

# Agenda

## Rulemaking Advisory Committee

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

<b>Type of meeting:</b>	Rulemaking advisory committee
<b>Date, time, &amp; place:</b>	Nov. 17, 2016, 9:00 a.m. to Noon, Pacific Standard Time Oregon-OSHA (Durham) office, PFO Training Room 16760 SW Upper Boones Ferry Rd, Ste 200 Tigard, OR 97224 Teleconference: 1-213-787-0529   Access code: 9221262#
<b>Facilitator:</b>	Fred Bruyns, Workers' Compensation Division
<b>9:00 to 9:10</b>	Welcome and introductions; meeting objectives
<b>9:10 to 10:30</b>	Discussion of issues
<b>10:30 to 10:45</b>	Break
<b>10:45 to 11:45</b>	Discussion of issues continued New issues?
<b>11:45 to 11:55</b>	Summing up – next steps – thank you!

Attached: [Issues document](#)

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

**Issue # Standing**

**Rule: OAR 436-009-0004 and Appendices B - E (Temporary rule, effective January 1, 2017)**

**Issue:** Should WCD issue a temporary rule, effective January 1, 2017, adopting the new CPT codes for 2017. Should WCD assign maximum payment amounts to CPT and HCPCS codes in Appendices B – E, where possible?

**Background:**

- The American Medical Association publishes new CPT codes, effective January 1, 2017.
- CMS publishes Medicare fee schedule amounts for these CPT codes, also effective January 1, 2017.
- Additionally, CMS publishes a new DMEPOS fee schedule, effective January 1, 2017 that may contain new HCPCS codes.
- In order to allow time for public input, WCD has published a new physician fee schedule (Appendix B), new ASC fee schedules (Appendices C and D), and a new DMEPOS fee schedule (Appendix E), effective April 1 of each year.
- This prohibits providers from using the latest set of codes for workers' compensation billings and forces insurers to return bills as unpayable if provides use new codes between January 1 and April 1.
- Adopting the new CPT and HCPCS codes would simplify billing for providers and wouldn't force insurers to return bills as unpayable due to invalid new codes.
- For those new codes that CMS publishes relative value units (RVUs) or payment amounts, WCD could update appendices B – E, effective Jan. 1, 2017, and assign maximum payment amounts using the 2016 conversion factors/multipliers. One should bear in mind that due to time and staffing restraints, it may not be possible to update all appendices.

**Options:**

- Adopt new CPT codes through a temporary rule, effective January 1, 2017.
- Update appendices B – E with payment amounts for new codes using the 2016 conversion factors/multipliers, where possible.
- Not issue a temporary rule.
- Other?

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

**Recommendations:**

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

**Issue # Standing**

**Rule:** OAR 436-009: Appendices B through E

**Issue:**

- Should WCD update the fee schedule amounts listed in:
  - 1) Appendix B (Physician fee schedule amounts)
  - 2) Appendix C (ASC fee schedule amounts for surgical procedures)
  - 3) Appendix D (ASC fee schedule amounts for ancillary services)
  - 4) Appendix E (DMEPOS fee schedule amounts)

**Background:**

- The above listed appendices are based on conversion factors and multipliers developed by DCBS, and on values and fee schedule amounts listed in spreadsheets published by the Centers for Medicare & Medicaid Services (CMS). In particular:
  - 1) Appendix B is based on the CMS file *RVU16A*, effective January 2016. We expect that CMS will publish the file containing the 2017 RVUs sometime in November 2016.
  - 2) Appendix C is based on spreadsheets published by CMS in CMS-1633-FC. We expect that CMS will publish CMS-1656-FC, containing the 2017 ASC fee schedule amounts, in November 2016.
  - 3) Appendix D is based on spreadsheets published by CMS in CMS-1633-FC. We expect that CMS will publish CMS-1656-FC, containing the 2017 ASC fee schedule amounts, in November 2016.
  - 4) Appendix E is based on the CMS file *DME16-A*, effective January 2016. We hope that CMS will publish the file containing the 2017 DMEPOS fee schedule sometime in November.
- Every year, there are some CPT<sup>®</sup> and HCPCS codes that are deleted and some new codes are introduced. Updating Appendices B through E allows us to stay current with valid CPT<sup>®</sup> and HCPCS codes.
- Every year, DCBS develops updated conversion factors and multipliers taking into account utilization of medical services and the new values and fee schedule amounts developed by CMS.

**Options:**

- Update appendices A through E using more current CMS spreadsheets.
- Other?

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

**Recommendations:**

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

**Issue # 1226**

**Rule: OAR 436-009-0010(9)(a)**

**Issue:** Should OAR 436-009-0010(9)(a) clarify that a medical provider must not attempt to collect payment for any medical service from an injured worker?

**Background:**

- Prior to April 1, 2014, OAR 436-009-0015(1) stated that an injured worker 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. A medical provider must not attempt to collect payment for any medical service from an injured worker, except as follows: ... (*Emphasis added*)
- The above section was moved to OAR 436-009-0010(9) and modified, effective April 1, 2014. Current OAR 436-009-0010(9)(a) states that 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: ...
- While the meaning of OAR 436-009-0010(9) [formerly OAR 436-009-0015(1)] has not changed, it may be helpful to clearly state that a provider may not attempt to collect payment from a worker for treatment related to the accepted injury.

**Options:**

- Change OAR 436-009-0010(9) to: 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,~~ **and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows: ...**
- No change.
- Other?

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

**Recommendations:**

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

**Issue # 1225**

**Rule: OAR 436-009-0020(5)(g) and Bulletin 290**

**Issue:** Should the director publish updated Bulletin 290s, listing hospitals cost-to-charge ratios, only once a year instead of twice a year?

**Background:**

- Bulletin 290 – the Hospital Fee Schedule is updated twice each year with new cost-to-charge ratios effective April 1 and October 1.
- Bulletin 290 is the only one of the several different medical fee schedules that changes on a date other than April 1.
- The revision of a hospital’s cost-to-charge ratio in the April or October bulletin is based on timing of the hospital’s fiscal year. When hospitals change their fiscal year end dates, they often also change the timing of their fee schedule changes. Approximately half of hospitals are updated in the October 1 bulletin. However, certain formulaic parameters applying to all hospitals change with the April 1 bulletin, so the cost-to-charge ratios for all hospitals are affected. This leads to confusion among stakeholders and possibly delays payment and unnecessarily complicates the fee schedule process.
- Updating Bulletin 290 for all hospitals once a year, effective April 1, would make the timing of the hospital fee schedule changes consistent with all other medical fee schedule changes.

**Options:**

- Update Bulletin 290 for all hospitals once per year, effective April 1, i.e., eliminate the October Bulletin.
- No change.
- Other?

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

**Recommendations:**

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

**Issue # 1235**

**Rule: OAR 436-009-0025**

**Issue:** Should the director establish a timeframe for an insurer to reimburse a worker after reimbursement is determined to be due to a worker as a result of litigation, e.g. after the Medical Resolution Team (MRT) determines that insurer is liable for a worker's out-of-pocket expenses.

**Background:**

- OAR 436-009-0025(2)(d) contains detailed timeframes for insurers to issue reimbursement after compensability of the claim is determined. However, there are no timeframes in OAR 436-009-0025 regarding reimbursement when litigation does not involve compensability of the claim, such as when the MRT determines that an insurer is liable for reimbursement for a worker's out-of-pocket expenses.
- OAR 436-009-0030(3) contains a provision for payment of medical bills after litigation of the medical services:
  - (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.
- The director proposes to have a provision similar to OAR 436-009-0030(3)(d) in OAR 436-009-0025(2).

**Options:**

- Add the following provision to OAR 436-009-0025(2):

**(new) Worker reimbursement is required within 14 days of any action causing the service to be payable, or within 30 days of the insurer's receipt of the reimbursement requests, whichever is later.**

- No change.
- Other?

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

**Recommendations:**

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

**Issue # 419**

**Rules: OAR 436-009-0030**

**Issue:** Should the division 009 rules contain a provision requiring an insurer obtains provider consent regarding issuing payment to providers through electronic fund transfer (EFT) system, automated teller machine card or debit card, or other means of electronic transfer?

**Background:**

- Over the past year, the medical resolution team (MRT) has seen a number of disputes involving electronic payments to providers. The division 009 rules have no provision regarding electronic payments to providers.
- The MRT noted that in the disputes before the MRT there is an additional expense to the provider when accessing electronic payments and providers are only given the opportunity to opt out after receiving payment as opposed to being asked whether they are willing to accept electronic payment beforehand.
- The division 060 rules contain regulation regarding electronic payments to workers:  
**436-060-0153 Electronic Payment of Compensation**
  - (1) An insurer may pay benefits through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the worker voluntarily consents. The worker's consent must be obtained prior to initiating electronic payments and may be written or verbal. The insurer must provide the worker a written confirmation when consent is obtained verbally. The worker may discontinue receiving electronic payments by notifying the insurer in writing.
  - (2) The worker must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued prior to or at the time the initial electronic payment is made.
  - (3) The instrument of payment must be negotiable and payable to the worker for the full amount of the benefit paid, without cost to the worker. The worker must be able to make an initial withdrawal of the entire amount of the benefit paid without delay or cost to the worker.

**Options:**

- Add the following provision to OAR 436-009-0030:

**(New) Electronic Payment.**

**(a)An insurer may pay a provider through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the provider voluntarily consents.**

**(A) The provider's consent must be obtained before initiating electronic payments.**

**(B) The consent may be written or verbal. The insurer must provide the provider a written confirmation when consent is obtained verbally.**

**(C) The provider may discontinue receiving electronic payments by notifying the insurer in writing.**

**(b) Cardholder agreement for ATM or debit cards.**

**The provider must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued before or at the time the initial electronic payment is made.**

**(c) Instrument of payment.**

**The instrument of payment must be negotiable and payable to the provider for the full amount of the benefit paid, without cost to the provider.**

- No change
- Other?

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

**Recommendations:**

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

**Issue # 424**

**Rule: OAR 436-009-0030(3)(b)**

**Issue:** Should OAR 436-009-0030(3)(b) contain a timeframe for the insurer to issue an EOB?

**Background:**

- OAR 436-009-0030(3)(a) states in part that insurers must pay bills within 45 days of receipt of the bill.
- However, there is no timeframe in OAR 436-009-0030(3)(b) for issuing an explanation of benefits:

**(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 EOB has the same meaning as an explanation of review (EOR).
- Generally, when an insurer issues a payment to a provider, the insurer also sends an EOB, i.e., the EOB is issued within 45 days.
- The director expects when an insurer denies payment, the insurer provides an EOB to a provider, and that such an EOB is issued within 45 days of receiving the bill.

**Options:**

- OAR 436-009-0030(3)(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied **within 45 days of receipt of the bill**. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).
- No change.
- Other?

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

**Recommendations:**

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

**Issue # 418**

**Rule: OAR 436-009-0040(2)**

**Issue:** Should WCD increase the maximum payment amount for anesthesiology services?

**Background:**

- This issue was raised by a stakeholder who stated: “This anesthesia rate has been in place since 2010. Unlike specialists reimbursed under an RBRVS system, anesthesia fees do not increase if the conversion factor doesn’t increase because the ASA RVU’s don’t shift every year the way that RBRVS RVU’s do. We request that the Work Comp division apply the same % increase to the anesthesia conversion factor that other specialists receive.”
- The division increased the overall maximum payment amounts for most physician services by 3%, effective April 1, 2016. However, the payment amounts for anesthesiology services were not raised.
- The stakeholder went on to say that the American Society of Anesthesiology provides a blinded conversion factor study each year by region. Currently the work comp division is reimbursing anesthesiologists 12% under the 2015 ASA commercial conversion factor median for the western region.
- The division estimates that a 3% increase in maximum payments for anesthesia services would increase total medical payments by \$136,000 or 0.05 % per year.

**Options:**

- Increase the conversion factor by 3% for anesthesia services from \$58.00 to \$59.74.
- No change.
- Other?

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

**Recommendations:**

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

**Issue # 1226**

**Rule: OAR 436-009-0040(6) and Appendix B**

**Issue:** Should the director increase the maximum payment amount for physical therapy and rehabilitation services or should the director increase the limit for modalities and therapeutic procedures per day for each provider from three to four?

**Background:**

- This issue was raised by a stakeholder who stated: “Raise our fees! Everything is going up. The cost of heating and maintaining a clinic, the wage the new PTs are demanding, insurance rates....I could go on and on.  
Or allow one more code. We always do 4-5 things. So we are losing on the rate AND the number of codes.”
- The division increased the overall maximum payment amounts for most physician services by 3%, effective April 1, 2016. However, the payment amounts for physical therapy services were not raised.
- Except for CPT<sup>®</sup> codes for the initial or re-evaluation (e.g., 97001, 97002, 97003, or 97004), payment for modalities and therapeutic procedures is limited to a total of three separate CPT<sup>®</sup>-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT<sup>®</sup> code does not count as a separate code.
- The limitation of three separate CPT<sup>®</sup>-coded services per day for each provider has been in place since January 1, 1997. It was implemented to support utilization guidelines and keep excessive physical therapy in check.
- The division estimates that a 3% increase in maximum payments for physical therapy and rehabilitation services would increase total medical payments by \$1,689,220 or 0.57% per year.

**Options:**

- Increase the maximum payment amount for physical therapy and rehabilitation services by 3 percent.
- Increase the limit for modalities and therapeutic procedures per day for each provider from three to four.
- No change.
- Other?

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

**Recommendations:**

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

**Issue # 420**

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

**Issue:**

- Should the division apply a yearly cost-of-living adjustment to the maximum payment amount for hearing aids listed in OAR 436-009-0080(10)?
- Should insurers have to pay for certain hearing aid accessories needed to keep up with daily life even if they are not medically necessary?

**Background:**

- OAR 436-009-0080(10) states that without approval from the insurer or director, the payment for hearing aids may not exceed \$7000 for a pair of hearing aids, or \$3500 for a single hearing aid.
- This issue was raised by a stakeholder who stated: “One minor suggestion for next year's consideration would be to emplace a cost-of-living adjustment [for hearing aids] so that you could avoid having to look at reimbursement as an issue in the future. As an example, if the consumer price index for Oregon increases by 2% in 2017, the reimbursement would change from \$3,500 to \$3,570 per aid, a small amount all things considered.”
- Effective April 1, 2016, the division increased the maximum payment amount without insurer or director approval from \$5000 to \$7000 for a pair of hearing aids and from \$2500 to \$3500 for a single hearing aid.
- Currently, the division does not apply an automatic cost-of-living adjustment to any fee schedule for medical services.
- The stakeholder states, “Another suggestion I made was to allow for certain accessories, which currently are only allowed if deemed "medically necessary." These include remote controls, Bluetooth interfaces, TV and remote microphone transmitters, and personal FM systems. While these accessories are rarely medically necessary, in a world of increasing communication demands using cell phones and other systems creates a non-medical need to keep up with daily life.”
- The stakeholder states, “I would, however, suggest that this not be in addition to the \$3,500 limit, but rather be cost-contained to be within the limit. As an example, if a client needed a Bluetooth interface (which generally retail for \$350), then this would come out of the \$7,000 a pair limit, leaving \$6,650 available for the hearing aid. This way, therefore, the cost would not increase to the insurance carrier but would allow for greater flexibility to outfit the worker with the equipment they need for daily life. An explanation for the need should still be required.”
- The Oregon Revised Statute states in relevant part that for every compensable injury the insurer shall cause to be provided medical services for conditions caused in material part by the injury. Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and when necessary, physical restorative services. (ORS 656.245(1))

**Options:**

- Apply a yearly cost-of-living adjustment to the maximum payment amount for hearing aids without insurer or director approval.
- Add language to OAR 436-009-0080(10) that states that an insurer has to pay for certain hearing aid accessories that are not medically necessary, but are needed to keep up with daily life, if the provider justifies the use of such accessories.
- No change.
- Other?

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

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

**Issue # 414**

**Rule: OAR 436-009-0090(2)(d)**

**Issue:** Should WCD establish a separate fee schedule methodology for pre-packaged pain pump refills?

**Background:**

- Providers purchase pain pump refills as pre-packaged syringes often containing compounded drugs.
- The pharmacy fee schedule (OAR 436-009-0090(2)(d)) provides that compound drugs be paid at 83.5% of the average wholesale price (AWP) for each individual ingredient plus a single compounding fee of \$10.
- The medical resolution team has seen several disputes where the insurer paid the provider according to OAR 436-009-0090(2)(d), which was less than what the provider paid for the pre-packaged drugs.

**Options:**

- Modify OAR 436-009-0090(2)(d) as follows?

Unless directly purchased by the worker (see 009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

<b>If the drug dispensed is:</b>	<b>Then the maximum allowable fee is:</b>
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
A compound drug	83.5 % of the AWP for each individual ingredient plus a single compounding fee of \$10.00 (The compounding fee includes the dispensing fee.)
<b><u>Pre-packaged pain pump refill</u></b>	<b><u>110% of the provider's actual cost documented on a receipt of sale</u></b>

- No change.

- Other?

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

**Recommendations:**

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

**Issue # 417**

**Rule: OAR 436-009-0090**

**Issue:** Should WCD develop rule language relating to insurers' use of pharmacy benefit managers (PBMs)?

**Background:**

- A stakeholder asked the division to bring this issue up at the next advisory committee.
- The stakeholder explained that PBMs essentially provide a worker with a pharmacy card which allows access to direct billing of medications at participating dispensaries.
- The stakeholder opined that the programs are generally beneficial for workers since most medications are dispensed without the need for "approvals," however, the problem he sees is with medications classified as "non-formulary," such as narcotics.
- Overall, PBMs seem to have a positive impact on the workers' comp system. It appears easier for workers to receive many prescribed medications without having to pay for them out-of-pocket and then request reimbursement from the insurer. Pharmacies are used to interacting with PBMs in private health.
- The division does not have direct jurisdiction over PBMs; rather, the division regulates insurers, and PBMs are viewed as an extension of the insurer.

**Options:**

- Add language to OAR 436-009-0090 relating to insurers' use of PBMs.
- No change.
- Other?

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

**Recommendations:**

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

**Issue # Standing (Housekeeping)**

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

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

**Background:**

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

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2015 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2015, 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<sup>®</sup> 2016), Fourth Edition Revised, 2015, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT<sup>®</sup> 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<sup>®</sup> Assistant, Volume 0, Issue 04 1990 through Volume 25, Issue 12, 2015. If there is a conflict between the CPT<sup>®</sup> manual and CPT<sup>®</sup> Assistant, the CPT<sup>®</sup> manual is the controlling resource.

(4) To get a copy of the CPT<sup>®</sup> 2016 or the CPT<sup>®</sup> 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<sup>®</sup> codes or that provide more detail than a CPT<sup>®</sup> 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](http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html).

(6) The director adopts, by reference, CDT 2016: 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](http://www.ada.org).

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

(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2015 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](http://www.nubc.org).

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – (5/2009). To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or on the Web at: [www.ncdp.org](http://www.ncdp.org).

- Each year the division reviews the above listed standards to assure that we are requiring the correct standards.

**Options:**

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

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

**Recommendations:**

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

**Issue # 1224 (Housekeeping)**

**Rule: OAR 436-009-0023(4)(e)**

**Issue:** The current fee schedule methodology does not establish a fee schedule amount when the cost of an implant is exactly \$100. Should OAR 436-009-0023(4)(e) clarify that when the cost of an implant is ***\$100 or more***, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale?

**Background:**

- OAR 436-009-0023(4)(e) provides that when the ASC's cost of an implant is more than \$100, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.
- Subsection (4)(f) provides that when the ASC's cost of an implant is less than \$100, insurers are not required to pay separately for the implant.

**Options:**

- Change OAR 436-009-0023(4)(e) to: When the ASC's cost of an implant is ~~more than~~ \$100 **or more**, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.
- No change.
- Other?

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

**Recommendations:**

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

**Issue # 1222**

**Rule: OAR 436-010-0210**

**Issue:** The director has received multiple inquiries from type B providers who did not get paid for their services because they have not certified to the director prior to providing services to workers. Should OAR 436-010-0210 contain language listing the statutory requirements and limitations for type B providers, similarly as OAR 436-010-0210(3) does for nurse practitioners?

**Background:**

- The statute provides the following requirements and limitations for chiropractic physicians, naturopathic physicians, and physician assistants (type B providers):
  - Prior to providing any compensable medical service or authorize temporary disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director. ORS 656.799(2).
  - Type B providers may assume the role of attending physician for a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first. ORS 656.005(12)(b)(B).
  - Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim. ORS 656.245(2)(b)(B).
  - Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability. ORS 656.245(2)(b)(C).
- The division 010 rules refer the reader to ORS 656.005(12)(b) when defining "attending physician," and the Matrix (Appendix A) lists the limitation regarding attending physician status, authorizing payment of temporary disability benefits, and making findings of impairment.
- The division 010 rules do not contain any provision regarding the certification requirement listed in ORS 656.799.
- While it is not essential to repeat statutory requirements in rules, it is more likely that a medical provider will look for provisions in administrative rules than in the Oregon revised statutes; hence listing the statutory requirements and limitations for type B providers in rule may increase compliance by these providers.

**Options:**

- Add the following rule language to OAR 436-010-0210:

**(New) Chiropractic Physicians, Naturopathic Physicians, Physician Assistants (Type B providers).**

**(a) Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director.**

**(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first.**

**(c) Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim to any type B provider.**

**(d) Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.**

- No change.
- Other?

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

**Recommendations:**