written statement and supporting documentation from the ordering/prescribing physician to establish the medically appropriate need for the ordered/prescribed treatments, services, or items.

Timely Filing – Specific time frame set forth by a jurisdiction to submit a bill for services rendered.

Third Party Administrator (TPA) – An organization that administers insurance claims, bills or certain aspects of workers' compensation plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures coverage for its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA.

Third Party Biller – An entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, receive reimbursement, and seek medical dispute resolution for the health care provider services billed, as permitted by an individual jurisdiction. A third party biller may "purchase" a given service from the provider and take on the risk associated with recouping payment from the responsible payer. May also be referred to as a billing agent, processing agent, factoring agent or assignee.

Treatment Guidelines – Established and effective treatment protocol(s) intended to assist in the provision of medical treatment by offering an analytical framework for the evaluation and treatment of an injured worker, in order to achieve the best medical outcome based on scientific medical evidence. Some jurisdictions have adopted existing national treatment guidelines; others have established state-specific guidelines.

Usual and Customary (U&C) – Often dependent on jurisdictional requirements, may mean either the usual and customary amount charged by a particular provider for a particular health care service or product to the general public; the average of such charges for all providers in a particular geographical area for the same specific service or product; or other jurisdiction specific methods of calculating U&C.

Utilization Review (UR) – Evaluation to determine the medical necessity for medical treatments. It includes prospective, concurrent and/or retrospective review of treatments. Utilization review may be defined and regulated by a given jurisdiction.

Utilization Review Entity – An organization (may be a private vendor, a carrier or its affiliate, a self-insured employer, a third-party administrator, a group fund, or a state agency) that provides utilization review.

Workers' Compensation Coverage – A form of "no-fault insurance" that most jurisdictions require employers to carry to cover employees for on-the-job injuries/illnesses. Employers may self-insure or

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

purchase workers' compensation insurance. Some jurisdictions administer workers' compensation claims on behalf of employers (called "state funds").

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

C. ACRONYMS

Acronym	Spelled Out
ACOEM	American College of Occupational and Environmental Medicine
BR	By Report
CARC	Claim Adjustment Reason Code
COB	Coordination Of Benefits
DOI	Date Of Injury
ECL	External Code List
EOB	Explanation Of Benefits
EOBR	Explanation Of Bill Review
EOMB	Explanation Of Medical Benefits
EOP	Explanation Of Payment
EOR	Explanation Of Review
FROI	First Report Of Injury
FS/SFS	Fee Schedule/State Fee Schedule
IAIABC	International Association of Industrial Accident Boards and Commissions
IBR	Independent Bill Review
IME	Independent Medical Exam(iner)
IMR	Independent Medical Review
JCN	Jurisdiction Claim Number
MMI	Maximum Medical Improvement
MPN	Medical Provider Network
MSA	Medicare Set-Aside
MTG	Medical Treatment Guidelines
MTUS	Medical Treatment Utilization Schedule
NCCI	National Council on Compensation Insurance
ODG	Official Disability Guidelines
PBN	Pharmacy Benefits Network
PWP	Pay With (or Without) Prejudice
RARC	Remittance Advice Remark Code
RFA	Request For Authorization
RTW	Return To Work
SBR	Second Bill Review
SMN	Statement of Medical Necessity
SOJ	State Of Jurisdiction
SROI	Subsequent Report Of Injury
U&C	Usual And Customary
UCR	"Usual, Customary and Reasonable"
UR	Utilization Review
URA	Utilization Review Agent
WC	Workers' Compensation
WC-HCN	Workers' Compensation Health Care Network
WC/PC UCF	Workers' Compensation/Property & Casualty Universal Claim Form

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

WCRI	Workers' Compensation Research Institute
------	--

II. FREQUENTLY ASKED QUESTIONS

QUESTION 1: Florida requires submission of the pharmacist's state license number in addition to the pharmacy's NPI number. How do I handle submitting the pharmacist's license number?

Paper Billing – Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Instructions:

NCPDP has approved Florida's use of Jurisdictional Field 57 on the WC/PC UCF Form as the location for the pharmacist's state license number. Field 58 should be used for the designated qualifier code "Ø7" (State Issued - unique identification number issued by a state program or organization other than Medicaid) to a provider of service.

Electronic Billing - Telecommunication D. Ø instructions:

The Pharmacy Provider Segment, field Provider ID (444-E9) is to be used to report the pharmacist's state license number. Field Provider ID Qualifier (465-EY) is to be used to report the qualifier code "Ø7".

QUESTION 2: I am submitting a bill for a repackaged medication and my jurisdiction is requiring the innovator or manufacturer's original NDC number to be submitted in addition to the NDC for the repackaged medication. How do I properly submit that information?

Paper Billing – Workers' Compensation/ Property & Casualty Universal Claim Form (WC/PC UCF) Instructions:

NCPDP has approved the following standard billing methodology when there is a jurisdictional requirement to submit the original NDC number. The jurisdiction requiring the submission of an original or underlying NDC should indicate in their implementation guide that the jurisdictionally defined Field 61 on the WC/PC UCF is designated as the location for the original manufacturer or innovator NDC.

Electronic Billing - Telecommunication D. Ø instructions:

NCPDP has approved the use of these existing fields in the NCPDP Telecommunication Standard version D.Ø to submit the original NDC number:

- Originally Prescribed Product/Service ID Qualifier (453-EJ) value of "Ø3" (National Drug Code (NDC))
- Originally/underlying Prescribed Product/Service Code (445-EA) contains the actual (original) NDC

The Product/Service ID Qualifier (436-E1) contains the value of "Ø3" (National Drug Code (NDC)) and Product/Service ID (4Ø7-D7) contains the actual dispensed (repackaged) NDC.

QUESTION 3: How do I as a physician bill for a drug I dispense on the WC/PC UCF?

Answer: The WC/PC UCF contains designated fields for both the prescriber (Fields 40-48) and the pharmacy (Fields 32-39). It is recommended that a physician dispenser complete the fields for pharmacy entering their information in the section designated for Pharmacy, including their ID as required by the jurisdiction in Field 32. If the physician is also the prescriber, also complete the information in the Prescriber Section of the form, including their ID as required by the jurisdiction in Field 40.

III. DETAILED GUIDANCE

A. ***WORKERS' COMPENSATION – BRAND/GENERIC SELECTION AND INVOICING WHEN BOTH THE BRAND AND GENERIC NDCs AND THEIR COSTS MUST BE PRESENT***

1. **Background**

In workers' compensation the rules promulgated in the various state jurisdictions dictate how pharmacy services/prescriptions should be fulfilled. Some of these regulations have not taken into consideration the real-time process or other complexities of pharmacy services/prescription processing.

More specifically, some jurisdictions have passed generic-only dispensing for workers' compensation bills unless the physician specifically writes "brand medically necessary" upon the prescription. (The pharmacy would this indicate by sending a DAW code value of 1.) Taking into consideration some rights of the injured worker (patient), a number of these same jurisdictions, have allowed for the injured worker to select the brand name drug, when not specified medically necessary, and have advised that the injured worker must pay the cost difference between the brand dispensed and the generic that would have been dispensed. (The pharmacy would indicate by sending a DAW code value of 2.) Additionally, not all billing rules in these particular states are specific in detailing how the billing for these types of transactions should be completed. Some state rules detail that the pharmacy must invoice showing the brand NDC that was dispensed and its cost, the generic NDC that would have been dispensed and its cost, and the amount paid by the injured worker - leaving the amount due from the payer. The payer could be a third party entity (biller, PBM, TPA) or the insurance carrier directly, dependent upon jurisdictional requirements and specific business relationships and agreements.

The intent of this section of the document is to provide some guidance to the pharmacy services industry on how to bill for this scenario both electronically and through paper invoicing when utilizing the NCPDP standards.

2. **Pricing the Patient Selected Branded Drug**

There is an underlying theme of selecting the lowest-priced therapeutically equivalent generic for pricing purposes when the patient opts for the brand name drug versus the generic equivalent. For electronic transactions, NCPDP Work Group 16 recommends the following to complete the transaction:

Generic medication prescribed – Brand medication dispensed

Using either the NCPDP Telecommunication Standard D.Ø or the Workers' Compensation/Property and Casualty Universal Claim Form (WC/PC UCF), the pharmacy should submit the following data. (Valium and Diazepam are being used within the example. The dollar values detailed below are not meant to represent true market data.)

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

D.Ø Transaction

Claim Segment			
Field ID	Field Name	Example	General Notation about Field(s)
4Ø7-D7	Product/Service ID	00140-0006-35	Brand drug dispensed – Valium
4Ø8-D8	Dispensed as Written	2	DAW2 – Patient Selected Brand
445-EA	Originally Prescribed Product/Service Code	00228-2053-10	Generic prescribed drug - Diazepam
Pricing Segment			
Field ID	Field Name	Example	General Notation about Field(s)
4Ø9-D9	Ingredient Cost Submitted	.55	Cost of 1 tablet of Valium
412-DC	Dispensing Fee Submitted	4.00	
433-DX	Patient Paid Amount Submitted	.50	Cost difference between Valium and Diazepam
43Ø-DU	Gross Amount Due	4.55	

These examples do not show the exact data transmitted which must include the proper format and overpunch requirements. See the NCPDP *Telecommunication Standard* for requirements.

WC/PC UCF

The WC/PC UCF does not have a field defined to support the Generic Equivalent Product ID. State-specific assigned Jurisdictional Fields are used to report the Generic prescribed drug. For more information see Section II of this document and the NCPDP *Manual Claim Forms Reference Guide*.

Claim Section			
			General Notation about Field(s)
69	Product/Service ID	00140-0006-35	Brand drug dispensed – Valium
73	Dispensed as Written	2	DAW2 – Patient Selected Brand
57-61 as assigned	Generic Equivalent Product ID	00228-2053-10	Generic prescribed drug - Diazepam
Pricing Segment			
			General Notation about Field(s)
102	Ingredient Cost Submitted	.55	Cost of 1 tablet of Valium
103	Dispensing Fee Submitted	4.00	
107	Patient Paid Amount Submitted	.50	Cost difference between Valium and Diazepam
106	Gross Amount Due	4.55	

B. ASSIGNMENT OF JURISDICTIONAL FIELDS

The Jurisdictional Fields (Fields 57 through 61) in the NCPDP Workers' Compensation Property and Casualty Universal Claim Form (WC/PC UCF) were developed to accommodate state-specific billing requirements for workers' compensation pharmacy services that are not otherwise supported in a specific field. Jurisdictional Field use is determined and assigned by NCPDP to maintain standard content and submission and allow consistent reporting and processing of the data.

As new state regulations are proposed, billing requirements that cannot be accommodated in the standard NCPDP Telecommunication Standard Version D.0 and WC/PC UCF need to be brought to NCPDP for review and assignment of an appropriate state-specific jurisdictional field. Ideally the state/jurisdiction or the International Association of Industrial Accident Boards and Commissions (IAIABC) on behalf of the state/jurisdiction would consult with NCPDP (and other standards development organizations) as regulations are being developed to assure that the data requirements can be accommodated. In absence of that consultation, any individual aware of the requirement is encouraged to bring the request/business requirement forward to NCPDP WG16 Property & Casualty/Workers' Compensation. The request may be in the form of memo or submission of a Data Element Request Form (DERF). See <http://www.ncdp.org/Standards/Standards-Development-Process>.

1. Work Group Review of the Request

Upon receipt, WG16 will review the request for use of a Jurisdictional Field to determine the optimum solution for the data requirement. WG16 will:

- a. Notify the state/IAIABC of the requested review and invite their participation in defining the solution.
- b. Verify whether the requesting state has available jurisdictional fields.
- c. Determine whether the data can be accommodated in the current electronic and/or paper billing formats.
- d. Determine through review of state regulations and by outreach to multiple states whether the data need is common to them, and if so
 - i. Do the states have a shared jurisdictional field assignment
 - ii. Is the requirement becoming universal so that a permanent solution is needed
 - iii. Is the data requirement billing/payment related, and if not, are there alternate ways of providing the data.
- e. Approve or deny the request at the next quarterly NCPDP Work Group meetings.
- f. Inform the submitter of the decision. If approved, inform the state(s)/IAIABC of the solution including the DERF process and timeline before the solution might be available for implementation.

2. Solution

Once it has been determined that the request is appropriate and additional data specification is needed for the paper and/or electronic billing formats, WG16 will determine the optimal technical solution, create/revise the DERF and move it through the NCPDP process.

- a. If a single state issue, and
 - i. there is no alternative for providing the data, and

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

- ii. the state has open Jurisdictional Fields,
initiate a Data Element Request Form (DERF) to assign a Jurisdictional Field and update the *NCPDP Manual Claim Forms Reference Implementation Guide*.
- b. If the requesting state
 - i. has no other Jurisdictional requirements, and
 - ii. the requirement is a multi-state issue and those states have no other Jurisdictional requirements,
initiate a DERF to assign the state(s) to a shared Jurisdiction field and update the *NCPDP Manual Claim Forms Reference Implementation Guide*.
- c. If the requesting state
 - i. has shared Jurisdictional requirements, and
 - ii. the requirement is applicable to those states in that shared requirement,
initiate a DERF to assign a new Jurisdictional field to the shared requirement and update the *NCPDP Manual Claim Forms Reference Implementation Guide*.
 - i. the requirement is NOT applicable to those states in that shared requirement,
initiate a DERF to remove the state from the shared Jurisdiction field, assign the state the previous fields and a new Jurisdictional field and update the *NCPDP Manual Claim Forms Reference Implementation Guide*
- d. If the data requirement is becoming universal then, based on the urgency
 - i. Short Term – assign to a jurisdiction field as above for use until a permanent solution is developed and adopted.
 - ii. Long Term – explore solution for making the data element available to all states
- e. If the requirement is not billing related and there are other mechanisms for reporting
 - i. Deny the request
 - ii. Inform the state/IAIABC of the alternative mechanism
- f. Notify the state(s)/IAIABC of the resolution
 - i. Jurisdictional Field assigned
 - ii. Long term solution being pursued if appropriate

3. Long Term and/or Electronic Solution

If a long term and/or electronic solution are determined to be needed, WG16 will engage WG1 Telecommunication to assist in determining the best technical solution for accommodating the business requirement. Possible solutions will be communicated to the IAIABC, state agencies and industry for comments. Once a solution has been agreed to, a DERF will be initiated to incorporate the technical solution into the *NCPDP Manual Claim Forms Reference Implementation Guide* and *Telecommunication Standard* (if applicable). The state(s)/IAIABC will be informed of the time frames for the adjudication process and how to participate. The modifications will go through the NCPDP ballot process (<http://www.ncpdp.org/Standards/Standards-Development-Process>). Once the ballot process is complete the state(s)/IAIABC will be informed of the outcome and effective date of the change.

14725 SW Glenbrook Rd. Beaverton, OR 97007

Phone: 503-644-5575 Fax: 503-641-8375

vrooman@msn.com

Communication & Language Services

February 17, 2015

Hi Fred,

This is regarding the proposed Rule #436-009-0110 Interpreters:

1. Choosing an interpreter: "or someone who provides interpreter services as a profession"

I find it interesting that for the past few years, qualified and certified has been an issue by the hospitals, clinics and the state for interpreters. To be qualified or certified is important and in the rules they leave out "interpreting services as a profession" and replaces everything with "an interpreter" Which means pretty much anyone who speaks the other language can be an interpreter. [Not true; bi-lingual is not interpreting] That doesn't mean it's a competent interpreter and can do a good job.

This is why for many years hospitals decided to hire professional interpreters and didn't want family members to insure that the patient was getting the best care. Interpreters are working hard to better themselves by taking classes, passing the required tests to be certified. Once they're certified they ask the interpreting companies to pay them more and as an interpreting company, we have to honor that. I think that this rule should be more specific to meet and reflect the real requirements demanded by interpreting companies and most importantly, the clinics they serve.

2. As a result of paying the interpreter more, I believe that Rule #436-009-0155, the amount allowed should be raised to \$70.00 an hour. We provide a good service and I'm speaking strictly for A & R Enterprises Language Services Inc. I go beyond and above to provide through our interpreter and office staff the best service possible to patients, doctors, clinics etc. As a result insurance companies get their money well spent and the treatment to the patient with good communication through patient and provider. I believe that diminishing the interpreting profession is not going to provide a good outcome.

3. Rule #436-009-0110 Billing:

I am in charge of doing billing for A & R Enterprises, Inc. In October of last year, I was told by the MRT group (Worker's Comp. Division) that I should go directly to SAIF Corporation management, Laura Smith, to resolve any billing issues I had with our invoices and if she couldn't resolve the problem, then I could escalate the issue to the MRT group. Most of billing issues with SAIF is that if an appt. goes more than one hour, they challenge the invoice and don't want to pay for the remaining time (1/4 or 1/2 hour) Then I have to go to the SAIF website (SAIF Medical Provider) and send Laura an email requesting the rest of the payment. Which at that point it takes an extra few days to get a check. This happens very often and it's extremely time consuming.

Aida Vrooman
Alexandra Jones
D'Andria Ornee

14725 SW Glenbrook Rd. Beaverton, OR 97007

Phone: 503-644-5575 Fax: 503-641-8375

vrooman@msn.com

Communication & Language Services

February 18, 2015

Hi Fred,

This is regarding the proposed Rule #436-009-0110 Interpreters:

(1) Choosing an interpreter.

Add: The patient will be informed that if the interpreter does not meet their needs, they can change interpreters

(2) Billing.

(b) Therefore the insurer must pay as the general public pays 30 day net. The late payment penalties is \$30.00 for every 30 days late or portion of 30 days late.

(c) You cannot say "Round Trip" in one sentence and then not mention it on the next sentence. "For the purpose of this rule "mileage" means the number of miles traveling for the interpreter's starting point to the exam or treatment location" What about return mileage?

(5) Billing Form.

(J) When the provider staff and patient sign off on time/date on work order the time will not be challenged prior to payment. Patient, care giver and interpreter attesting to time is sufficient for total payment.

(6) Payment Calculations.

(b)

Change to **\$70.00**. Compare the cost indexes since our payment was reduced to \$60.00 from \$65.00 per hour.

\$15.00 per 15 minute increment, change it back to per minute at the new rate of **\$70.00** per hour or even if the old rate prevails.

Change to **\$70.00** no show fee plus payment for mileage if 15 or more miles round trip.

An interpreter who is the only person in Oregon able to interpret a specific language. Ridiculous rule. The sky is not the limit. However, difficulty on exotic language should pay \$80.00.

(7) Payment Requirements.

(b) Any other medical appointment pay at least ½ fee.

(c)

(A) Should be **30** days of receiving the invoice.

(B) Should be **30** days as is standard.

(i)

(C) A statement that the insurer or its representative must respond to an interpreter's payment questions within **24** hours, excluding weekends and legal holidays.

(F) A notice of the right to administrative review as follows:

Not necessary; they have the invoice.

Sanctions should start immediately at due date.

(j) Duplicate notification not necessary. They have the invoice.

Aida Vrooman, Alexandra Jones and D'Andria Ornee

A and R Enterprises Inc. Since 1992 OMWESB Certified
14725 SW Glenbrook Rd. Beaverton, OR 97007
Phone: 503-644-5575 Fax: 503-641-8375
vrooman@msn.com

Communication & Language Services

February 20, 2015

Hi Fred,

We think that a solution needs to be found for interpreter's invoice being denied or temporarily held up. The same solution should also apply to care givers (provided there was an interpreter). When an invoice from a care giver or interpreter is submitted for payment, the work order that generated the invoice will have three signatures: patient, care giver and interpreter all verifying an appointment happened. Also the correct place, time and date are provided. Even if the caregiver's and interpreter's amount of time has a discrepancy on time the caregiver spent with patient versus the amount of time the interpreter spends at the clinic. Even if the invoices arrived on different days. Three signatures should be enough proof for the insurer to pay the invoice when received. Not 45 days later if they choose. If the insurer wishes to challenge the veracity of the three involved persons attesting to an invoice in writing with place, names, date and time the insurer should be penalized for deceitful business practices. Huge hassle factor!

Several hassle factors that have been demonstrated to WCD many times over:

- The invoice from A & R Enterprises Inc. is denied, the doctor's invoice had a different amount of time.
- The doctor is only billing for his/her time spent with the patient.
- The interpreter bills for requested time of the appointment until he/she is discharged, which includes paper work, time with nurse, and any other provider he/she needs to see and waits for the time with the doctor.

Thus begins the float. The insurer has 45 days to pay. Fred and John told Alexandra and Ron that they would be looked into. 30 days seems to be the commercial and industrial standard. That was two years ago. As it is now 45 days before they are late. In one particular case the insurer refused to pay A and R because the doctor's invoice was for a different amount of time. When Alexandra called the doctor, the insurer had refused the doctor's invoice also. When the insurer does not pay the invoice as is proper in the business community, the insurer will incur a penalty.

With the Sanctions committee not facilitating pay anymore as I have indicated specifically to Fred. Alexandra and Ron met with Fred, John and several members of WCD about several items, such as: collecting our fees for services is a giant expense that we need to reduce. When a care giver signs off on an interpreter's work order for interpreting service, time in, time out, care giver, name, interpreter name, total time all of the necessary information to provide a valid invoice.

It is imperative that this situation is resolved.

Ron Vrooman, consultant for A & R.

**BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON**

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR:)
436-009, Oregon Medical Fee and Payment Rules) **TRANSCRIPT**
) **OF TESTIMONY**
)
)

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated February, 2015. On Feb. 23, 2015, a public rulemaking hearing was held as announced at 9 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record will be held open for written comment through Feb. 23, 2015.

INDEX OF WITNESSES

Witnesses	Page
<u>Don Emerson, SAIF Corporation</u>	<u>2</u>
<u>Scott Anderson, SAIF Corporation.....</u>	<u>2</u>

TRANSCRIPT OF PROCEEDINGS

Fred Bruyns: Good morning and welcome. This is a public rulemaking hearing. My name is Fred Bruyns, and I’ll be the presiding officer for the hearing. The time is now 9:01 a.m. on Monday, Feb. the 23rd, 2015. We are in Room F of the Labor & Industries Building, 350 Winter Street NE, in Salem, Oregon. We are making an audio recording of today’s hearing.

If you wish to present oral testimony today, please sign in on the “Testimony Sign-In Sheet” on the table by the entrance. If you plan to testify over the telephone, I will sign-in for you.

The Department of Consumer & Business Services, Workers’ Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically, division 009, Oregon Medical Fee and Payment Rules. The department has summarized the proposed changes in the Notice of Proposed Rulemaking Hearing. This hearing notice, a Statement of Need and Fiscal Impact, and proposed rules with marked changes, are on the table by the entrance. You may also pick up an information page that explains how to access testimony that we post to our website.

The Workers’ Compensation Division filed the Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact with the Oregon Secretary of State on Jan. 15, 2015, mailed the Notice and Statement to its postal and electronic mailing lists, notified Oregon Legislators as

required by ORS chapter 183, and posted public notice and the proposed rules to its website.

The Oregon Secretary of State published the hearing notice in its February 2015 Oregon Bulletin.

This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including Feb. 26, 2015, and will make no decisions until all of the testimony is considered. We are ready to receive testimony. If you are reading from written testimony and give the agency a copy of that testimony, we will add it to the rulemaking record.

When I read your name, would you please come forward to the table at my right? Don Emerson?
Good morning.

Don Emerson: Good morning. So I just had a couple things in reference to the ICD-10 change-over, and one was that nowhere does it specify that a bill cannot have both ICD-9 and ICD-10 codes. And from some correspondence that has gone through I understand that it is the case that you should never have a bill with both codes.

The other thing is according to the CMS documentation, there are certain bill types that allow ICD-9 codes to go up through the service through date versus the service from date. And I understand these are like inpatient hospital, swing beds, and those types of bill types, and the rule don't address those at all. And, if we are staying consistent with the CMS rules, I would expect to see those.

Fred Bruyns: Anything else?

Don Emerson: That's all.

Fred Bruyns: Okay. Thank you very much for testifying this morning. Would anyone else like to testify? Okay, come on up. If I could get you to sign in.

Scott Anderson: Of course, sorry.

Fred Bruyns: That's okay. That helps. Very good. So if you want to state your name for the record and go ahead and testify.

Scott Anderson: Scott Anderson, SAIF Corporation. This is a follow-up on Don's questions. It has to do also with ICD-10 and the question about how the proposed rule changes will impact the EDI medical system, and whether there are any new or changing data or editing requirements expected in that system. For example, in Don's observation that the rule doesn't speak to the fact that you can't intermix ICD-9 and 10 on the same bill. If it is actually a requirement will the EDI system be modified to enforce that requirement? I think there are already changes like that anticipated in the EDI system. The sooner we can know about it, the better so we can program to it.

Fred Bruyns: Okay.

Scott Anderson: And then one other question too about ICD-10 is whether the department has a position on the fact that we don't really know if ICD-10 is going to implement October first or not. It's like in the past, you know, what are the plans for dealing with that uncertainty? Is there some anticipated date certain that we could plan on, or – how that will be addressed in the rules?

Fred Bruyns: Okay. Thank you very much Scott, for testifying this morning.

Transcript of public rulemaking hearing
Feb. 23, 2015

Is there anyone on the telephone who'd like to testify this morning? Anyone else here? Jaye? Okay, it's our policy to keep our hearing, at least the meeting room open at least a half an hour, so if anyone arrives late they may testify. So, I'm going to go ahead and recess in just a moment, but just to remind you again that the record remains open for written testimony through and including Feb. 26, 2015. You may submit testimony in any written form, whether hard copy or electronic. I encourage you to submit your testimony by email or as attachments to email. However, you may also fax, use fax, use USPS mail, courier, or you may hand deliver testimony to Workers' Compensation Division Central Reception on the second floor of the building. On the table by the entrance are business cards that include my contact information. I will acknowledge all testimony received.

The hearing is recessed at 9:08 a.m.

The hearing is resumed at 9:30 a.m. Would anyone else here like to testify?

Hearing no one, the time is still 9:30 a.m. Thank you for coming. This hearing is adjourned.

Transcribed from a digital audio recording by Fred Bruyns, Feb. 23, 2015.



February 24, 2015

Fred Bruyns, Rules Coordinator
Workers' Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

RE: SAIF Corporation testimony for proposed changes to workers'
compensation rules:
OAR 436-009, Oregon Medical Fee Payment rules

Dear Fred:

SAIF Corporation (SAIF) has reviewed the proposed Workers' Compensation Division (WCD) rule changes. SAIF, as always, appreciates the opportunity to provide input on the proposed rule changes. SAIF provides the following comments for WCD's consideration:

OAR 436-009-0004(7), 436-009-0010(3)(b) Billing forms

SAIF supports the proposed rule eliminating the 08/05 version of the CMS form since this form is outdated and does not contain all the fields needed for EDI reporting.

OAR 436-009-008(2)(d)(B) Request for administrative review

SAIF is concerned about adding language that allows a provider to request administrative review within 90 days of the mailing date of the *most recent explanation of benefits*. The proposed language is inconsistent with WCD's statement at its November 24, 2014 Rule Making Advisory Meeting where WCD staff indicated it did not intend to give providers a new 90 day administrative review period for each subsequent EOB issued. SAIF regularly receives provider rebills of the same bill multiple times, sometimes years after the original bill and EOB. With every rebill a new EOB is issued. SAIF recommends that the rule clarify that a rebill with an accompanying EOB for the same services does not extend the 90-day review period when subsequent EOB's are issued.

OAR 436-009-0023, Appendix D, Ancillary Services ASC Fee Schedule

The proposed fee schedule significantly increases reimbursement for ancillary ASC services which will result in unnecessary additional costs to policyholders. This proposed change was not discussed at the rule advisory meetings. SAIF is opposed to the estimated \$600,000 increase in costs to policyholders.

OAR 436-009-0025(5)(b) Reimbursement for generic drug when worker requests brand-name drug

SAIF supports this proposed rule.

OAR 436-009-0040(4) Reimbursement for radiology

WCD is proposing a significant increase in reimbursement for multiple radiological procedures. ORS 656.248 requires that fee schedules shall represent the reimbursement generally received for the services provided. During the rule advisory committee meeting there was no information provided by WCD about typical fees received by providers for these services. It is unclear whether the increase in costs to policyholders is justified.

OAR 436-009-0040(7) Reimbursement for reports and record review

This proposed rule seems to allow medical providers to request another medical provider to prepare a report, or review records or reports and then bill insurers for this service. If this is WCD's intent, SAIF opposes a rule that allows a provider to bill for a service SAIF did not request. SAIF suspects that WCD intends that the party preparing a report should bill the party who requested the provider's services. SAIF recommends the proposed rule read as follows:

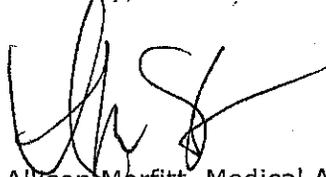
- (a) Except as otherwise provided in OAR 436-009-006, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the requesting party for their report or review of the records using CPT codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.

In addition, SAIF notes that OAR 436-009 does not state that a bill cannot have mixed ICD-9 and ICD-10 codes. SAIF interprets this to mean that service dates before 10/1/15 must be billed separately from service dates after 10/1/15.

We also note that CMS MM7492 describes exception bill types allowing bill service dates that begin before 10/1/15, but end after 10/1/2015 (Table A; <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1408.pdf>). SAIF understands that these exceptions would utilize the service through date to determine if ICD-9 or ICD-10 codes should be utilized.

Again, SAIF greatly appreciates the opportunity to participate in the rulemaking process. Please let us know if you have any questions.

Sincerely,



Allison Morfitt, Medical Audit Supervisor
440 Church Street SE
Salem, Oregon 97312
P: 503.315.3232 or 800.285.8525 ext. 3232
F: 503.945.3232
allmor@saif.com



February 25, 2014

Fred Bruyns, Rules Coordinator
Workers' Compensation Division
350 Winter Street NE
Salem, OR 97309-0405
Email: fred.h.bruyns@state.or.us

Cc: Nanci Johnston, Medical Policy Analyst
Email: nanci.j.johnston@oregon.gov

Re: Proposed amendments to OAR 436-009

Introduction

The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit American National Standards Institute (ANSI)-accredited Standards Development Organization (SDO) consisting of nearly 1500 members who represent drug manufacturers, chain and independent pharmacies, drug wholesalers, insurers, mail order prescription drug companies, claims processors, pharmacy benefit managers, physician services organizations, prescription drug providers, software vendors, telecommunication vendors, industry professional societies, service organizations, government agencies, and other parties interested in electronic standardization within the pharmacy services sector of the healthcare industry. NCPDP creates the standards that facilitate the interchange between pharmacies, physicians, pharmacy benefits managers, payers, processors and manufacturers—including the Telecommunication Standard Version D.0, the Universal Claim Form (UCF) and the Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF).

NCPDP Work Group 16 Property & Casualty/Workers' Compensation (WG16) focuses specifically on pharmacy issues impacting the workers' compensation healthcare sector. WG16's Billing and State Reporting Task Group further narrows its specific focus to billing and reporting requirements and standards within the industry. We appreciate your decision to adopt both the NCPDP Telecommunication Standard Version D.0 and the NCPDP WC/PC UCF under the Oregon workers' compensation rules for billing of pharmacy transactions. Relative to billing and associated payment processes, the Billing and Reporting Task Group's comments focus on two areas of the proposed amendments: Reimbursement for dispensed brand-name drugs when the injured worker has insisted on receiving the brand in lieu of a generic drug despite the prescriber not prohibiting substitution; and submission of a prescriber identification number on a pharmacy bill.

Injured Worker Reimbursement for Brand-Name Drugs

Proposed 436-009-0025(5)(b) adds provisions detailing injured worker reimbursement for prescription medication, including the liability of the insurer to cover the cost of a dispensed brand-name drug when the injured worker insists on receiving the brand-name drug despite the prescriber not prohibiting generic substitution. To clarify this scenario of bill submission the NCPDP transactions use the "dispense as written" (DAW) code "DAW 2." The task group supports the intent of the Division in adding clarification concerning injured worker and insurer liability given the existing generic dispensing requirement for pharmacies. However, the proposed language appears to only focus on the process by which the injured worker would directly invoice the insurer for their applicable cost. The task group feels this continued burden on the injured worker may not necessarily be warranted given the capabilities of pharmacies and pharmacy benefit managers (PBMs) when utilizing the Division's adopted NCPDP

pharmacy billing standards. In addition, following these standards should alleviate confusion on the part of the dispensing pharmacy and provide greater overall efficiency in the process.

Other states supporting a workers' compensation rule that allows the injured worker to request a brand-name drug require the worker to pay the difference between the brand and generic. This can be supported in a real-time point of sale transaction using NCPDP Telecommunication Standard Version D.0 with the pharmacy billing request identifying both the brand-name drug dispensed and the generic drug that would have been dispensed along with the corresponding pricing information for each. In the paid response, the bill adjudicator (PBM/processor acting on behalf of the insurer) pays the pharmacy at the generic drug rate and communicates the brand-generic difference as patient responsibility, based on state regulations. The pharmacy may then collect the difference from the injured worker at the point of sale (prior to dispensing). Very similar support is provided when billed on paper using the NCPDP WC/PC UCF. The pharmacy identifies and calculates the brand-generic difference in specific fields designated for this purpose on the form and collects the difference from the injured worker prior to dispensing. The worker is spared the need to pay for the full cost of the drug and can be provided with the billing information needed to request reimbursement of the brand-generic difference from the insurer.

In order to standardize the processing of these transactions, provide greater efficiency, and relieve the injured worker of the burden of paying the full cost of the brand drug and/or separately having to invoice the insurer, the task group recommends the following change to the proposed language in 436-009-0025(5)(b) (recommended deletions indicated with strikethrough; recommended additions underlined):

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket, or pay the difference between the cost of the brand-name drug and generic to the pharmacy, and request reimbursement, if permitted, from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse ~~the worker~~ the generic price of the drug.

In order to provide consistency throughout the rules, we also recommend the following changes to 436-009-0090(1)(b):

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

We believe these recommended changes would also align well with the Division's existing pharmaceutical fee schedule table under 436-009-0090(2), providing greater consistency and clarity in the rules. That table specifically states that a pharmacy should only be reimbursed based on the average AWP for the class of generic drugs when dispensing a brand-name drug with a generic equivalent and the prescribing provider has not prohibited substitution.

NCPDP has published guidance on how these DAW 2 transactions are to be processed for workers' compensation using our standards. To assist the Division in understanding the process, we have included/attached with our written comments a copy of NCPDP WG16's *Guidance for the Workers' Compensation Industry* (Version 2.1), which contains details related to this on pages 14 and 15.

Prescriber ID

Proposed 436-009-0090(2)(b) adds that bills from pharmacies must include either the prescribing provider's NPI or license number. However, the Division's adopted electronic billing requirements (specifically the table in 6.3 of the Division's *Electronic Billing and Payment Companion Guide*) requires submission of the prescribing provider's NPI

as the only allowable provider identifier in an electronic bill from a pharmacy. The task group believes the proposed language should maintain consistency with those electronic billing requirements.

To achieve this, we recommend the following change to the proposed language in 436-009-0090(2)(b):

(b) All bills from pharmacies must include the prescribing provider's NPI ~~or license number~~.

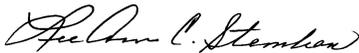
If, however, it is the Division's intent to allow either identifier, then the electronic guidance should be updated. If the intent is to allow the license number when the prescriber does not have an NPI (e.g.; the treatment occurs outside the U.S.), then the task group recommends this situational provision be clarified in these proposed rules and those governing electronic billing.

Conclusion

Thank you for the opportunity to comment and your consideration of our recommendations. Please let the task group know if we can provide any additional explanation, clarification or documentation related to our comments. For direct inquiries or questions related to this letter, please contact:

Sue Ann Thompson
Standards Advisor, NCPDP
Direct: (304) 372-5178
sthompson@ncdpd.org

Sincerely,



Lee Ann C. Stember
President
National Council for Prescription Drug Programs (NCPDP)
9240 E. Raintree Drive
Scottsdale, AZ 85260

NCPDP Work Group 16 Property & Casualty/Workers' Compensation

GUIDANCE FOR THE WORKERS' COMPENSATION INDUSTRY

VERSION 2.1

This document offers guidance to the Workers' Compensation industry on the use of NCPDP standards.

February 2015

National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260

Phone: (480) 477-1000
Fax: (480) 767-1042
E-mail: ncpdp@ncpdp.org
http: www.ncpdp.org



NCPDP Work Group 16 Property & Casualty/Workers' Compensation Guidance for the Workers' Compensation Industry

Version 2.1

This work is owned by National Council for Prescription Drug Programs, Inc., 9240 E. Raintree Drive, Scottsdale, AZ 85260, (480) 477-1000, ncdpd@ncdpd.org, and protected by the copyright laws of the United States. 17 U.S.C. §101, et. seq. Permission is given to Council members to copy and use the work or any part thereof in connection with the business purposes of the Council members. The work may not be changed or altered. The work may not be sold, used or exploited for commercial purposes. This permission may be revoked by National Council for Prescription Drug Programs, Inc., at any time. The National Council for Prescription Drugs Programs, Inc. is not responsible for any errors or damage as a result of the use of the work.

NCPDP recognizes the confidentiality of certain information exchanged electronically through the use of its standards. Users should be familiar with the federal, state, and local laws, regulations and codes requiring confidentiality of this information and should utilize the standards accordingly.

NOTICE: In addition, this NCPDP Standard contains certain data fields and elements that may be completed by users with the proprietary information of third parties. The use and distribution of third parties' proprietary information without such third parties' consent, or the execution of a license or other agreement with such third party, could subject the user to numerous legal claims. **All users are encouraged to contact such third parties to determine whether such information is proprietary and if necessary, to consult with legal counsel to make arrangements for the use and distribution of such proprietary information.**

Published by:
National Council for Prescription Drug Programs

Publication History:
Version 1.0 February 2010
Version 2.1 February 2015
Version 2.1
Copyright © 2015

All rights reserved.
Permission is hereby granted to any organization to copy and distribute this material as long as the copies are not sold.

National Council for Prescription Drug Programs
9240 E. Raintree Drive
Scottsdale, AZ 85260
(480) 477-1000
ncdpd@ncdpd.org

TABLE OF CONTENTS

I. PURPOSE AND SCOPE 5

A. IMPORTANT REFERENCE DOCUMENTS 6

B. DEFINITIONS 7

C. ACRONYMS 11

II. FREQUENTLY ASKED QUESTIONS..... 13

III. DETAILED GUIDANCE 14

A. WORKERS' COMPENSATION – BRAND/GENERIC SELECTION AND INVOICING WHEN BOTH THE BRAND AND GENERIC NDCS AND THEIR COSTS MUST BE PRESENT 14

 1. BACKGROUND 14

 2. PRICING THE PATIENT SELECTED BRANDED DRUG..... 14

B. ASSIGNMENT OF JURISDICTIONAL FIELDS..... 16

 1. WORK GROUP REVIEW OF THE REQUEST..... 16

 2. SOLUTION..... 16

 3. LONG TERM AND/OR ELECTRONIC SOLUTION..... 17

Disclaimer

This document is Copyright © 2015 by the National Council for Prescription Drug Programs (NCPDP). It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holders. This document is provided "as is" without any express or implied warranty.

While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice. If you require legal advice, you should consult with an attorney. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by NCPDP. The listing of an organization does not imply any sort of endorsement and the NCPDP takes no responsibility for the products or tools.

The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by the NCPDP.

The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

I. PURPOSE AND SCOPE

NCPDP Work Group 16 Property & Casualty/Workers' Compensation (WG16) has created this document as a resource to the industry on the use and application of NCPDP standards to meet the business requirements of the Workers' Compensation Insurance environment. The document contains two sets of information: Frequently Asked Questions (FAQ) and Detailed Guidance. Periodic additions and modifications are anticipated as new issues and business needs are brought forward. Questions and issues needing industry guidance should be submitted to the WG16 Co-Chairs or the assigned NCPDP staff liaison.

In the Workers' Compensation arena there is a growing trend among the states to move to the standard transactions and code sets adopted under the Health Insurance and Portability and Accountability Act (HIPAA) for the healthcare industry for the billing and reporting of healthcare products and services. The providers of the healthcare services are familiar with these transactions and code sets which makes the move advantageous both in terms of efficient work flow and administrative costs. The states derive benefit by having a greater ability to do comparative analysis of their services and costs with those in the general healthcare arena. Utilization of the electronic standards also saves the system administrative costs as electronic claims processing and adjudication is more cost effective than the processing of paper claims.

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

A. IMPORTANT REFERENCE DOCUMENTS

Users of this document should consult the NCPDP documents listed below for further information and clarification.

MANUAL CLAIM FORMS REFERENCE IMPLEMENTATION GUIDE

Intended to provide guidance information for completing and processing

- The NCPDP Universal Claim Form that aligns with NCPDP Telecommunication Standard Version D.Ø and above
- The NCPDP Workers' Compensation/Property and Casualty Universal Claim Form that aligns with NCPDP Telecommunication Standard Version D.Ø and above

The Manual Claim Forms Reference Implementation Guide is available with purchase or licenses of NCPDP claim forms.

TELECOMMUNICATION STANDARD IMPLEMENTATION GUIDE

Specifies transmission formats for claim submission and response. Refer to NCPDP *Telecommunication Standard Implementation Guide Version D.Ø* and above.

DATA DICTIONARY

Full reference to all fields used in NCPDP standards.

EXTERNAL CODE LIST

Full reference to all values used in NCPDP standards.

STANDARDS MATRIX

This document contains charts that list the Standards and Implementation Guides versions approved or under consideration by NCPDP, with reference to the Data Dictionary and External Code List documents appropriate for use.

EDITORIAL DOCUMENT

This document contains clarifications, corrections, examples, and questions/answers that were obtained after the publication of the NCPDP *Telecommunication Standard Implementation Guide*. It must be used as a reference between official publications of the implementation guide. This document may be updated as often as quarterly and new versions should be downloaded. It is available from the public and members only sections of the NCPDP website.

These documents are available with NCPDP membership; contact the NCPDP office at 48Ø-477-1ØØØ, or via e-mail at ncpdp@ncpdp.org. The documents are available in the "Members" section of the website at www.ncpdp.org.

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

B. DEFINITIONS

The following represent common terms used in the delivery of pharmacy care in the context of the workers' compensation market. The definitions provided are meant to be informational and general in nature. Individual jurisdictions may have specific definitions for these terms that govern.

Adjuster – The individual who handles the overall claims process for the insurance carrier (payer).

Apportionment – The process the Workers' Compensation Appeals Board (or other similar governmental entity) uses to determine what portion of a worker's injury or illness is legally attributable to the worker's industrial injury or illness and, consequently, to the employer.

Bill – The submitted request for payment for a medical or pharmaceutical product or service provided. In the context of workers' compensation the concepts "bill" and "claim" are not interchangeable.

Bill Review – The evaluation and adjudication of pharmaceutical services bills for appropriateness of reimbursement including, but not limited to, medical necessity and prevailing or mandated rates of reimbursement (fee schedules), duplication of charges, unbundling of charges, medical relatedness of services to compensable injury or illness, and any other prevailing adjudication criteria that may apply. Also referred to as bill screening or bill audit.

Claim – A claim in the workers' compensation context represents an injury or an illness arising out of a work related event. A claim covers: medical bills, loss of wages, and other expenses as a result of an injury/illness.

Claim Number – A number assigned by the insurance carrier, self-insured employer and/or jurisdiction (e.g., workers' compensation board or division) to identify a specific claim for an injury. A particular claim may have two claim numbers associated with it: one assigned by the payer and the other by the jurisdiction.

Claimant – Injured worker/employee (injured while at work) who has filed a workers' compensation claim.

Compensable – Eligible for, or subject to, compensation for a bodily injury or illness.

Compound – A pharmaceutical product that results from the combining, mixing, or altering of one or more ingredients, excluding flavorings, to create a customized medication (not typically produced by a manufacturer) for an individual patient in response to a licensed practitioner's prescription.

Controverted – A disputed workers' compensation claim.

Date of Injury (DOI) – The date the employee was injured or contracted an illness while on the job as identified in reports to the jurisdiction and confirmed by the insurer.

Denied Claim – A claim in which the insurance company believes the injury or illness is not covered by workers' compensation.

Denied Service – A service which is deemed non-compensable based on the nature of the claimant's injury or illness, or contradicted by established treatment protocols, or as permitted by the relevant jurisdiction's statutes or regulations.

Division/Department of Worker's Compensation (DWC) – Government entity that monitors and enforces the administration of workers' compensation claims, and provides administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers'

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

compensation benefits. May also be referred to as a Bureau, Board or other type of governmental body.

Eligibility – A determination by the carrier/payer that the individual is entitled to receive benefits based on a claim for a compensable injury/illness. Eligibility does not guarantee payment.

Explanation of Benefits (EOB) – A summary statement (paper or electronic) that explains medical bill payment, adjustment and/or the reason for denial of specific charges. May also be referred to as an Explanation of Review (EOR), Explanation of Bill Review (EOBR), Explanation of Medical Benefits (EOMB) or other similar term.

Fee Schedule – A defined table/set of allowable fees per service/item (usually a maximum) promulgated by law or the jurisdictional workers' compensation agency's rules.

Formulary – A list(s) of brand name and generic drugs chosen, often based on safety, medical effectiveness and/or cost effectiveness. Formularies in workers' compensation may be injury/illness-specific and/or established by jurisdictional rules. Drugs not included on a formulary typically require preauthorization or prospective utilization review by the payer.

FROI – First Report of Injury

Generic Mandate – A jurisdictional requirement for prescribers to prescribe and/or dispensers to dispense a therapeutically equivalent generic drug in place of a brand name drug, often for cost-containment purposes. Dependent on particular jurisdictional requirements, a brand name drug may at times still be permitted to be prescribed and/or dispensed based on medical necessity, specific direction from the prescriber, unavailability of the generic equivalent, or where permitted at the specific request of the claimant who will be responsible for paying the difference in cost between the brand and generic.

Jurisdiction – The governmental entity (federal or state) with legal authority over the workers' compensation claim.

Medical Necessity – A determination that certain services/items are medically necessary for the treatment of a specific condition or combination of conditions relative to a particular patient. Entails an individual assessment rather than a general determination of what works in the ordinary case.

Original/Underlying NDC – The original manufacturer/labeler's established national drug code for the drug actually used in a repackaged or compounded product.

Payer – An entity that assumes the risk of paying for medical treatments. This can be a self-insured employer, a workers' compensation insurance carrier, or another third party (health care plan or health maintenance organization) ultimately responsible for payment under given circumstances.

Pharmacy Benefit Manager (PBM) – An entity, other than a pharmacy, pharmacist, or third party biller that acts as an administrator or processor in connection with workers' compensation pharmacy benefits. PBM services may include any of the following: retail network administration; mail service pharmacy; or patient compliance, therapeutic intervention, and generic substitution programs. PBMs generally contract with both the pharmacy and the insurer (payer). Dependent on specific contractual agreements, transactional relationships, and business models, a PBM may be considered either a bill submitter or a bill receiver in a given transaction.

Physician Dispensing – Used for when a physician provides a patient, on an outpatient basis (not administered or in conjunction with an office or surgical procedure), a medication supply (other than a free sample) from their office.

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

Repackaged Drug – A drug that FDA-approved repackagers have purchased in bulk and repackaged (often into individual prescription sizes) and assigned a new NDC.

Return to Work (RTW) – Phrase used in relation to an injured or ill employee who has reached substantial medical improvement to be able to return to the position for which the employee was hired with either no workplace modifications or restrictions, or with permanent workplace modifications or restrictions that are not essential to the job function for which the employee was hired.

Statement of Medical Necessity – A written statement and supporting documentation from the ordering/prescribing physician to establish the medically appropriate need for the ordered/prescribed treatments, services, or items.

Timely Filing – Specific time frame set forth by a jurisdiction to submit a bill for services rendered.

Third Party Administrator (TPA) – An organization that administers insurance claims, bills or certain aspects of workers' compensation plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures coverage for its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA.

Third Party Biller – An entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, receive reimbursement, and seek medical dispute resolution for the health care provider services billed, as permitted by an individual jurisdiction. A third party biller may "purchase" a given service from the provider and take on the risk associated with recouping payment from the responsible payer. May also be referred to as a billing agent, processing agent, factoring agent or assignee.

Treatment Guidelines – Established and effective treatment protocol(s) intended to assist in the provision of medical treatment by offering an analytical framework for the evaluation and treatment of an injured worker, in order to achieve the best medical outcome based on scientific medical evidence. Some jurisdictions have adopted existing national treatment guidelines; others have established state-specific guidelines.

Usual and Customary (U&C) – Often dependent on jurisdictional requirements, may mean either the usual and customary amount charged by a particular provider for a particular health care service or product to the general public; the average of such charges for all providers in a particular geographical area for the same specific service or product; or other jurisdiction specific methods of calculating U&C.

Utilization Review (UR) – Evaluation to determine the medical necessity for medical treatments. It includes prospective, concurrent and/or retrospective review of treatments. Utilization review may be defined and regulated by a given jurisdiction.

Utilization Review Entity – An organization (may be a private vendor, a carrier or its affiliate, a self-insured employer, a third-party administrator, a group fund, or a state agency) that provides utilization review.

Workers' Compensation Coverage – A form of "no-fault insurance" that most jurisdictions require employers to carry to cover employees for on-the-job injuries/illnesses. Employers may self-insure or

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

purchase workers' compensation insurance. Some jurisdictions administer workers' compensation claims on behalf of employers (called "state funds").

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

C. ACRONYMS

Acronym	Spelled Out
ACOEM	American College of Occupational and Environmental Medicine
BR	By Report
CARC	Claim Adjustment Reason Code
COB	Coordination Of Benefits
DOI	Date Of Injury
ECL	External Code List
EOB	Explanation Of Benefits
EOBR	Explanation Of Bill Review
EOMB	Explanation Of Medical Benefits
EOP	Explanation Of Payment
EOR	Explanation Of Review
FROI	First Report Of Injury
FS/SFS	Fee Schedule/State Fee Schedule
IAIABC	International Association of Industrial Accident Boards and Commissions
IBR	Independent Bill Review
IME	Independent Medical Exam(iner)
IMR	Independent Medical Review
JCN	Jurisdiction Claim Number
MMI	Maximum Medical Improvement
MPN	Medical Provider Network
MSA	Medicare Set-Aside
MTG	Medical Treatment Guidelines
MTUS	Medical Treatment Utilization Schedule
NCCI	National Council on Compensation Insurance
ODG	Official Disability Guidelines
PBN	Pharmacy Benefits Network
PWP	Pay With (or Without) Prejudice
RARC	Remittance Advice Remark Code
RFA	Request For Authorization
RTW	Return To Work
SBR	Second Bill Review
SMN	Statement of Medical Necessity
SOJ	State Of Jurisdiction
SROI	Subsequent Report Of Injury
U&C	Usual And Customary
UCR	"Usual, Customary and Reasonable"
UR	Utilization Review
URA	Utilization Review Agent
WC	Workers' Compensation
WC-HCN	Workers' Compensation Health Care Network
WC/PC UCF	Workers' Compensation/Property & Casualty Universal Claim Form

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

WCRI	Workers' Compensation Research Institute
------	--

II. FREQUENTLY ASKED QUESTIONS

QUESTION 1: Florida requires submission of the pharmacist's state license number in addition to the pharmacy's NPI number. How do I handle submitting the pharmacist's license number?

Paper Billing – Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Instructions:

NCPDP has approved Florida's use of Jurisdictional Field 57 on the WC/PC UCF Form as the location for the pharmacist's state license number. Field 58 should be used for the designated qualifier code "Ø7" (State Issued - unique identification number issued by a state program or organization other than Medicaid) to a provider of service.

Electronic Billing - Telecommunication D. Ø instructions:

The Pharmacy Provider Segment, field Provider ID (444-E9) is to be used to report the pharmacist's state license number. Field Provider ID Qualifier (465-EY) is to be used to report the qualifier code "Ø7".

QUESTION 2: I am submitting a bill for a repackaged medication and my jurisdiction is requiring the innovator or manufacturer's original NDC number to be submitted in addition to the NDC for the repackaged medication. How do I properly submit that information?

Paper Billing – Workers' Compensation/ Property & Casualty Universal Claim Form (WC/PC UCF) Instructions:

NCPDP has approved the following standard billing methodology when there is a jurisdictional requirement to submit the original NDC number. The jurisdiction requiring the submission of an original or underlying NDC should indicate in their implementation guide that the jurisdictionally defined Field 61 on the WC/PC UCF is designated as the location for the original manufacturer or innovator NDC.

Electronic Billing - Telecommunication D. Ø instructions:

NCPDP has approved the use of these existing fields in the NCPDP Telecommunication Standard version D.Ø to submit the original NDC number:

- Originally Prescribed Product/Service ID Qualifier (453-EJ) value of "Ø3" (National Drug Code (NDC))
- Originally/underlying Prescribed Product/Service Code (445-EA) contains the actual (original) NDC

The Product/Service ID Qualifier (436-E1) contains the value of "Ø3" (National Drug Code (NDC)) and Product/Service ID (4Ø7-D7) contains the actual dispensed (repackaged) NDC.

QUESTION 3: How do I as a physician bill for a drug I dispense on the WC/PC UCF?

Answer: The WC/PC UCF contains designated fields for both the prescriber (Fields 40-48) and the pharmacy (Fields 32-39). It is recommended that a physician dispenser complete the fields for pharmacy entering their information in the section designated for Pharmacy, including their ID as required by the jurisdiction in Field 32. If the physician is also the prescriber, also complete the information in the Prescriber Section of the form, including their ID as required by the jurisdiction in Field 40.

III. DETAILED GUIDANCE

A. ***WORKERS' COMPENSATION – BRAND/GENERIC SELECTION AND INVOICING WHEN BOTH THE BRAND AND GENERIC NDCs AND THEIR COSTS MUST BE PRESENT***

1. **Background**

In workers' compensation the rules promulgated in the various state jurisdictions dictate how pharmacy services/prescriptions should be fulfilled. Some of these regulations have not taken into consideration the real-time process or other complexities of pharmacy services/prescription processing.

More specifically, some jurisdictions have passed generic-only dispensing for workers' compensation bills unless the physician specifically writes "brand medically necessary" upon the prescription. (The pharmacy would this indicate by sending a DAW code value of 1.) Taking into consideration some rights of the injured worker (patient), a number of these same jurisdictions, have allowed for the injured worker to select the brand name drug, when not specified medically necessary, and have advised that the injured worker must pay the cost difference between the brand dispensed and the generic that would have been dispensed. (The pharmacy would indicate by sending a DAW code value of 2.) Additionally, not all billing rules in these particular states are specific in detailing how the billing for these types of transactions should be completed. Some state rules detail that the pharmacy must invoice showing the brand NDC that was dispensed and its cost, the generic NDC that would have been dispensed and its cost, and the amount paid by the injured worker - leaving the amount due from the payer. The payer could be a third party entity (biller, PBM, TPA) or the insurance carrier directly, dependent upon jurisdictional requirements and specific business relationships and agreements.

The intent of this section of the document is to provide some guidance to the pharmacy services industry on how to bill for this scenario both electronically and through paper invoicing when utilizing the NCPDP standards.

2. **Pricing the Patient Selected Branded Drug**

There is an underlying theme of selecting the lowest-priced therapeutically equivalent generic for pricing purposes when the patient opts for the brand name drug versus the generic equivalent. For electronic transactions, NCPDP Work Group 16 recommends the following to complete the transaction:

Generic medication prescribed – Brand medication dispensed

Using either the NCPDP Telecommunication Standard D.Ø or the Workers' Compensation/Property and Casualty Universal Claim Form (WC/PC UCF), the pharmacy should submit the following data. (Valium and Diazepam are being used within the example. The dollar values detailed below are not meant to represent true market data.)

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

D.Ø Transaction

Claim Segment			
Field ID	Field Name	Example	General Notation about Field(s)
4Ø7-D7	Product/Service ID	00140-0006-35	Brand drug dispensed – Valium
4Ø8-D8	Dispensed as Written	2	DAW2 – Patient Selected Brand
445-EA	Originally Prescribed Product/Service Code	00228-2053-10	Generic prescribed drug - Diazepam
Pricing Segment			
Field ID	Field Name	Example	General Notation about Field(s)
4Ø9-D9	Ingredient Cost Submitted	.55	Cost of 1 tablet of Valium
412-DC	Dispensing Fee Submitted	4.00	
433-DX	Patient Paid Amount Submitted	.50	Cost difference between Valium and Diazepam
43Ø-DU	Gross Amount Due	4.55	

These examples do not show the exact data transmitted which must include the proper format and overpunch requirements. See the NCPDP *Telecommunication Standard* for requirements.

WC/PC UCF

The WC/PC UCF does not have a field defined to support the Generic Equivalent Product ID. State-specific assigned Jurisdictional Fields are used to report the Generic prescribed drug. For more information see Section II of this document and the NCPDP *Manual Claim Forms Reference Guide*.

Claim Section			
			General Notation about Field(s)
69	Product/Service ID	00140-0006-35	Brand drug dispensed – Valium
73	Dispensed as Written	2	DAW2 – Patient Selected Brand
57-61 as assigned	Generic Equivalent Product ID	00228-2053-10	Generic prescribed drug - Diazepam
Pricing Segment			
			General Notation about Field(s)
102	Ingredient Cost Submitted	.55	Cost of 1 tablet of Valium
103	Dispensing Fee Submitted	4.00	
107	Patient Paid Amount Submitted	.50	Cost difference between Valium and Diazepam
106	Gross Amount Due	4.55	

B. ASSIGNMENT OF JURISDICTIONAL FIELDS

The Jurisdictional Fields (Fields 57 through 61) in the NCPDP Workers' Compensation Property and Casualty Universal Claim Form (WC/PC UCF) were developed to accommodate state-specific billing requirements for workers' compensation pharmacy services that are not otherwise supported in a specific field. Jurisdictional Field use is determined and assigned by NCPDP to maintain standard content and submission and allow consistent reporting and processing of the data.

As new state regulations are proposed, billing requirements that cannot be accommodated in the standard NCPDP Telecommunication Standard Version D.0 and WC/PC UCF need to be brought to NCPDP for review and assignment of an appropriate state-specific jurisdictional field. Ideally the state/jurisdiction or the International Association of Industrial Accident Boards and Commissions (IAIABC) on behalf of the state/jurisdiction would consult with NCPDP (and other standards development organizations) as regulations are being developed to assure that the data requirements can be accommodated. In absence of that consultation, any individual aware of the requirement is encouraged to bring the request/business requirement forward to NCPDP WG16 Property & Casualty/Workers' Compensation. The request may be in the form of memo or submission of a Data Element Request Form (DERF). See <http://www.ncdp.org/Standards/Standards-Development-Process>.

1. Work Group Review of the Request

Upon receipt, WG16 will review the request for use of a Jurisdictional Field to determine the optimum solution for the data requirement. WG16 will:

- a. Notify the state/IAIABC of the requested review and invite their participation in defining the solution.
- b. Verify whether the requesting state has available jurisdictional fields.
- c. Determine whether the data can be accommodated in the current electronic and/or paper billing formats.
- d. Determine through review of state regulations and by outreach to multiple states whether the data need is common to them, and if so
 - i. Do the states have a shared jurisdictional field assignment
 - ii. Is the requirement becoming universal so that a permanent solution is needed
 - iii. Is the data requirement billing/payment related, and if not, are there alternate ways of providing the data.
- e. Approve or deny the request at the next quarterly NCPDP Work Group meetings.
- f. Inform the submitter of the decision. If approved, inform the state(s)/IAIABC of the solution including the DERF process and timeline before the solution might be available for implementation.

2. Solution

Once it has been determined that the request is appropriate and additional data specification is needed for the paper and/or electronic billing formats, WG16 will determine the optimal technical solution, create/revise the DERF and move it through the NCPDP process.

- a. If a single state issue, and
 - i. there is no alternative for providing the data, and

NCPDP Work Group 16 Guidance for the Workers' Compensation Industry

- ii. the state has open Jurisdictional Fields,
initiate a Data Element Request Form (DERF) to assign a Jurisdictional Field and update the *NCPDP Manual Claim Forms Reference Implementation Guide*.
 - b. If the requesting state
 - i. has no other Jurisdictional requirements, and
 - ii. the requirement is a multi-state issue and those states have no other Jurisdictional requirements,
initiate a DERF to assign the state(s) to a shared Jurisdiction field and update the *NCPDP Manual Claim Forms Reference Implementation Guide*.
 - c. If the requesting state
 - i. has shared Jurisdictional requirements, and
 - ii. the requirement is applicable to those states in that shared requirement,
initiate a DERF to assign a new Jurisdictional field to the shared requirement and update the *NCPDP Manual Claim Forms Reference Implementation Guide*.
 - i. the requirement is NOT applicable to those states in that shared requirement,
initiate a DERF to remove the state from the shared Jurisdiction field, assign the state the previous fields and a new Jurisdictional field and update the *NCPDP Manual Claim Forms Reference Implementation Guide*
 - d. If the data requirement is becoming universal then, based on the urgency
 - i. Short Term – assign to a jurisdiction field as above for use until a permanent solution is developed and adopted.
 - ii. Long Term – explore solution for making the data element available to all states
 - e. If the requirement is not billing related and there are other mechanisms for reporting
 - i. Deny the request
 - ii. Inform the state/IAIABC of the alternative mechanism
 - f. Notify the state(s)/IAIABC of the resolution
 - i. Jurisdictional Field assigned
 - ii. Long term solution being pursued if appropriate

3. Long Term and/or Electronic Solution

If a long term and/or electronic solution are determined to be needed, WG16 will engage WG1 Telecommunication to assist in determining the best technical solution for accommodating the business requirement. Possible solutions will be communicated to the IAIABC, state agencies and industry for comments. Once a solution has been agreed to, a DERF will be initiated to incorporate the technical solution into the *NCPDP Manual Claim Forms Reference Implementation Guide* and *Telecommunication Standard* (if applicable). The state(s)/IAIABC will be informed of the time frames for the adjudication process and how to participate. The modifications will go through the NCPDP ballot process (<http://www.ncpdp.org/Standards/Standards-Development-Process>). Once the ballot process is complete the state(s)/IAIABC will be informed of the outcome and effective date of the change.

BRUYNS Fred H * DCBS

From: Karen Ritchie <Karen.Ritchie@mitchell.com>
Sent: Thursday, February 26, 2015 11:50 AM
To: Bruyns Fred H (fred.h.bruyns@state.or.us)
Cc: Miriam Encarnacion; Mercedes Hudgins
Subject: RE: Questions to Oregon Workers' Compensation Board - TESTIMONY

Please accept the following questions comments with regard to proposed changes for Oregon 436-009

Question 1:

In reference to section 436-009-0040 Section (3) (d) Nurse Practitioners or physician assistants:

When Nurse Practitioner or Physician assistants act as surgical assistants, they must apply modifier '81'. We are recommending/requesting the industry standard HCPCS Level II modifier 'AS' be applied. Modifier -81 is typically used by physicians when acting as an assistant at surgery. The modifier AS description reads:

AS- Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery.

Question 2:

Section 436-009-0020 (1) (b) (A):

Mitchell is proposing the following:

For dates of **discharge** prior to Oct. 1, 2015, ICD-9-CM codes, and on or after Oct. 1, 2015, ICD-10-CM codes...

See Link below to support to support Mitchell's proposal.

<https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10MythsandFacts.pdf>

436-009-0020 Hospitals**(1) Inpatient.**

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes; and on or after Oct. 1, 2015, ICD-10-CM codes;

(B) When applicable, procedural codes;

(C) The hospital's NPI; and

(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.

Question 3:

Regarding Appendix B – “Global Days”:

- Currently Appendix B indicates global period of 0-10-90 days. Please advise the source for determining the global period. Is the global period as defined in Appendix B different than global days as published by CMS (Medicare).

Karen Ritchie | Sr. Manager, Regulatory Affairs

Mitchell International, Inc. | (o) 858.368-8305 | (c) 951-906-2279 | e: karen.ritchie@mitchell.com | www.mitchell.com