



<a href="#"><u>10</u></a>	Transcript of hearing: <a href="#"><u>A. Workers' Compensation Division</u></a> <a href="#"><u>B. Sandy Shtab, Healthsystems</u></a> <a href="#"><u>C. Kevin Tribout, Helios</u></a> <a href="#"><u>D. John Di Paola, M.D, Occupational Orthopedics</u></a>
<a href="#"><u>11</u></a>	Howard Tsang, M.D., Salem Occupational Health Clinic
<a href="#"><u>12</u></a>	John Di Paola, M.D., Occupational Orthopedics
<a href="#"><u>13</u></a>	Joan Takacs, DO, John Takacs, DO and Susan Schmitt, MD, Physical Medicine and Injury Rehabilitation
<a href="#"><u>14</u></a>	Allison Morfitt, SAIF Corporation
<a href="#"><u>15</u></a>	Mercedes Hudgins, Mitchell
<a href="#"><u>16</u></a>	Jaye Fraser, SAIF Corporation
<a href="#"><u>17</u></a>	Kim Ehrlich, Express Scripts, Inc.

**NOTES about the summaries of testimony:** Unless information is enclosed in brackets, it is the exact words from the testimony. However, if the author presented substantially similar testimony both orally and in writing, and the exhibit numbers for both the oral and written testimony are listed above the testimony, quoted text is extracted only from the written testimony.

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**Testimony: OAR 436-009**

***Exhibit 4***

“NCCI estimates that the proposed changes to the Oregon Workers Compensation Medical Fee Schedule, proposed to become effective April 1, 2016, would result in an overall impact of +0.5% (\$3.0M\* \* \*) on Oregon workers compensation system costs if enacted. \* \* \*”

“In Oregon, payments for physician services represent 53.4% of total medical payments. \* \* \* The estimated overall weighted average percentage change in MARs [maximum allowable reimbursements] is +1.7%. \* \* \* Since the overall average maximum reimbursement for physician services increased, NCCI expects that 88% of the increase would be realized on physician price levels (based on an assumed price departure of 0% \* \* \*). The impacts on physician payments, after the adjustment, is +1.5% (= +1.7% x 0.88). The above estimated impact on physician payments is then multiplied by the Oregon percentage of medical costs attributed to physician payments (53.4%) to arrive at the estimated impact of +0.8% on medical costs. The resulting impact on medical costs is then multiplied by the percentage of Oregon benefit costs attributed to medical benefits (57.1%) to arrive at the estimated impact on Oregon’s overall workers compensation system costs of +0.5% (\$3.0M).”

“\* \* \* The estimated overall weighted average percentage change in reimbursements for ASC

services is -0.5%. Since the reimbursements for ASC services decreased, NCCI expects that 50% of the decrease will be realized on ASC price levels. The estimated impact on ASC payments after applying the 50% price realization factor is -0.3%. The above estimated impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in Oregon (3.3%) to arrive at a negligible \* \* \* impact on medical costs and overall workers compensation costs.”

“\* \* \* The estimated overall weighted average percentage change in reimbursements for DMEPOS is -0.3%. Since the overall average maximum reimbursement for DMEPOS decreased, NCCI expects that 50% of the decrease would be realized on DMEPOS price levels. The estimated impact on DMEPOS payments, after the adjustment, is -0.2% (= -0.3% x 0.5). The above estimated impact on DMEPOS costs is then multiplied by the percentage of medical costs attributed to DMEPOS payments in Oregon (2.1%) to arrive at a negligible impact on medical costs and overall workers compensation costs.”

“\* \* \* The estimated overall percentage change in reimbursements for hearing aids is +40%. Since the overall average maximum reimbursement for hearing aids increased, NCCI expects that 88% of the increase would be realized on hearing aid price levels (based on an assumed price departure of 0%). The impacts on hearing aid payments, after the adjustment, is +35.2% (= +40% x 0.88). The above estimated impact on hearing aid costs is then multiplied by the percentage of medical costs attributed to hearing aid payments in Oregon (0.4%) to arrive at an estimated impact of +0.1% medical costs. The resulting estimated impact on medical costs is then multiplied by the percentage of Oregon benefit costs attributed to medical benefits (57.1%) to arrive at the estimated impact on Oregon’s overall workers compensation system costs of +0.1% (\$1.0M). \* \* \*.”

**Response:** Thank you for your testimony.

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**Testimony: OAR 436-009**

***Exhibit 14***

“The proposed fee schedule increases costs by approximately \$1.7 million. We assume WCD has thoroughly analyzed the physician reimbursement data that supports the fee schedule increase for these services.”

**Response:** Thank you for your testimony. WCD analyzes medical fee and payment data each year before proposing new fee schedule amounts.

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**Testimony: OAR 436-009**

***Exhibit 16***

“Since the rules may not be published until the third week in March, will WCD push the effective date? SAIF appreciates that WCD must consider the all the testimony it received, and may wish to amend the proposed rules. That said, SAIF is a bit concerned that there is quite a bit of programming that needs to be accomplished before the effective date for these rules. It will be tough with a mid-March publication date.”

**Response:** Thank you for your testimony. WCD expects to publish the final rules earlier than the third week in March and therefore the proposed effective date of 4-1-16 will remain.

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**Testimony: OAR 436-009-0004(9)**

***Exhibit 8***

“Helios would like to take this opportunity to recommend the Division update references to the NCPDP Manual Claim Forms Reference Implementation Guide in the rules to the most current

version published by NCPDP – which is version 1.4 (July 2015). Of particular note for this rule-making is that this latest version of the NCPDP implementation guide added instructions for how to bill a compound medication with more than seven ingredients (along with several other editorial changes). OAR 436-009 currently refers to version 1.2 after the table of contents describing where to order the implementation guide and version 1.3 in the actual adoption of standards under 436-009-0004. We recommend the Division update both of these parts of the rules to reference version 1.4 of the implementation guide.”

**Response:** Thank you for your testimony. WCD made the suggested changes.

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**Testimony: OAR 436-009-0004(9)**

***Exhibit 17***

“Express Scripts suggested revisions to proposed language:

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

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 ~~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.ncdp.org](http://www.ncdp.org).”

**Response:** Thank you for your testimony. WCD made the suggested changes.

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**Testimony: OAR 436-009-0010(3)(e)**

***Exhibit 14***

“Rather than clarifying the instructions, it appears that the proposed Oregon specific instructions for boxes 32, 32A are inconsistent with the national standards created by the NUCC. The national standard requires payers to complete these fields if the facility is not a component or subpart of the billing provider.”

**Response:** Thank you for your testimony. Over the last year, WCD has received several disputes regarding these fields, and it appears that the national standards instructions created by NUCC are not clear. The Oregon specific instructions are consistent with the EDI medical bill reporting requirements and WCD expects that the instructions as proposed will help clarify what’s expected on the provider’s bill. Therefore, WCD will implement this change as proposed.

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**Testimony: OAR 436-009-0020(1)**

***Exhibit 14***

“The proposed rule does not define “critical access hospital” (CAH). SAIF suggests WCD’s rules define CAH so that the payer may properly exclude CAHs from the DRGs.”

**Response:** Thank you for your testimony. WCD agrees with your testimony and we have added a reference to Bulletin 290 which identifies each critical access hospital in Oregon.

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**Testimony: OAR 436-009-0023**

***Exhibit 2, 10A***

“Appendix C contains the ambulatory surgery center (ASC) fee schedule amount for surgical procedures. The second column indicates whether a surgical procedure is subject to the multiple procedure discount. \* \* \* In the proposed 4-1-16 Appendix C, many procedures that are subject to the multiple procedure discount are listed erroneously as not being subject to the multiple procedure discount. WCD intends to correct this error in Appendix C when filing notice of the

permanent OAR 436-009 with the secretary of state. \* \* \*

**Response:** WCD changed Appendix C as indicated in this testimony.

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**Testimony: OAR 436-009-0030(3)**

***Exhibit 3***

“\* \* \* We respectfully request that the Division add a simple phrase to section 436-009-0030 under (3) Payment Requirements subsection (c) item (A).

(A) **The original amount billed and** 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; \* \* \*.”

**Response:** Thank you for your testimony. Currently there’s no evidence that payers do not list the original amount billed on an EOB. Therefore, WCD feels there’s no need to add language as proposed in your testimony. Please feel free to raise this issue at the next Division 009 advisory committee meeting.

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**Testimony: OAR 436-009-0040, Physician Fee Schedule**

***Exhibit 15***

“Regarding the proposed rule listed under the 436-009 Rule Summary: To Replace two laboratory HCPCS codes with seven new codes assigned by the Centers for Medicare and Medicaid Services (CMS): replace G0431 with G0480, G0481, G0482, and G0483; replace G0434 with G0477, G0478, and G0479.

“Reviewing CMS Clinical Lab Fee Schedule 2016 final determination document \* \* \*

“G0434 ➤ CMS supports New Code G0478 as a one to one crosswalk. Fees for the new codes replacing G0434 (G0477, G0478 and G0479) are derived by using multipliers of the fee for G0478.

“G0431 ➤ Does not appear to have a one to one crosswalk. Fees for the new codes replacing G0431 (G0480, G0481, G0482 and G0483) are derived by using multipliers of the fee for CPT code 82542 (Which is still valid and has its own CMS fee).

“Please confirm if Oregon is proposing to accept 82542 as a crosswalk to G0431?”

**Response:** Thank you for your testimony. For the fee schedule amounts of the new codes, we used WCD’s fee schedule amount of G0434 and applied the multipliers suggested by CMS for the codes G0477, G0478 and G0479 as you describe. For codes G0480, G0481, G0482 and G0483, we used CMS’ lab fee schedule amount for code 82542 as the basis only and then used multipliers for WCD’s fee schedule amounts. Keep in mind that we have not adopted CMS’ lab fee schedule per se.

We are not proposing the crosswalk of 82542 to G0431 because we generally don’t tell providers what specific code they have to use. Instead, we refer them to CPT guidelines for the use of CPT codes. That means providers may use code 82542 as a crosswalk to G0431 if code 82542 correctly describes the service provided. Our fee schedule for CPT code 82542 is 80% of billed.

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**Testimony: OAR 436-009-0060(2)**

***Exhibit 5***

“As a provider who performs closing examinations on a regular basis, \* \* \* I am concerned regarding some of the proposed reimbursement changes.

“First, I would agree that changes need to be made. Some closing exams can be very basic, but

others very complex. \* \* \*

“The majority of closing examinations are for one body part. \* \* \* the proposed reimbursement fee for one body part has plummeted from the current fee schedule (\$476 for non-AP exam and \$264 for AP exams). The new proposal would reimburse \$250 for non-AP exams (price includes report). This would pay less than what a current level 4 (99204) evaluation would be reimbursed, and yet the closing exam would require much more attention to issues not necessarily dealt with in a regular initial evaluation.

“I also have the same concern for the 1 body part exam for AP exams, also paying less than what a current level 4 follow up exam pays. I have some concerns regarding the proposal for 2-3 body part exams, albeit not as much as the proposal for 1 body part exams.

“If this proposal goes through as currently stated, I would no longer find it cost effective to offer to do closing exams on patients. This will likely lead to a significant increase in IME's for the purpose of claim closure, which can be costly and time delaying.

“The only way I would consider the current cost proposal to be cost effective would be if the closing exam requirements were only to provide impairment measurements but no longer opinions on appointment/causation, work limitations, and future treatment. In this scenario, the chart review, no matter how large the chart, could be substantially abbreviated.”

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

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**Testimony: OAR 436-009-0060(2)**

*Exhibit 7, 10D (Supporting testimony is listed below.)*

[See also the spreadsheet attached to the unabridged testimony.]

“The proposed changes to the Medical Fee Schedule for closing examinations are inappropriate and short sighted which will lead to strongly negative impacts on all stakeholders. The financial impact on providers (especially those who are most committed to the Workers' Compensation system and the injured workers it serves) is strongly negative and dis-incentivizes treating physicians from choosing to meet the requirements delineated by the Director \* \* \* and the carriers \* \* \*

“First of all, the proposed fees appear to only reimburse for an impairment exam and a report, which is insufficient to meet the requirements for closure. This will lead to added administrative costs, either by narrative requests and phone conferences with providers, or by an increase in the number of requests for Arbitrator Exams to meet the requirements for closure; all at an added expense to the carrier. The notion that the treating physician can accurately answer the requirements of the closing exam without reviewing the chart is totally erroneous given the fact that physicians in full time practice typically have 200-300 active patients at any given time. The value of that service is borne out by the reimbursement for Narrative Requests (\$116.28 for up to five responses/ \$231.88 for over five responses). It can be argued that since the requirements for closure beyond the impairment exam and report necessitates that more than five other items be

addressed then the reimbursement should reflect that.

“\* \* \* When comparing to the tiered form of reimbursement used in the Washington L&I where the requirements are limited primarily to an impairment examination which does not necessitate the added time and effort of a file review, the treating physicians’ fees are significantly more than that designated in the Oregon proposed rules \* \* \*. It is also notable that each tier of arbiter examinations, which have comparatively fewer issues requiring a response, are reimbursed significantly higher than the proposed fees \* \* \*. Currently, my practice "backs in" to the appropriate reimbursement by charging [such that net payment is what] \* \* \* we feel reflects the value of exactly the same information presented in exactly the same format using the methods required by law, based upon payments traditionally made in our region. We do not change the charge based on number of body parts. The reductions imposed by the proposed fees would impose significant losses to our practice income for the most frequently performed closing exams \* \* \*. Since most claims involve one or two body parts and the negative impact on providers would be substantial. The occasional gain for the rarely required Tier 3 closing exam would in no way come close to offsetting the significant losses from the more commonly performed Tier 1 & 2 exams. The value of the information required by the Director for claim closure and resolution should be comparable no matter what format it is presented: Oregon or Washington closing exam, Oregon Narrative Response, or Oregon Arbiter Exam. For those providers who are willing to meet this standard, they should be reimbursed appropriately. Maintaining appropriate reimbursement levels will encourage more providers to participate in the performance of closing exams and improve access to these services.

“The proposed rule has an immediate direct and devastating financial impact on those providers who are most involved in the delivery of medical care to injured workers in Oregon. It would disincentivize the very providers that the system relies upon the most to "make the system work.”

“Without an appropriate incentive to provide the mandated information, the payers would see a significant increase in the need to obtain Narrative Responses, to close active claims. It would delay the time to closure in many cases with potentially negative impact on the workers and potentially negatively impact the indemnity costs incurred by the payers.

“I have offered a potential solution by adding in the current value of N0002 to the current proposed fees and rounding out. Something close to this would produce no negative impact on any patients or stakeholders.”

Exhibit 9: “I am writing to endorse the testimony recently provided by John Di Paola MD, relating to closing examination reimbursement. Please add my support as a provider to the advocacy relating to this matter.”

Exhibit 11: “Dr. Howard Tsang has reviewed the attached testimony of Dr. Dipaola and supports his opinion completely.”

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

**Testimony: OAR 436-009-0060(2)**

*Exhibit 7, 10D (Supporting testimony is listed below.)*

“For those providers who do not provide an exam to meet the Legal standard for closing, they should not be able to successfully charge for a closing exam. They should be reimbursed with the appropriate office visit code and be required to either perform an appropriate exam or refer the patient for a closing examination. \* \* \* The Department should detail the requirements for a valid closing examination in the rules so that it is clear to providers what specific criteria must be met. Perhaps a sample template should be provided that would satisfy the criteria.

“This strategy shifts reimbursement away from those who are not providing a real closing exam to those that are. By not having to reimburse inadequate exams as closings, the overall financial impact on stakeholders would be neutral.”

Exhibit 9: “I am writing to endorse the testimony recently provided by John Di Paola MD, relating to closing examination reimbursement. Please add my support as a provider to the advocacy relating to this matter.”

Exhibit 11: “Dr. Howard Tsang has reviewed the attached testimony of Dr. Dipaola and supports his opinion completely.”

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

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**Testimony: OAR 436-009-0060(2)**

*Exhibit 12*

“Here is an example of a note from a provider that is not sufficient for a closing and does not sufficiently document to meet Directors requirements. Please include it in the exhibits.”

[Refer to unabridged testimony.]

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

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**Testimony: OAR 436-009-0060(2)**

*Exhibit 13*

“The proposed changes to the Medical Fee Schedule for closing examinations are inappropriate and short sighted which will lead to strongly negative impacts on all providers. The impact on providers who are most committed to the Workers' Compensation system and the injured workers it serves is strongly negative and dis-incentivizes treating physicians from choosing to meet the requirements delineated by the Director and the carriers. \* \* \* Without the appropriate information in the closing exam we feel there will be added administrative costs, either by narrative requests and phone conferences with providers, or by an increase in the number of requests for Arbiter Exams to meet the requirements for closure; all at an added expense to the

carrier. Currently, our practice charges [what] \* \* \* we feel reflects the value of exactly the same information presented in exactly the same format using the methods required by law, based upon payments traditionally made in our region (\$150.00 loss with the new proposal). We do not change the charge based on number of body parts. The reductions imposed by the proposed fees would impose significant losses to our practice income for the most frequently performed closing exams. Since most claims involve one or two body parts and the negative impact on providers would be substantial. The occasional gain for the rarely required Tier 3 closing exam would in no way come close to offsetting the significant losses from the more commonly performed Tier 1 & 2 exams. The value of the information required by the Director for claim closure and resolution should be comparable no matter what format it is presented: Oregon or Washington closing exam, Oregon Narrative Response, or Oregon Arbiter Exam. For those providers who are willing to meet this standard, they should be reimbursed appropriately. Maintaining appropriate reimbursement levels will encourage more providers to participate in the performance of closing exams and improve access to these services. \* \* \* Providers producing a valid closing exam that meets the standards set by the Director should be reimbursed under a Tiered Fee Schedule that accurately reflects the value of their work.

“The proposed rule has an immediate direct and devastating financial impact on those providers who are most involved in the delivery of medical care to injured workers in Oregon. \* \* \*

“Without an appropriate incentive to provide the mandated information, the payers would see a significant increase in the need to obtain Narrative Responses, to close active claims. It would delay the time to closure in many cases with potentially negative impact on the workers and potentially negatively impact the indemnity costs incurred by the payers. It will result in an increase in claims that are closed without meeting the letter of the law making them susceptible to disputes that would drive up indemnity costs when a higher volume of Arbiter exams and other activities are needed to resolve the claim. \* \* \*”

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

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**Testimony: OAR 436-009-0060(2)**

***Exhibit 13***

“For those providers who do not provide an exam to meet the Legal standard for closing, they should not be able to successfully charge for a closing exam. They should be reimbursed with the appropriate office visit code and be required to either perform an appropriate exam or refer the patient for a closing examination. The Department should detail the requirements for a valid closing examination in the rules so that it is clear to providers what specific criteria must be met. Perhaps a sample template should be provided that would satisfy the criteria. \* \* \* By not having to reimburse inadequate exams as closings, the overall financial impact on stakeholders would be neutral.”

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee

schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

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**Testimony: OAR 436-009-0060(2)**

***Exhibit 14***

“The proposed rule creates six new codes for closing exams and 3 new codes for closing reports. We believe this creates unnecessary administrative complexity in the workers’ compensation system. Closing exams are evaluation and management services for which there are appropriate national codes and a fee schedule already established. In SAIF’s experience, most providers bill evaluation and management codes for these services. For administrative simplification we recommend that Oregon Specific Codes for closing exams and reports be eliminated. If WCD adopts a rule to include separate closing exam code(s), then SAIF recommends that the rule also include the requirements described in the Bulletin.”

**Response:** Thank you for your testimony. WCD received several pieces of testimony opposed to the proposed changes to the closing exam fee schedule. WCD proposed these changes based on a limited discussion during the advisory committee meeting and based on limited medical fee and payment data for those services. Therefore, WCD will not make any changes to the current fee schedule for closing exams at this time. WCD plans to have a more thorough discussion at the next Division 009 advisory committee meeting.

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

***Exhibit 14***

“The proposed rules increase reimbursement for hearing aids by 40%; SAIF estimates this would increase SAIF’s costs by more than \$300,000 per year. Between 7/1/14-6/30/15 SAIF paid for 157 hearing aids using the current fee schedule. We have received very few complaints about access issues, nor have providers disputed the reimbursement amount. In most instances the \$5,000 includes all related items such as fittings, batteries, supplies, accessories, examinations, molds and other related services. If a worker has a medical need for a pair of hearing aids over \$5000, then SAIF reimburses the additional amount as an exception. SAIF recommends that rather than adopting an across the board 40% increase, WCD adopt language that allows for exceptions above the \$5000 limit per pair if medically necessary. We also recommend the rules specify that the hearing aid include all related supplies and services.”

**Response:** Thank you for your testimony. The \$5000 fee for a pair of hearing aids has existed since 2002. WCD finds it reasonable to increase this fee to \$7000 based on the input received at the advisory committee meeting. WCD is not aware of any problems surrounding the issue of what is included in the fee for the hearing aid and there did not appear to be any disagreement regarding this issue amongst the stakeholders. Therefore, WCD will not add rule language about what’s included in the fee for the hearing aid.

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

***Exhibit 6, 10B (Supporting testimony is listed below.)***

“\* \* \* The proposed language on page 67 of the draft regulation recommends the maximum allowable fee for compounded drugs as follows:

*A non-sterile compound drug - 83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$2.00 for each ingredient*

*and*

*A sterile compound drug - 83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$4.00 for each ingredient*

“We recommend the Division strike this language above and replace it with the following:

*All compounded drugs – 83.5% of the AWP for each individual component ingredient, plus a compounding fee of \$x.xx*

“We recommend striking the initial proposal language because it will be difficult to administer and could lead to an increase in fee disputes between providers and payers. The proposal requires an “educated guess” by the payer as to the sterility of the drug and if that drug was required to be prepared in a sterile environment under the pharmacy practice act. \* \* \*

“The pharmacy practice act defines when a compounded drug shall be prepared in a sterile environment, yet there is no clear mechanism to determine if the drug was prepared beyond the standards, in others words if the drug was made sterile when it was not required to be done in this way. It also bears mention that the variability of the dispense fee when tied to not only the sterility of the drug, but the number of ingredients in the compound itself might incentivize providers to use more ingredients in order to artificially increase the reimbursement rate.

“Data from both California and Texas demonstrated an increasing trend towards using more NDCs and higher cost NDCs in recent years. \* \* \*

“\* \* \* we recommend the Division assign a single maximum dispense fee to all compounded drugs. \* \* \* Most stakeholders find a single compounding dispense fee to be easy to implement into both PBM and bill review platforms. \* \* \*”

Exhibit 10C: “\* \* \* I mirror what Sandy [Shtab] said about the compounding issue. \* \* \*”

**Response:** Thank you for your testimony. Based on similar feedback from multiple stakeholders, WCD revised the proposed rule by eliminating the differentiation between sterile and non-sterile compounded drugs. WCD also replaced the per ingredient fee with a single compounding fee of \$10 which includes the dispensing fee.

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

*Exhibit 6, 10B (Supporting testimony is listed below.)*

“\* \* \* we recommend the Division \* \* \* require a mandatory pre-authorization for any compounded medication. Compounds are generally not recommended as a first line of therapy and are a known cost driver in workers’ compensation claims. \* \* \* If a compounded medication is appropriate for the patient, a physician should be able to easily demonstrate why that drug is appropriate for the injured worker, for example if they have tried and failed with a commercially available drug, or if the patient has a known allergy to an ingredient and there are no other viable options for the patient.”

Exhibit 10C: “\* \* \* I mirror what Sandy said about the compounding issue. \* \* \*”

**Response:** Thank you for your testimony. WCD is not aware that the inappropriate prescribing of compounding drugs is a problem in the Oregon workers’ compensation arena. There was no discussion about preauthorization for compounded drugs at the advisory committee meeting. In Oregon, if the insurer believes a prescribed compounded drug is inappropriate, the insurer may request director review. Therefore, WCD will not mandate a preauthorization for compounded drugs.

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

*Exhibit 8, 10C*

“As part of the advisory committee leading up to this rule-making, Helios recommended additions to 436-009 regarding the billing and reimbursement for compounded medications – one specifically to require billing and reimbursement at the component ingredient level. As such, we are grateful to the Workers’ Compensation Division for now including our recommendation in these proposed changes under 436-009-0090(2). \* \* \* this will add needed clarity and transparency to the process while also aligning with national pharmacy billing and processing standards already adopted by the Division. Helios also believes this may alleviate disputes between providers and payers as to the proper reimbursement for these unique products.”

**Response:** Thank you for your testimony. WCD is implementing the rule as proposed.

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

*Exhibit 17*

“\* \* \* Express Scripts supports the billing efforts already made by the Division and the proposal for compound drugs to be billed at the ingredient level. \* \* \*”

**Response:** Thank you for your testimony. WCD is implementing the rule as proposed.

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

*Exhibit 8, 10C*

“The Division’s proposed language in the table under 436-009-0090(2)(d) also would require reimbursing providers a separate “compounding fee” for each individual ingredient included in the compound, in addition to distinguishing the applicable compounding fee amounts based on whether the compound is “sterile” or “non-sterile.” Helios recommends not including either of these provisions in the final adopted rules for three reasons.

The first reason is that the national pharmacy billing standards (NCPDP) previously adopted by the Division for both paper and electronic billing, and used by stakeholders across the country, do not facilitate the submission of a separate compounding fee for each ingredient within a compound. \* \* \* NCPDP’s electronic billing standard actually permits up to 25 individual ingredients and their related ingredient charges to be submitted as part of one compound, but not a separate compounding fee for each of those ingredients.

“The second reason is that we fear this may unintentionally incentivize some providers to include unnecessary ingredients in the compound as a means to gain greater reimbursement. \* \* \*

“The third reason we recommend removing this language is that we are not aware of a sure, objective way to determine in a given pharmacy billing transaction whether the compound is “sterile” or “non-sterile.” There are no fields that specifically indicate this in either the NCPDP paper or electronic standards. The closest possible way to ‘back in’ to this is to review the codes submitted in the “route of administration” field, which indicates the route of administration of the complete compound mixture (examples: injection, topical, nasal); however, that is not purely objective and does not specifically get to the distinction between “sterile” and “non-sterile.” We are concerned that this level of subjectivity may lead to disagreements and potential disputes between providers and payers as to what the appropriate reimbursement should be for a dispensed compound.

“Instead, Helios recommends including only a single, per-compound “compounding fee” in the table under 436-009-0090(2)(d). We are not committed to any particular dollar amount for this

single fee, but recommend the Division review the dollar amounts adopted by other jurisdictions for this purpose in making its decision as to what fee would be reasonable. Our suggested language \* \* \* – leaving out the specific compounding fee amount:

**A compound drug 83.5 % of the AWP for each individual component ingredient plus a single compounding fee of \$#.##**

**Response:** Thank you for your testimony. Based on similar feedback from multiple stakeholders, WCD revised the proposed rule by eliminating the differentiation between sterile and non-sterile compounded drugs. WCD also replaced the per ingredient fee with a single compounding fee of \$10 which includes the dispensing fee.

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

***Exhibit 14***

“The proposed rules create two dispensing fees for sterile versus non-sterile ingredients. There is no guidance on how to determine whether an ingredient is sterile. This adds unnecessary administrative complexity. The dispensing fee should remain \$2.00, consistent with the fee for all other medications. Any rules adopted should be consistent with NCPDP billing requirements.”

**Response:** Thank you for your testimony. Based on similar feedback from multiple stakeholders, WCD revised the proposed rule by eliminating the differentiation between sterile and non-sterile compounded drugs. WCD also replaced the per ingredient fee with a single compounding fee of \$10 which includes the dispensing fee. WCD considers the processing of compounding drugs to be more extensive than simply dispensing non-compounded drugs. Therefore, the dispensing fee of \$2 is not adequate for compounded drugs.

---

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

***Exhibit 17***

“Express Scripts supports the Divisions proposal to bill compound drugs at the ingredient level; however, the NCPDP standards adopted by the Division for paper and electronic billing do not allow for the submission of a separate compounding fee for each ingredient within a compound. We recommended that the Division adopt one compounding fee for each scenario as outlined below. See the recommended changes below:

**436-009-0090 Pharmaceutical**

**(2) Pharmaceutical Billing and Payment**

A non-sterile compound drug 83.5 % of the AWP for each individual component ingredient plus a compounding fee of (\$X.XX). ~~\$2.00 for each ingredient~~

A sterile compound drug 83.5 % of the AWP for each individual component ingredient plus a compounding fee of (\$X.XX). ~~\$4.00 for each ingredient~~”

**Response:** Thank you for your testimony. Based on similar feedback from multiple stakeholders, WCD revised the proposed rule by eliminating the differentiation between sterile and non-sterile compounded drugs. WCD also replaced the per ingredient fee with a single compounding fee of \$10 which includes the dispensing fee.

---

**Testimony: OAR 436-009-0090(2)(e)**

***Exhibit 10B***

“\* \* \* There’s a reference on page 67 about insurers using a nationally published prescription pricing guide for calculating the payment to the provider. And, the examples given are First DataBank, RED BOOK, or Medi-Span. I just wanted to point out that First DataBank has

**Oregon Administrative Rules, Chapter 436**  
**Public Testimony & Agency Responses**  
**Page 14**

stopped publishing average wholesale price data several years ago, so that citation \* \* \* is definitely outdated and should probably be removed as an example, because they don't publish that information that would be used under the Oregon fee schedule.”

**Response:** Thank you for your testimony. WCD removed the reference to First DataBank as you suggested.

**Dated this 4<sup>th</sup> day of March, 2016.**



# Oregon

Kate Brown, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
350 Winter St. NE  
P.O. Box 14480  
Salem, OR 97309-0405  
1-800-452-0288, 503-947-7810  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

Jan. 15, 2016

**Exhibit  
"1"**

## **Proposed Changes to Workers' Compensation Rules**

### **Amendment of rules governing workers' compensation medical services and medical billing and payment**

The Workers' Compensation Division proposes changes to OAR:

- [436-009, Oregon Medical Fee and Payment Rules](#)
- [436-010, Medical Services](#)

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 hearing.

**When is the hearing?**

Feb. 22, 2016      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@oregon.gov](mailto:fred.h.bruyns@oregon.gov)  
Fred Bruyns, rules coordinator  
Workers' Compensation Division  
350 Winter Street NE (for courier or in-person delivery)  
PO Box 14480, Salem, OR 97309-0405  
Fax – 503-947-7514

**The closing date for written comments is Feb. 25, 2016.**

**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](http://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.

Blank page for two-sided printing

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

**FILED**  
1-12-16 3:33 PM  
ARCHIVES DIVISION  
SECRETARY OF STATE

Department of Consumer and Business Services, Workers' Compensation Division

436

Agency and Division

Administrative Rules Chapter Number

Fred Bruyns

(503) 947-7717

Rules Coordinator

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 services and 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
2-22-16	9:00 a.m.	Room F, Labor & Industries Bldg, 350 Winter St. NE, Salem	Fred Bruyns

**RULEMAKING ACTION**

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

**ADOPT:**

**AMEND:**

OAR 436-009, 436-010

**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 656.245, 656.248; 656.252; 656.327; 656.704

**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;
- Increase maximum allowable payment rates by three percent for physician services except for physical therapy services;
- Replace two laboratory HCPCS codes with seven new codes assigned by the Centers for Medicare and Medicaid Services (CMS): replace G0431 with G0480, G0481, G0482, and G0483; replace G0434 with G0477, G0478, and G0479;
- Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
- Specify how providers must complete boxes 32 and 32a on the National Uniform Claim Committee 1500 Claim Form;
- Exclude platelet rich plasma injections from compensability;
- Eliminate the list of hospitals subject to including Medicare Severity Diagnosis Related Group (MS-DRG) codes on their bills, in favor of a general requirement to include the MS-DRG codes, unless the hospital is a critical access hospital or if the bill contains revenue code 002x.
- Replace the requirement for an insurer or insurer's representative to respond to a question from a provider or a worker about reimbursement within 48 hours with a requirement to do so within two days; require that explanations to workers about out-of-pocket expenses and explanations of benefits sent to health care providers specify two days instead of 48 hours to respond to questions;
- Remove a redundant requirement for health care providers to send multidisciplinary treatment programs to insurers - already in OAR 436-010;
- Establish new Oregon Specific (billing) Codes and associated fees for closing medical examinations of three levels of complexity, and for

related closing reports;

- Increase the maximum payable for hearing aids, without approval by the insurer or director, from \$5000 to \$7000 for a pair and from \$2500 to \$3500 for a single hearing aid;
- Allow a worker to upgrade a hearing aid by paying the price difference;
- Require that compounded drugs be billed at the component ingredient level, listing each ingredient national drug code (NDC), and that ingredients without an NDC are not reimbursable;
- Set the maximum allowable fee for a non-sterile compound drug at 83.5% of the average wholesale price (AWP) for each individual component ingredient, plus a compounding fee of \$2.00 for each ingredient;
- Set the maximum allowable fee for a sterile compound drug at 83.5% of the average wholesale price (AWP) for each individual component ingredient, plus a compounding fee of \$4.00 for each ingredient;
- Replace the mileage reimbursement rate payable to interpreters, currently \$0.50 per mile, with the private vehicle mileage rate published in Bulletin 112; and
- Clarify that, in the matrix for health care provider types, when a provider is not, or is no longer, eligible to provide treatment as a Type B attending physician, if care is provided because it is authorized by an attending physician, physician assistants are not required to have a written treatment plan.

The agency proposes to amend OAR 436-010, "Medical Services," to:

- Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
- Replace the requirement for an insurer to forward a copy of an independent medical exam report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report with a requirement to do so within three days; and
- Clarify that, in the matrix for health care provider types, when a provider is not, or is no longer, eligible to provide treatment as a Type B attending physician, if care is provided because it is authorized by an attending physician, physician assistants are not required to have a written treatment plan.

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.

02-25-2016 Close of Business	Fred Bruyins	fred.h.bruyins@oregon.gov
Last Day (m/d/yyyy) 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**  
1-12-16 3:33 PM  
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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 services and 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  
OAR 436-010, Medical Services

**Statutory Authority:**

ORS 656.248, 656.726(4)

**Other Authority:**

**Statutes Implemented:**

ORS 656.245, 656.248; 656.252; 656.327; 656.704

**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. This document is available for public inspection in the Administrator's Office, Workers' Compensation Division, 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.

**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. State agencies: The agency estimates that proposed rule changes will have no significant effect on costs of state agencies.
- b. Units of local government: 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 public: The agency estimates that proposed rule changes will affect costs to the public as follows:  
(References to "insurers" include self-insured employers.)
  - The agency estimates that the proposed increase in the maximum allowable payments for physician services will increase payments to health care providers by approximately \$1,535,000, at a corresponding cost to insurers. This will increase the total medical costs by 0.5 percent.
  - The agency projects a potential fiscal impact due to the replacement of two laboratory HCPCS codes with seven new codes assigned by CMS. However, the impact cannot be accurately estimated because it is not known which new codes will be used and how frequently each will be used. CMS used the following multipliers to derive new maximum allowable payments:

<input type="checkbox"/>	Current	New	Multiplier
<input type="checkbox"/>	G0431	G0480	3.25 times CPT@ 82542
<input type="checkbox"/>	G0431	G0481	5.00 times CPT@ 82542
<input type="checkbox"/>	G0431	G0482	6.75 times CPT@ 82542
<input type="checkbox"/>	G0431	G0483	8.75 times CPT@ 82542
<input type="checkbox"/>	G0434	G0477	0.75 times G0434
<input type="checkbox"/>	G0434	G0478	1.00 times G0434
<input type="checkbox"/>	G0434	G0479	4.00 times G0434.

- The agency estimates that the proposed creation of Oregon Specific Codes to be used when billing for closing medical examinations and reports may have economic effects on health care providers and insurers. However, the agency cannot project specific impacts because it cannot predict how many closing exams, and related reports, will be billed at level 1, level 2, and level 3.
- The agency estimates that the proposed increase in the maximum amounts payable for hearing aids (without approval by the insurer or the director), from \$5000 to \$7000 for a pair and from \$2500 to \$3500 for a single hearing aid, will increase payments to hearing aid providers at a corresponding cost to insurers. The agency estimates a maximum potential increase of \$223,000 per year. This will increase the total medical costs by 0.07 percent.
- The agency estimates that the proposed requirement that compounded drugs be billed at the ingredient level and at 83.5% of the average wholesale price for each individual component ingredient, plus a compounding fee for each ingredient, may reduce payments to compounding pharmacies, and provide a corresponding savings for insurers. However, the agency does not have enough data on the current costs of compounded drugs to estimate a specific impact.
- The proposed replacement of the \$0.50 per mile reimbursement rate for interpreters with a rate published in Bulletin 112 should produce a small increase in payments to interpreters in the near term, because the rate published in Bulletin 112 is currently \$0.54 per mile. There will be a corresponding cost for insurers. At \$0.54 per mile, an 8 percent increase, the payments for interpreter mileage will rise by approximately \$6,900 per year. This will increase the total medical costs by 0.002 percent. However, the rate in Bulletin 112 is the rate published by the U. S. General Services Administration (applicable to federal employees), and this rate is adjusted from time to time. Given the downward trend in gas prices, the GSA's mileage reimbursement rate may fall as well.
- The agency estimates that additional proposed rule changes will not have significant fiscal or economic impacts.

**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 small businesses most affected by proposed rule changes are medical providers, pharmacies, and interpreter firms. The agency estimates that Oregon has at least 12,000 medical providers, 100 independently owned pharmacies, and 200 interpreter firms. Many of these businesses are small businesses as defined by ORS 183.310(10).

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

The agency projects that there will be no increased costs for small businesses for reporting, recordkeeping, or other administrative activities, including costs for professional services, required for compliance.

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

The agency projects that there will be no increased costs for small businesses for equipment, supplies, labor, or increased administration required for compliance.

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

Small business representatives attended the rulemaking advisory committee meetings and provided advice.

**Administrative Rule Advisory Committee consulted?: Yes  
If not, why?:**

<u>02-25-2016 Close of Business</u>	<u>Fred Bruyns</u>	<u>fred.h.bruyns@oregon.gov</u>
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address



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

*Proposed*

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

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

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**Historical rules:** <http://www.cbs.state.or.us/wcd/policy/rules/history.html>

**NOTE:** Revisions are marked as follows:

Deleted text has a "strike-through" style, as in	<del>Deleted</del>
Added text is underlined, as in	<u>Added</u>

**The Workers' Compensation Division (WCD) adopts, by reference, the American Society of Anesthesiologists (ASA) Relative Value Guide and Current Procedural Terminology (CPT<sup>®</sup>). 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:** 20145 *Relative Value Guide*

To order the **CPT<sup>®</sup>** 2016, 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>

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](http://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](http://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](http://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 Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

### **(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  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **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> 2015~~6~~), Fourth Edition Revised, 2014~~5~~, 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 24~~5~~, Issue 12, 2014~~5~~. 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> 2015~~6~~ 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).

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

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(6) The director adopts, by reference, CDT 2015~~6~~: 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 1.3 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.ncdp.org](http://www.ncdp.org).

(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2015, CPT<sup>®</sup> 2015~~6~~, CPT<sup>®</sup> Assistant, HCPCS 2015~~6~~, CDT 2015~~6~~, 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 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## 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.

~~(e)~~(a) CMS means Centers for Medicare & Medicaid Services.

~~(d)~~(b) CPT<sup>®</sup> means Current Procedural Terminology published by the American Medical Association.

~~(e)~~ DME means durable medical equipment.

~~(f)~~(c) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies.

~~(g)~~(d) EDI means electronic data interchange.

~~(h)~~(e) HCPCS means Healthcare Common Procedure Coding System published by CMS.

~~(i)~~ IAIABC means International Association of Industrial Accident Boards and Commissions.

~~(j)~~(f) 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)~~(g) 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)~~(h) MCO means managed care organization certified by the director.

~~(n)~~(i) NPI means national provider identifier.

~~(o)~~(j) OSC means Oregon specific code.

~~(p)~~(k) PCE means physical capacity evaluation.

~~(q)~~(l) 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) “**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

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(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 AF, “Matrix for Health Care Provider Types”.

(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 who 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”**<sup>®</sup> means the Current Procedural Terminology codes and terminology published by the American Medical Association unless otherwise specified in these rules.

(12) **“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.

(13) **“Days”** means calendar days.

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(14) **“Director”** means the director of the Department of Consumer and Business Services or the director’s designee.

~~(14)~~(15) **“Division”** means the Workers’ Compensation Division of the Department of Consumer and Business Services.

~~(15)~~(16) **“Enrolled”** means an eligible worker 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 MCO’s certified geographical service area.

~~(16)~~(17) **“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.

~~(17)~~(18) **“Hearings Division”** means the Hearings Division of the Workers’ Compensation Board.

~~(18)~~(19) **“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 that do not result in admission are also considered outpatient services.

~~(19)~~(20) **“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.

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~~(20)~~(21) **“Insurer”** means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407.

~~(21)~~(22) **“Interim medical 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.

~~(22)~~(23) **“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.

~~(23)~~(24) **“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.

~~(24)~~(25) **“Mailed or mailing date”** 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.

~~(25)~~(26) **“Managed care organization”** or “MCO” means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

~~(26)~~(27) **“Medical provider”** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

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~~(27)~~(28) **“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.

~~(28)~~(29) **“Medical service provider”** means a person duly licensed to practice one or more of the healing arts.

~~(29)~~(30) **“Medical treatment”** 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)~~(31) **“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.

~~(31)~~(32) **“Patient”** means the same as worker as defined in ORS 656.005(30).

~~(32)~~(33) **“Physical capacity evaluation”** 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 have the same meaning as Physical Capacity Evaluation.

~~(33)~~(34) **“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.

~~(34)~~(35) **“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.

~~(35)~~(36) **“Residual functional capacity”** means a patient's remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting,

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climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.

**(36)(37) “Specialist physician”** means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, 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.

**(37)(38) “Type A attending physician”** means an attending physician under ORS 656.005(12)(b)(A). See Appendix AF, “Matrix for Health Care Provider Types”.

**(38)(39) “Type B attending physician”** means an attending physician under ORS 656.005(12)(b)(B). See Appendix AF, “Matrix for Health Care Provider Types”.

**(39)(40) “Usual fee”** means the medical provider’s fee charged to the general public for a given service.

**(40)(41) “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 has the same meaning as Work Capacity Evaluation.

**(41)(42) “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 3/12/14 as Admin. Order 14-052, eff. 4/1/14  
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-009-0008 Request for Review 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 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 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 worker, and the worker's attorney has given written notice of representation to the

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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 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 before the director.

(d) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO:

(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. Rebillings without any relevant changes will not provide a new 90 day period to request administrative review.

(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.

(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.

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

**(3) Form and Required Information.**

**(a)** Requests for administrative review 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 and their representatives, if known, of the dispute. The notice must:

- (i)** Identify the worker's name, date of injury, insurer, and claim number;
- (ii)** Specify the issues in dispute and the relief sought; and
- (iii)** 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 codes of services 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:

- (i)** The request for review;
- (ii)** Any attached supporting documentation; and
- (iii)** 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 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, at no charge, to the director and all other parties or their representatives as follows:

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(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 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 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

(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 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~~ received by 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 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

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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) through (6) 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 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 3/12/14 as Admin. Order 14-052, eff. 4/1/14  
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

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

### **(1) General.**

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

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

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

**(b)** All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

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

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

**(e)** When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

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(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.

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**(3) Billing Forms.**

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

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:

(A) Dental billings, which must be submitted on American Dental Association dental claim forms;

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or

(C) Electronic billing transmissions of medical bills (see OAR 436-008).

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

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

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

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	<p>The provider must use the following codes to accurately describe the services rendered:</p> <ul style="list-style-type: none"> <li>• CPT<sup>®</sup> codes listed in CPT<sup>®</sup> 2015<del>6</del>;</li> <li>• Oregon Specific Codes (OSCs); or</li> <li>• HCPCS codes, only if there is no specific CPT<sup>®</sup> or OSC.</li> </ul> <p>If there is no specific code for the medical service:</p> <ul style="list-style-type: none"> <li>• The provider should use an appropriate unlisted code from CPT<sup>®</sup> 2015<del>6</del> (e.g., CPT<sup>®</sup> code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and</li> <li>• The provider should describe the service provided.</li> </ul> <p>Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.</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>
<u>32</u>	<u>If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.</u>
<u>32a</u>	<u>If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.</u>

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**(4) Billing Codes.**

(a) When billing for medical services, a medical provider must use codes listed in CPT<sup>®</sup> 2015~~6~~ or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

If there is no specific CPT<sup>®</sup> 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<sup>®</sup> 2015~~6~~ or the appropriate unlisted HCPCS code, and provide a description of the service provided.

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

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

**(5) Modifiers.**

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT<sup>®</sup> 2015~~6~~, 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;

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- (E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or
- (F) The services rendered are significantly more complex than described for the submitted CPT®.

**(6) Physician Assistants and Nurse Practitioners.**

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

**(7) Chart Notes.**

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

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

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

**(8) Challenging the Provider’s Bill.**

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

**(9) Billing the Patient / 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

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

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

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

**(12) Excluded Treatment.**

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

- (a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
- (b) Intradiscal electrothermal therapy (IDET);
- (c) Surface electromyography (EMG) tests;
- (d) Rolfing;
- (e) Prolotherapy;
- (f) Thermography;
- (g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:
  - (A) The single level artificial disc replacement is between L3 and S1;

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- (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; ~~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; and

(i) Platelet rich plasma (PRP) injections.

**(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 6/13/14 as Admin. Order 14-055, eff. 7/1/14  
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-009-0018 Discounts and Contracts**

### **(1) Medical Service Providers and Medical Clinics.**

For the purpose of this rule:

(a) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(b) "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.

(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 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;
- (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.

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(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.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248  
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14  
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.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 for dates of service on and 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, except for bills: from those hospitals listed in Appendix A.

(i) Bills from critical access hospitals; or

(ii) Bills containing revenue code 002x.

(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 for dates of service on and after Oct. 1, 2015, ICD-10-CM codes,

(C) CPT<sup>®</sup> codes and HCPCS codes; and

(D) The hospital's NPI.

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

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"> <li>• For hospitals listed in Bulletin 290, the amount billed multiplied by the cost-to-charge ratio.</li> <li>• For in-state hospitals not listed in Bulletin 290, 80% of the amount billed.</li> <li>• For out-of-state hospitals, the amount billed multiplied by a cost-to-charge ratio of 1.000.</li> </ul>	

**(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 are considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment is 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.

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(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.

(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 is 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 is 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 is 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~~ director to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio is 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.

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(e) The basic cost-to-charge ratio is 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 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 ~~is~~are 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 its CMS 2552 and financial statements each year within 150 days of the end of the hospital's 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 determines 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 subsections (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

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hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital 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 6/13/14 as Admin. Order 14-055, eff. 7/1/14  
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

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

### **(1) Billing Form.**

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

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

### **(2) ASC Facility Fee.**

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

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

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

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**(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.

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CPT <sup>®</sup> Code	Maximum Payment Amount	CPT <sup>®</sup> 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 for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.

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

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

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

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

Stat. Auth.: ORS 656.726(4)  
 Stats. Implemented: ORS 656.245; 656.248; 656.252  
 Hist: Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
 See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-009-0025 Worker Reimbursement**

### **(1) General.**

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

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

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

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

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

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

- (A) The amount of reimbursement for each type of out-of-pocket expense requested.
- (B) The specific reason for 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~~ two days, 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](http://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:

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**“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.”**

(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.

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(d) When the insurer receives a reimbursement request before 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:

(i) Reimburse the worker if the request shows the costs are related,

(ii) Disapprove the request if unreasonable or if the costs are not related,  
or

(iii) 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:

(i) Reimburse the worker if the request shows the costs are related,

(ii) Disapprove the request if unreasonable or if the costs are not related,  
or

(iii) 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.

**(5) Other Reimbursements.**

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

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515.

When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.

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

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

**(6) Advancement Request.**

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

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 3/12/14 as Admin. Order 14-052, eff. 4/1/14  
Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

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

### **(2) Bill Processing.**

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b) 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.

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(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~~b), 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 EOB has the same meaning as an explanation of review (EOR).

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

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

(B) The specific reason for 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~~ two days, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access information about Oregon's Medical Fee and Payment Rules, visit [www.oregonwcdoc.info](http://www.oregonwcdoc.info) or call 503-947-7606.";

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

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**(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~~ two days, 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 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **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, i.e., the patient's private health insurance. 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

(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.

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**(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 10/17/14 as Admin. Order 14-060, eff. 1/1/15

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## 436-009-0040 Fee Schedule

### (1) Fee Schedule Table.

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

Services	Codes	Payment Amount:	
Services billed with <b>CPT</b> <sup>®</sup> codes, <b>HCPCS</b> codes, or Oregon Specific Codes ( <b>OSC</b> ):	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 <b>not</b> performed in medical service provider's office	Lesser of:	Amount in facility column in Appendix B*, or Provider's usual fee
<b>Dental</b> Services billed with dental procedure codes:	D0000 through D9999	90% of provider's usual fee	
<b>Ambulance</b> Services billed with <b>HCPCS</b> codes:	A0425, A0426, A0427, A0428, A0429, A0433, and A0434	100% of provider's usual fee	
Services billed with <b>HCPCS</b> 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.

### (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

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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.

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

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

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

**(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:

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(a) One surgeon

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

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

**(c) Assistant surgeons**

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

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**(d) Nurse practitioners or physician assistants**

Procedures	Appendix B lists:	The payment amount is:	
One or more surgical procedures as the primary surgical provider, billed without modifier "81."	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	85% of the surgeon(s) fee calculated in subsections (a) or (b)	
One or more surgical procedures as the surgical assistant*	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	15% of the surgeon(s) fee calculated in subsections (a) or (b)	

\*Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.

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

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

**(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.

**(4) Radiology Services.**

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

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

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

**(5) Pathology and Laboratory Services.**

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

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

**(6) Physical Medicine and Rehabilitation Services.**

(a) Time-based CPT<sup>®</sup> codes must be billed and paid according to this table:

<b>Treatment Time</b>	<b>Bill and Pay As</b>
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<sup>®</sup> codes 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.

(c) CPT<sup>®</sup> 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<sup>®</sup> codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.

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

**(7) Reports.**

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

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of the records using CPT<sup>®</sup> 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 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## 436-009-0060 Oregon Specific Codes

### (1) Multidisciplinary Services.

(a) Services provided by multidisciplinary programs not otherwise described by CPT<sup>®</sup> 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.~~

**(eb)** Bills using the multidisciplinary codes must include copies of the treatment record that specifies:

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

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

Service	OSC
<b>Arbiter exam - level 1:</b> A basic medical exam with no complicating factors.	AR001
<b>Arbiter exam - level 2:</b> A moderately complex exam that may have complicating factors.	AR002
<b>Arbiter exam - level 3:</b> A very complex exam that may have several complicating factors.	AR003
<b>Arbiter exam – limited:</b> A limited exam that may involve a newly accepted condition, or a partial exam.	AR004
<b>Arbiter file review - level 1:</b> A file review of a limited record.	AR021
<b>Arbiter file review - level 2:</b> A file review of an average record.	AR022

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Service	OSC
<b>Arbiter file review - level 3:</b> A file review of a large record or a disability evaluation without an exam.	AR023
<b>Arbiter file review - level 4:</b> A file review of an extensive record.	AR024
<b>Arbiter file review - level 5:</b> A file review of an extensive record with unique factors.	AR025
<b>Arbiter report - level 1:</b> A report that answers standard questions.	AR011
<b>Arbiter report - level 2:</b> A report that answers standard questions and complicating factors.	AR012
<b>Arbiter report - level 3:</b> A report that answers standard questions and multiple complicating factors.	AR013
<b>Arbiter report - complex supplemental report:</b> A report to clarify information or to address additional issues.	AR032
<b>Arbiter report - limited supplemental report:</b> A report to clarify information or to address additional issues.	AR031
<b>Closing exam:</b> <del>An exam to measure impairment after the worker's condition is medically stationary.</del>	CE001
<b>Closing report:</b> <del>A report that captures the findings of the closing exam.</del>	CR001
<b><u>Closing exam by AP– level 1:</u></b> <u>A history and exam by the attending physician to measure impairment after the worker's condition is medically stationary. Involves one body part.</u>	<u>CE011</u>
<b><u>Closing exam by AP– level 2:</u></b> <u>A history and exam by the attending physician to measure impairment after the worker's condition is medically stationary. Involves two to three body parts.</u>	<u>CE012</u>
<b><u>Closing exam by AP– level 3:</u></b> <u>A history and exam by the attending physician to measure impairment after the worker's condition is medically stationary. Involves at least one of the following:</u> <ul style="list-style-type: none"> <li>• <u>More than three body parts;</u></li> <li>• <u>Conditions involving the eyes or head;</u></li> <li>• <u>Conditions related to hearing; or</u></li> <li>• <u>Vascular or dermatological conditions.</u></li> </ul>	<u>CE013</u>
<b><u>Closing exam by non-AP – level 1:</u></b> <u>A history and exam by a provider other than attending physician to measure impairment after the worker's condition is medically stationary. Involves one body part.</u>	<u>CE021</u>

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Service	OSC
<p><b><u>Closing exam by non-AP – level 2:</u></b>  <u>A history and exam by a provider other than attending physician to measure impairment after the worker's condition is medically stationary. Involves two to three body parts.</u></p>	<u>CE022</u>
<p><b><u>Closing exam by non-AP – level 3:</u></b>  <u>A history and exam by a provider other than attending to measure impairment after the worker's condition is medically stationary. Involves at least one of the following:</u></p> <ul style="list-style-type: none"> <li>• <u>More than three body parts;</u></li> <li>• <u>Conditions involving the eyes or head;</u></li> <li>• <u>Conditions related to hearing; or</u></li> <li>• <u>Vascular or dermatological conditions.</u></li> </ul>	<u>CE023</u>
<p><b><u>Closing report – level 1:</u></b>  <u>A closing report that captures the findings of a level 1 closing exam.</u></p>	<u>CR011</u>
<p><b><u>Closing report – level 2:</u></b>  <u>A closing report that captures the findings of a level 2 closing exam.</u></p>	<u>CR012</u>
<p><b><u>Closing report – level 3:</u></b>  <u>A closing report that captures the findings of a level 3 closing exam.</u></p>	<u>CR013</u>
<p><b>Consultation – attorney:</b>  Time spent consulting with an insurer's attorney.</p>	D0001
<p><b>Consultation – insurer:</b>  Time spent consulting with an insurer.</p>	D0030
<p><b>Copies of medical records:</b>  Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.</p>	R0001
<p><b>Copies of medical records electronically:</b>  Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.</p>	R0002
<p><b>Deposition time:</b>  Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.</p>	D0002
<p><b>Director required medical exam or review time:</b>  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.</p>	P0001
<p><b>Director required medical report:</b>  Preparation and submission of the report.</p>	P0003
<p><b>Director required review - complex case fee:</b>  Preauthorized fee by the director for an extensive review in a complex case.</p>	P0004
<p><b>Director required exam – failure to appear:</b>  Patient fails to appear for a director required exam.</p>	P0005

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Service	OSC
<b>Ergonomic consultation - 1 hour (includes travel):</b> Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
<b>IME (independent medical exam):</b> Report, addendum to a report, file review, or exam.	D0003
<b>IME – review and response:</b> Insurer requested review and response by treating physician; document time spent.	D0019
<b>Interdisciplinary rehabilitation conference - 10 minutes:</b> A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655
<b>Interdisciplinary rehabilitation conferences – intermediate - 20 minutes:</b> A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
<b>Interdisciplinary rehabilitation conferences – complex - 30 minutes:</b> A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
<b>Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum:</b> Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
<b>Interpreter mileage</b>	D0041
<b>Interpreter services – other than American Sign Language (ASL)</b>	D0004
<b>Interpreter services – American Sign Language (ASL)</b>	D0005
<b>Job site visit - 1 hour (includes travel):</b> Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
<b>Job site visit - each additional 30 minutes</b>	97660
<b>Multidisciplinary conference – initial - up to 30 minutes</b>	97670
<b>Multidisciplinary conference - initial/complex - up to 60 minutes</b>	97671
<b>Narrative – brief:</b> 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

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Service	OSC
<b>Narrative – complex:</b> 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
<b>Nursing evaluation - 30 minutes:</b> Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
<b>Nursing evaluation - each additional 15 minutes</b>	97665
<b>Nutrition evaluation - 30 minutes:</b> Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
<b>Nutrition evaluation - each additional 15 minutes</b>	97667
<b>PCE (physical capacity evaluation) - first level:</b> This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196
<b>PCE - second level:</b> This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
<b>PCE – each additional 15 minutes</b>	99193
<b>Physical conditioning - group - 1 hour:</b> Conditioning exercises and activities, graded and progressive.	97642
<b>Physical conditioning - group - each additional 30 minutes</b>	97643
<b>Physical conditioning – individual - 1 hour:</b> Conditioning exercises and activities, graded and progressive.	97644
<b>Physical conditioning – individual - each additional 30 minutes</b>	97645

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Service	OSC
<b>Professional case management – individual 15 minutes:</b> Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
<b>Social worker evaluation - 30 minutes:</b> Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
<b>Social worker evaluation – each additional 15 minutes</b>	97669
<b>Therapeutic education – individual - each additional 30 minutes</b>	97650
<b>Therapeutic education – individual - each additional 15 minutes</b>	97651
<b>Therapeutic education - group 30 minutes:</b> Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
<b>Therapeutic education - group - each additional 15 minutes</b>	97653
<b>Vocational evaluation - 30 minutes:</b> Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
<b>Vocational evaluation - each additional 15 minutes</b>	97663
<b>Physical conditioning - group - 1 hour:</b> Conditioning exercises and activities, graded and progressive.	97642
<b>Physical conditioning - group - each additional 30 minutes</b>	97643
<b>WCE (work capacity evaluation):</b> This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: <ul style="list-style-type: none"> <li>• The ability to perform essential physical functions of the job based on a specific job;</li> <li>• Analysis as related to the accepted condition;</li> <li>• The ability to sustain activity over time; and</li> <li>• The reliability of the evaluation findings.</li> </ul>	99198
<b>WCE – each additional 15 minutes</b>	99193
<b>Work simulation - group 1 hour:</b> Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
<b>Work simulation - group - each additional 30 minutes</b>	97647

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Service	OSC
<b>Work simulation - individual 1 hour:</b> Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
<b>Work simulation - individual - each additional 30 minutes</b>	97649
<b>WRME (worker requested medical exam):</b> 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 will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

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

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

Stat. Auth.: ORS 656.726(4) Stats. Implemented: ORS 656.248  
 Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14  
 Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15  
 See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

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

(1) **Durable medical equipment** (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:

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

~~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.

The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged.

If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An **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.

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(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

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

<b>If DMEPOS is:</b>	<b>And HCPCS is:</b>	<b>Then payment amount is:</b>	
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):

<b>Code</b>	<b>Monthly Rate</b>	<b>Code</b>	<b>Monthly Rate</b>
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

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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:

- (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 \$57000 for a pair of hearing aids, or \$23500 for a single hearing aid.

If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.

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

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

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

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

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248

Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## 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 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.

(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. This includes compounded drugs, which must be billed at the component ingredient level, listing each ingredient NDC. Ingredients without an NDC are not reimbursable.

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

(c) 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.

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(d) 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
<u>A non-sterile compound drug</u>	<u>83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$2.00 for each ingredient</u>
<u>A sterile compound drug</u>	<u>83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$4.00 for each ingredient</u>

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

(e) 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<sup>®</sup>,
- (B) Cymbalta<sup>®</sup>,
- (C) Fentora<sup>®</sup>,
- (D) Kadian<sup>®</sup>,
- (E) Lidoderm<sup>®</sup>,
- (F) Lyrica<sup>®</sup>, or

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(G) OxyContin<sup>®</sup>.

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

(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 does not 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 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **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.

**(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 and back to the interpreter's starting point.

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

- (A)** The 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<sup>2</sup>, 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.

**(4) Billing Timelines.**

(a) Interpreters must bill within:

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

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

(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause. Good cause may include, but is not limited to, 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.

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**(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;
- (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.

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(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	<del>\$0.50 per mile</del> <u>The private vehicle mileage rate published in Bulletin 112</u>
An examination required by the director or insurer 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.

(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.

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(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;

(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~~ two days, 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](http://www.oregonwcdoc.info) or call 503-947-7606";

(E) Space for a signature and date; and

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(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~~two days, 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: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **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 provision 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.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.254, 656.745

Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

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**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	Asante Ashland Community Hospital*	1386644029	-	-
3	Asante Rogue Regional Medical Center Hospital	1770587107	1427277086	-
4	Asante Three Rivers Medical Center	1801891809	1598895690	-
5	Bay Area Hospital—Coos Bay	1225016561	-	-
6	Good Samaritan Regional Medical Center—Corvallis	1962453134	-	-
7	Kaiser Sunnyside Medical Center	1124182902	-	-
8	Kaiser Westside Medical Center	1891048807		
9	Legacy Emanuel Medical Center	1831112358	1295756898	-
10	Legacy Good Samaritan Medical Center	1780608216	-	-
11	Legacy Meridian Park Medical Center	1184647620	-	-
12	Legacy Mt. Hood Medical Center	1255354700	-	-
13	McKenzie Willamette Medical Center—Springfield	1568413573	1528006301	-
14	Mercy Medical Center—Roseburg*	1477590198	1134161391	-
15	Mid-Columbia Medical Center—The Dalles*	1306842752	-	-
16	Oregon Health & Science University Hospital	1609824010	1376873570	1548272511
17	Providence Medford Medical Center	1689755670	-	-
18	Providence Milwaukie Medical Center	1366536963	-	-
19	Providence Newberg Medical Center*	1952482275	-	-
20	Providence Portland Medical Center	1003991845	-	-
21	Providence St. Vincent Hospital & Medical Center	1114015971	1083866933	-
22	Providence Willamette Falls Medical Center	1639108434	-	-
23	Sacred Heart Medical Center Riverbend—Springfield	1083888515	1881928067	-
24	Sacred Heart Medical Center University Dist.—Springfield	1346237971	1164595617	-
25	Salem Hospital	1265431829	1114197894	-
26	Samaritan Albany General Hospital	1154372340	-	-
27	Santiam Hospital—Stayton*	1154302214	-	-
28	Silverton Hospital	1669424354	-	-
29	Sky Lakes Medical Center—Klamath Falls	1811130149	1659340370	-
30	St. Alphonsus Medical Center—Ontario*	1891891792	-	-
31	St. Charles Medical Center—Bend	1982621447	1598839789	-
32	St. Charles Medical Center—Redmond*	1225056146	-	-
33	Tuality Community Hospital—Hillsboro	1275591984	1336228659	-
34	Willamette Valley Medical Center—McMinnville*	1346269982	-	-

\*Denotes hospital as rural. All of the 25 OR Critical Access Hospitals are intentionally excluded from this list.

**Appendix FA - Matrix for health care provider types\***

**See OAR 436-009-0005**

	Attending physician status (primarily responsible for treatment of a patient)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient 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 physician Naturopathic physician 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. <u>(Note: physician assistants are not required to have a written treatment plan)</u>	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 physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No, if patient 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

**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, 2015~~6~~]

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, 2015~~6~~]

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, 2015~~6~~]

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, 2015~~6~~]

*Note: If the above links do not connect you to the ~~department's~~ division'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 2014~~5~~ 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.

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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

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES  
WORKERS' COMPENSATION DIVISION



**Medical Services**  
**Oregon Administrative Rules**  
**Chapter 436, Division 010**

*Proposed*

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NOTE: Revisions are marked as follows:

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

~~Deleted~~  
Added

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## Oregon Administrative rules OAR chapter 436

### 436-010-0001 Administration of These Rules

(1) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

#### (2) Authority for Rules.

These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.

#### (3) Purpose.

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

#### (4) Applicability of Rules.

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

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

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, 656.794

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## 436-010-0005    **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) “**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.

(3) “**Attending physician**” has the same meaning as described in ORS 656.005(12)(b). See Appendix A “Matrix for Health Care Provider Types.”

(4) “**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 who has been assigned an authorized nurse practitioner number by the director.

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

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

(7) “**Come-along provider**” means a primary care physician, chiropractic physician, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who continues to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)

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(8) **“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.

(9) **“Days”** means calendar days.

(10) **“Direct control and supervision”** means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

(11) **“Direct medical sequela”** means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a “direct medical sequela.”

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

(13) **“Eligible worker”** means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO’s authorized geographical service area, covered by an insurer that has a contract with that MCO.

(14) **“Enrolled”** means an eligible worker has received notification from the insurer that the worker is being required to treat 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’s certified geographical service area.

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(15) **“Health care practitioner or health care provider”** has the same meaning as a “medical service provider.”

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

(17) **“Home health care”** means necessary medical and medically related services provided in the patient’s home environment. These services may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

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

(19) **“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.

(20) **“Insurer”** means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407.

(21) **“Interim medical 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.

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(22) **“Mailed or mailing date”** 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.

(23) **“Managed care organization” or “MCO”** means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(24) **“Medical evidence”** includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, X-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(25) **“Medical provider”** means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

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

(27) **“Medical service provider”** means a person duly licensed to practice one or more of the healing arts.

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**(28) “Medical treatment”** 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.

**(29) “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.

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

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

**(32) “Physical restorative services”** means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the patient’s highest functional ability consistent with the patient’s condition.

**(33) “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.

**(34) “Residual functional capacity”** means a patient’s remaining ability to perform work-related activities. 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

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reaching, and the number of hours per day the patient can perform each activity.

**(35) “Specialist physician”** means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, 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.

**(36) “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 has the same meaning as Work Capacity Evaluation.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.000 et seq.; 656.005

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0008 Request for Review 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 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)** All issues pertaining to disagreements about medical services within a managed care organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the worker, are subject to ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter before the director.

**(c)** 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.

**(d)** The director may, on the director's own motion, initiate a review of medical services or medical treatment at any time.

**(e)** If the director issues an order declaring an already rendered medical treatment or medical service inappropriate, or otherwise in violation of the statute or medical rules, the worker is not obligated to pay for such.

**(2) Time Frames and Conditions.**

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

**(A)** For 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 unless the party can show good cause. When the aggrieved party is a represented 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.

**(B)** For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review 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 before the director.

**(C)** For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO, the aggrieved party must request administrative review before 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. 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.

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

**(3) Form and Required Information.**

(a) Requests for administrative review 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. The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must:

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

(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 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, 656.260, or 656.327~~(3)~~(e), the insurer must provide a record packet, at no charge, 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 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).**

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**(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 not 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 sanction the insurer under OAR 436-010-0340.

**(E)** Except for disputes regarding interim medical benefits, the packet must include certification stating that there is an issue of compensability of the underlying claim or condition or stating that there is not an issue of compensability of the underlying claim or condition. If the insurer issued a denial that has been reversed by the Hearings Division, the Board, or the Court of Appeals, the insurer must provide a statement regarding its intention, if known, to accept or appeal the decision.

**(4) Physician Review (E.g., appropriateness).**

If the director determines a review by a physician is indicated to resolve the dispute, the director, under OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical exam as part of the administrative review process, the worker may refuse an invasive test without sanction.

**(a)** A single physician selected to conduct a review must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

**(b)** When a panel of physicians is selected, at least one panel member must be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment or service is being reviewed.

**(c)** When such an exam of the worker is required, the director will notify the appropriate parties of the date, time, and location of the exam. Examinations will be at a place reasonably convenient to the worker, if possible. The parties must not directly contact the physician or panel unless it relates to the exam date, time, location, or attendance. If the parties have special questions they want addressed by the physician or panel, the questions must be submitted to the director for screening as to the appropriateness of the

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questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The exam may include, but is not limited to:

- (A) A review of all medical records and diagnostic tests submitted,
- (B) An examination of the worker, and
- (C) Any necessary and reasonable medical tests.

**(5) Dispute Resolution by Agreement (E.g., 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
- (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 worker's attorney.

(c) If the dispute does not resolve through mediation or alternative dispute resolution, the director will issue an order. If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order under ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

**(6) Director Order and Reconsideration.**

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(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~~ received by 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.

**(7) 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 action or order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an action or order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245, 656.247, 656.260(15) or (16), or 656.327(2), no new medical 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 Workers' Compensation 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.

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

(C) The administrator will forward the request and other pertinent information to the Workers' Compensation Board.

**(8) Other Proceedings.**

(a) Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party not covered under sections (1) through (7) of this rule, may request administrative review before the director.

(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 administrator may require and allow such input and information as it deems appropriate to complete the review.

**Stat. Auth.:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0200    Medical Advisory Committee**

The Medical Advisory Committee members are appointed by the director of the Department of Consumer and Business Services. The committee must include one insurer representative, one employer representative, one worker representative, one managed care organization representative, and a diverse group of health care providers representative of those providing medical care to injured or ill workers.

The director may appoint other persons as may be determined necessary to carry out the purpose of the committee. Health care providers must comprise a majority of the committee at all times. When appointing members, the director should select health care providers who will consider the perspective of specialty care, primary care, and ancillary care providers and consider the ability of members to represent the interests of the community at large.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.794

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0210    Attending Physician, Authorized Nurse Practitioner, and Time-Loss Authorization**

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes time loss, and prescribes and monitors ancillary care and specialized care.

(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.

(b) Type A and B attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types")

(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.

### **(2) Emergency Room Physicians.**

Emergency room physicians may authorize time loss for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in his or her private practice apart from their duties as an emergency room physician, the physician may be the attending physician.

### **(3) Authorized Nurse Practitioners.**

(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of authorization. (See [www.oregonwcdoc.info](http://www.oregonwcdoc.info)) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.

(b) An authorized nurse practitioner may:

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(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and

(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.

**(4) Unlicensed to Provide Medical Services.**

Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

**(5) Out-of-State Attending Physicians.**

The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days.

(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:

(A) The Oregon medical fee and payment rules, OAR 436-009;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and

(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.

(b) If the insurer disapproves the worker's out-of-state attending physician, the notice to the worker must:

(A) Clearly state the reasons for the disapproval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010,

(B) Identify at least two other physicians of the same healing art and specialty in the same area that the insurer would approve, and

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(C) Inform the worker that if the worker disagrees with the disapproval, the worker may request approval from the director under OAR 436-010-0220.

(6) If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician. The insurer must notify the worker and the physician in writing:

(a) The reasons for withdrawing the approval,

(b) That any future services provided by that physician will not be paid by the insurer, and

(c) That the worker may be liable for payment of services provided after the date of notification.

(7) If the worker disagrees with the insurer's decision to disapprove an out-of-state attending physician, the worker or worker's representative may request approval from the director under OAR 436-010-0220.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.005(12), 656.245, 656.260

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0220      Choosing and Changing Medical Providers**

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment he or she considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:

(a) Emergency services;

(b) Insurer or director requested examinations;

(c) A Worker Requested Medical Examination;

(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and

(e) Diagnostic studies provided by radiologists and pathologists upon referral.

### **(2) Changing Attending Physician or Authorized Nurse Practitioner.**

The worker may choose to change his or her attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:

(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;

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- (b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or
- (c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:
- (A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;
  - (B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;
  - (C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;
  - (D) When the period for treatment or services by a type B attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");
  - (E) When the authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;
  - (F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;
  - (G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or
  - (H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

**(3) Insurer Notice to the Worker.**

When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to

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notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change his or her attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.

**(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.**

(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:

- (A) Send the worker a written explanation of the reasons;
- (B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and
- (C) Inform the worker that he or she may request director approval by sending Form 2332 to the director.

(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.

(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:

- (A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.
- (B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date

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of the order.

**(5) Managed Care Organization (MCO) Enrolled Workers.**

An MCO enrolled worker must choose:

- (a) A panel provider unless the MCO approves a non-panel provider, or
  
- (b) A “come-along provider” who provides medical services subject to the terms and conditions of the governing MCO.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.245, 656.252, 656.260

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## 436-010-0225    **Choosing a Person to Provide Interpreter Services**

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

**Stat. Auth:** ORS 656.726(4)  
**Stats. Implemented:** ORS 656.245  
Adopted 5/27/10, as Admin. Order 10-053, eff. 7/1/10

## **436-010-0230 Medical Services and Treatment Guidelines**

(1) Medical services provided to the worker must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.

(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize time loss. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.

### **(4) Consent to Attend a Medical Appointment.**

(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.

(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.

(B) The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.

(C) The insurer must keep a copy of the signed consent form in the claim file.

(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.

### **(5) Request for Records at a Medical Appointment.**

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The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.

**(6) Requesting a Medical Provider Consultation.**

The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.

**(7) Ancillary Services – Treatment Plan.**

(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.

(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.

(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes.

(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")

(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.

(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants directed by the attending physician do not have to provide a written treatment

plan as prescribed in this section.

**(8) Massage Therapy.**

Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services provided by a massage therapist licensed by the Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by massage therapists must follow the same requirements as those for ancillary providers in section (5) of this rule.

**(9) Therapy Guidelines and Requirements.**

(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.

(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:

- (A) Subjective status of the patient;
- (B) Objective data from tests and measurements conducted;
- (C) Functional status of the patient;
- (D) Interpretation of above data; and
- (E) Any change in the treatment plan.

**(10) Physical Capacity Evaluation.**

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The attending physician or authorized nurse practitioner must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician or authorized nurse practitioner must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.

**(11) Prescription Medication.**

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. 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. 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 worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.

(b) Providers should review and are encouraged to adhere to the workers' compensation division's opioid guidelines. See <http://www.cbs.state.or.us/wcd/rdrs/mru/ogandcal.html>.

**(12) Diagnostics.**

Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.

**(13) Articles.**

Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices are not compensable unless a report by the attending physician or authorized nurse

practitioner clearly justifies the need. The report must:

- (a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and
- (b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.

#### **(14) Physical Restorative Services.**

(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:

- (A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and
- (B) A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.

(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

#### **(15) Lumbar Artificial Disc Replacement Guidelines.**

(a) Lumbar artificial disc replacement is always inappropriate for patients with the following conditions (absolute contraindications):

- (A) Metabolic bone disease – for example, osteoporosis;
- (B) Known spondyloarthropathy (seropositive and seronegative);
- (C) Posttraumatic vertebral body deformity at the level of the proposed surgery;
- (D) Malignancy of the spine;
- (E) Implant allergy to the materials involved in the artificial disc;
- (F) Pregnancy – currently;
- (G) Active infection, local or systemic;
- (H) Lumbar spondylolisthesis or lumbar spondylolysis;
- (I) Prior fusion, laminectomy that involves any part of the facet joint, or

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facetectomy at the same level as proposed surgery; or

**(J)** Spinal stenosis – lumbar – moderate to severe lateral recess and central stenosis.

**(b)** Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients with the following conditions, depending on severity, location, etc. (relative contraindications):

**(A)** A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;

**(B)** Arachnoiditis;

**(C)** Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);

**(D)** Facet arthropathy – lumbar – moderate to severe, as shown radiographically;

**(E)** Morbid obesity – BMI greater than 40;

**(F)** Multilevel degenerative disc disease – lumbar – moderate to severe, as shown radiographically;

**(G)** Osteopenia – based on bone density test;

**(H)** Prior lumbar fusion at a different level than the proposed artificial disc replacement; or

**(I)** Psychosocial disorders – diagnosed as significant to severe.

**(16) Cervical Artificial Disc Replacement Guidelines.**

**(a)** Cervical artificial disc replacement is always inappropriate for patients with any of the following conditions (absolute contraindications):

**(A)** Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;

**(B)** Significantly abnormal facets;

**(C)** Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g., -2.7);

**(D)** Allergy to metal implant;

**(E)** Bone disorders (any disease that affects the density of the bone);

**(F)** Uncontrolled diabetes mellitus;

**(G)** Active infection, local or systemic;

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- (H) Active malignancy, primary or metastatic;
- (I) Bridging osteophytes (severe degenerative disease);
- (J) A loss of disc height greater than 75 percent relative to the normal disc above;
- (K) Chronic indefinite corticosteroid use;
- (L) Prior cervical fusion at two or more levels; or
- (M) Pseudo-arthritis at the level of the proposed artificial disc replacement.

(b) Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) may be inappropriate for patients with any of the following conditions, depending on severity, location, etc. (relative contraindications):

- (A) A comorbid medical condition compromising general health, for example hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;
- (B) Multilevel degenerative disc disease – cervical – moderate to severe, as shown radiographically;
- (C) Osteopenia – based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;
- (D) Prior cervical fusion at one level;
- (E) A loss of disc height of 50 percent to 75 percent relative to the normal disc above; or
- (F) Psychosocial disorders – diagnosed as significant to severe.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.245, 656.248, 656.252

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0240 Medical Records and Reporting Requirements for Medical Providers**

### **(1) Medical Records and Reports.**

(a) Medical providers must maintain records necessary to document the extent of medical services provided.

(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).

### **(2) Diagnostic Studies.**

When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

### **(3) Multidisciplinary Programs.**

When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

**(4) Release of Medical Records.**

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and

(B) HIV-related information protected by ORS 433.045(3).

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

(A) Psychotherapy notes;

(B) Information compiled for use in a civil, criminal, or administrative action or

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proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or his or her representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of his or her medical records because of inability to pay.

**(5) Release to Return to Work.**

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

**(6) Time Loss and Medically Stationary.**

(a) When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

(A) The anticipated date of release to work;

(B) The anticipated date the patient will become medically stationary;

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- (C) The next appointment date; and
- (D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

**(7) Consultations.**

When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

**Stat. Auth:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.245, 656.252, 656.254

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0241 Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims**

### **(1) First Visit.**

(a) When the patient has filed an initial claim or wants to file an initial claim, the patient and the first medical service provider must complete and sign Form 827. The provider must send the form to the insurer no later than 72 hours after the patient's first visit (Saturdays, Sundays, and holidays are not counted in the 72-hour period).

(b) Form 3283 ("A Guide for Workers Recently Hurt on the Job") is included with Form 827. All medical service providers must give a copy of Form 3283 and Form 827 to the patient.

### **(2) New or Omitted Medical Condition.**

A patient may use Form 827 to request that the insurer formally accept a new or omitted medical condition. If the patient uses the form to request acceptance of a new or omitted medical condition during a medical visit, the medical service provider may write the claimed condition or the appropriate International Classification of Diseases (ICD) diagnosis code for the patient in the space provided on the form. After the patient signs the form, the provider must send it to the insurer within five days.

### **(3) Change of Attending Physician.**

When the patient changes attending physician or authorized nurse practitioner, the patient and the new medical service provider must complete and sign Form 827. The provider must send Form 827 to the insurer within five days after becoming a patient's attending physician or authorized nurse practitioner. The new attending physician or authorized nurse practitioner is responsible for requesting all available medical records from the previous attending physician, authorized nurse practitioner, or insurer. Anyone failing to forward the requested information to the new attending physician or authorized nurse practitioner within 14 days of receiving the request may be subject to sanctions under OAR 436-010-0340.

### **(4) Aggravation.**

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After the patient has been declared medically stationary, and an exam reveals an aggravation of the patient's accepted condition, the patient may file a claim for aggravation. The patient or the patient's representative and the attending physician must complete and sign Form 827. The physician, on the patient's behalf, must submit Form 827 to the insurer within five days of the exam. Within 14 days of the exam, the attending physician must send a written report to the insurer that includes objective findings that document:

(a) Whether the patient has suffered a worsened condition attributable to the compensable injury under the criteria in ORS 656.273; and

(b) Whether the patient is unable to work as a result of the compensable worsening.

**Stat. Auth:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.245, 656.252, 656.254, 656.273

**Hist:** Adopted 8/20/15 as Admin. Order 15-060, eff. 10/1/15

## **436-010-0250 Elective Surgery**

(1) "Elective surgery" is surgery that may be required to recover from an injury or illness, but is not an emergency surgery to preserve life, function, or health.

(2) Except as otherwise provided by the MCO, the attending physician, authorized nurse practitioner, or specialist physician must give the insurer at least seven days notice before the date of the proposed elective surgery to treat a compensable injury or illness. The notice must provide the medical information that substantiates the need for surgery, and the approximate surgical date and place if known. A chart note is considered "notice" if the information required by this section is included in the note.

(3) When elective surgery is proposed, the insurer may require an independent consultation (second opinion) with a physician of the insurer's choice.

(4) The insurer must respond to the recommending physician, the worker, and the worker's representative within seven days of receiving the notice of intent to perform surgery that the proposed surgery:

(a) Is approved;

(b) Is not approved and a consultation is requested by using Form 3228 (Elective Surgery Notification); or

(c) Is disapproved by using Form 3228.

(5) If the insurer does not complete Form 3228 (e.g., no specific date or consultant name) or communicate approval to the recommending physician within seven days of receiving the notice of intent to perform surgery, the insurer is barred from challenging the appropriateness of the surgery or whether the surgery is excessive or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

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(6) If the insurer requests a consultation, it must be completed within 28 days after sending Form 3228 to the physician.

(7) The insurer must notify the recommending physician of the consultant's findings within seven days of the consultation.

(8) When the consultant disagrees with the proposed surgery, the recommending physician and insurer should attempt to resolve disagreement. The insurer and recommending physician may agree to obtain additional diagnostic testing or other medical information, such as asking for clarification from the consultant, to assist in reaching an agreement regarding the proposed surgery.

(9) If the recommending physician cannot reach an agreement with the insurer and continues to recommend the proposed surgery, the physician must either send the signed and dated Form 3228 or other written notification to the insurer, the patient, and the patient's representative. If the insurer believes the proposed surgery is excessive, inappropriate, ineffectual, or in violation of these rules, the insurer must request administrative review before the director within 21 days of receiving the notification. If the insurer fails to timely request administrative review the insurer is barred from challenging whether the surgery is or was excessive, inappropriate, or ineffectual. The attending physician and the worker may decide whether to proceed with surgery.

(10) A recommending physician who prescribes or performs elective surgery and fails to give the insurer the seven day notice requirement may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340. The insurer may still be responsible to pay for the elective surgery.

(11) Surgery that must be performed before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases, the attending physician or authorized nurse practitioner should try to notify the insurer of the need for emergency surgery.

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**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.245, 656.248, 656.252, 656.260, 656.327

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0265 Independent Medical Exams (IMEs) and Worker Requested Medical Exams (WRMEs)**

### **(1) General.**

(a) Except as provided in section (12) of this rule, “independent medical exam” (IME) means any medical exam (including a physical capacity or work capacity evaluation or consultation that includes an exam) that is requested by the insurer under ORS 656.325. A “worker-requested medical exam” (WRME) is an exam available to a worker under ORS 656.325. An IME or WRME is completed by a medical service provider other than the worker’s attending physician or authorized nurse practitioner. The insurer may obtain three IMEs for each opening of the claim. These exams may be obtained before or after claim closure. For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as a statutory IME. A claim for aggravation, Board’s Own Motion, or reopening of a claim when the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 allows a new series of three IMEs. A medical service provider must not unreasonably interfere with the right of the insurer to obtain an IME by a physician of the insurer’s choice. The insurer must choose the medical service providers from the director’s list of authorized IME providers under ORS 656.328. The IME may be conducted by one or more providers of different specialties, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the IME must be completed within a 72-hour period and at locations reasonably convenient to the worker.

(b) The provider will determine the conditions under which the exam will be conducted.

(c) IMEs must be at times and intervals reasonably convenient to the worker and must not delay or interrupt treatment of the worker.

(d) When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(e) A medical provider who unreasonably fails to provide diagnostic records for an IME under OAR 436-010-0240 may be assessed a penalty under ORS 656.325.

(f) The worker may complete an online survey at [www.wcdimesurvey.info](http://www.wcdimesurvey.info) or make a complaint about the IME on the Workers’ Compensation Division’s website. If the worker does not have access to the Internet, the worker may call the Workers’

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Compensation Division at 503-947-7606.

**(2) IME/WRME Authorization.**

**(a)** Medical service providers can perform IMEs, WRMEs, or both once they complete a director-approved training and are placed on the director's list of authorized IME providers.

**(A)** To be on the director's list to perform IMEs or WRMEs, a medical service provider must complete the online application at [www.oregonwcdoc.info](http://www.oregonwcdoc.info), hold a current license, be in good standing with the provider's regulatory board, and must have:

**(i)** Reviewed IME training materials provided or approved by the director found at [www.oregonwcdoc.info](http://www.oregonwcdoc.info); or

**(ii)** Completed a director-approved training course regarding IMEs. The training curriculum must include all topics listed in Appendix B.

**(B)** By submitting the application to the director, the medical service provider agrees to abide by:

**(i)** The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or standards published in Appendix C if the provider's regulatory board does not have standards; and

**(ii)** All relevant workers' compensation laws and rules.

**(C)** A provider may be sanctioned or removed from the director's list of authorized IME providers after the director finds that the provider:

**(i)** Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C;

**(ii)** Has a current restriction on his or her license or is under a current disciplinary action from their professional regulatory board;

**(iii)** Has entered into a voluntary agreement with his or her regulatory board that the director determines is detrimental to performing IMEs;

**(iv)** Violated workers' compensation laws or rules; or

**(v)** Has failed to complete training required by the director.

**(D)** A provider may appeal the director's decision to exclude or remove the provider from the director's list within 60 days under ORS 656.704(2) and OAR 436-001-0019.

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(b) If a provider is not on the director's list of authorized IME providers at the time of the IME, the insurer may not use the IME report and the report may not be used in any subsequent proceedings.

**(3) IME Training.**

(a) The IME provider training curriculum must be approved by the director before the training is given. Any party may submit a curriculum to the director for approval. The curriculum must include:

- (A) A training outline,
- (B) Goals,
- (C) Objectives,
- (D) The method of training, and
- (E) All topics addressed in Appendix B.

(b) Within 21 days of the IME training, the training vendor must send the director the date of the training and a list of all medical providers who completed the training, including names and license numbers.

(c) Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

**(4) IME Related Forms.**

(a) When scheduling an IME, the insurer must ensure the medical service provider has:

- (A) Form 3923, "Important Information about Independent Medical Exams," available to the worker before the exam; and
- (B) Form 3227, "Invasive Medical Procedure Authorization," if applicable.

(b) The IME provider must make Form 3923 with the attached observer Form 3923A available to the worker.

**(5) IME Observer.**

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(a) A worker may choose to have an observer present during the IME, however, an observer may not participate in or obstruct the IME. An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must sign Form 3923A, "IME Observer Form," acknowledging that the worker understands the IME provider may ask sensitive questions during the exam in the presence of the observer. An observer must not participate in or obstruct the exam. If the worker does not sign Form 3923A, the provider may exclude the observer. The IME provider must verify that the worker signed the "IME Observer Form" acknowledging that the worker understands:

- (A) The IME provider may ask sensitive questions during the exam in the presence of the observer;
- (B) If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits; and
- (C) The observer must not be paid to attend the exam.

(c) A person receiving any compensation for attending the exam may not be a worker's observer. The worker's attorney or any representative of the worker's attorney may not be an observer.

**(6) Invasive Procedure.**

For the purposes of this rule, an invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure and sign the form.

**(7) Record the Exam.**

With the IME provider's approval, the worker may use a video camera or other recorder to record the exam.

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**(8) Objection to the IME Location.**

When a worker objects to the location of an IME, the worker may request review before the director within six business days of the mailing date of the appointment notice.

- (a) The request may be made in-person, by telephone, fax, email, or mail.
  
- (b) The director may facilitate an agreement between the parties regarding location.
  
- (c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.
  
- (d) The director will determine if travel is medically contraindicated or unreasonable because:
  - (A) The travel exceeds limitations imposed by the attending physician, authorized nurse practitioner, or any medical conditions;
  - (B) Alternative methods of travel will not overcome the limitations; or
  - (C) The travel would impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

**(9) Failure to Attend an IME.**

If the worker fails to attend an IME and does not notify the insurer before the date of the exam or does not have sufficient reason for not attending the exam, the director may impose a monetary penalty against the worker for failure to attend.

**(10) IME Report.**

- (a) Upon completion of the exam, the IME provider must:
  - (A) Send the insurer a copy of the report and, if applicable, the observer Form 3923A, the invasive procedure Form 3227, or both.
  - (B) Sign a statement at the end of the report acknowledging that any false statements may result in sanctions by the director and verifying:
    - (i) Who performed the exam;
    - (ii) Who dictated the report; and
    - (iii) The accuracy of the report content.

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(b) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within ~~72 hours~~ three days, excluding weekends and legal holidays, of the insurer's receipt of the report.

**(11) Request for Additional Exams.**

(a) When the insurer has obtained the three IMEs allowed under this rule and wants to require the worker to attend an additional IME, the insurer must first request authorization from the director. Insurers that fail to request authorization from the director may be assessed a civil penalty. The process for requesting authorization is:

(A) The insurer must submit a request for authorization to the director by using Form 2333, "Insurer's Request for Director Approval of an Additional Independent Medical Examination." The insurer must send a copy of the request to the worker and the worker's attorney, if any; and

(B) The director will review the request and determine if additional information from the insurer or the worker is necessary. Upon receiving a written request for additional information from the director, the parties have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

(b) To determine whether to approve or deny the request for an additional IME, the director may consider, but is not limited to, whether:

(A) An IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(B) There has been a significant change in the worker's condition.

(C) There is a new condition or compensable aspect introduced to the claim.

(D) There is a conflict of medical opinions about a worker's medical treatment, medical services, impairment, stationary status, or other issues critical to claim processing or benefits.

(E) The IME is requested to establish preponderance for medically stationary status.

(F) The IME is medically harmful to the worker.

(G) The IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

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(c) Any party who disagrees with the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the Workers' Compensation Board under ORS 656.283 and OAR chapter 438.

**(12) Other Exams – Not Considered IMEs.**

The following exams are not considered IMEs and do not require approval as outlined in section (11) of this rule:

(a) An exam, including a closing exam, requested by the worker's attending physician or authorized nurse practitioner;

(b) An exam requested by the director;

(c) An elective surgery consultation requested under OAR 436-010-0250(3);

(d) An exam of a permanently totally disabled worker required under ORS 656.206(5);

(e) A closing exam that has been arranged by the insurer at the attending physician's or authorized nurse practitioner's request; and

(f) An exam requested by the managed care organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under the MCO's contract.

**Stat. Auth:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0270 Insurer's Rights and Duties**

### **(1) Notifications.**

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

### **(2) Medical Records Requests.**

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

**(3) Pre-authorization.**

Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

**(4) Insurer's Duties under MCO Contracts.**

**(a)** Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

- (A)** The names and addresses of all MCO panel providers within the employer's geographical service area(s);
- (B)** How workers can receive compensable medical services within the MCO;
- (C)** How workers can receive compensable medical services by non-panel providers; and
- (D)** The geographical service area governed by the MCO.

**(b)** Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

**(c)** When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney to the MCO.

**(d)** When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

- (A)** Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:
  - (i)** Provide a telephone number the worker may call to ask for a written list; and
  - (ii)** Tell the worker that he or she has seven days from the mailing date of the notice to request the list;
- (B)** Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

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**(C)** Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

**(i)** Must to change attending physician or authorized nurse practitioner to an MCO panel provider, or

**(ii)** May continue to treat with the worker's current attending physician or authorized nurse practitioner;

**(D)** Explain how the worker can receive compensable medical treatment from a "come-along" provider;

**(E)** Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied; and

**(F)** Notify the worker of his or her right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

**(e)** When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

**(f)** When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

**(g)** If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0035(4).

**(h)** Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

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- (A) Send a copy of the dispute to the MCO; or
  - (B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.
- (i) The insurer must notify the MCO within seven days of receiving notification of the following:
- (A) Any changes to the worker's or worker's attorney's name, address, or telephone number;
  - (B) Any requests for medical services from the worker or the worker's medical provider; or
  - (C) Any request by the worker to continue treating with a "come-along" provider.
- (j) Insurers under contract with MCOs must maintain records including, but not limited to:
- (A) A listing of all employers covered by MCO contracts;
  - (B) The employers' WCD employer numbers;
  - (C) The estimated number of employees governed by each MCO contract;
  - (D) A list of all workers enrolled in the MCO; and
  - (E) The effective dates of such enrollments.
- (k) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.
- (l) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

**Stat. Auth:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

**Hist:** Amended 3/12/14 as WCD Admin. Order 14-053, eff. 4/1/14

Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0280    Determination of Impairment / Closing Exams**

(1) When a worker has received compensation for time loss or it is likely the worker has permanent impairment and becomes medically stationary, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, the provider must refer the worker to a type A attending physician to do a closing exam.

(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A “Matrix for Health Care Provider Types”.)

(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.

(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer.

(5) The attending physician must specify the worker’s residual functional capacity if:

(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and

(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.

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(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for:

(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or

(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.

(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary:

(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or

(b) An authorized nurse practitioner or a type B attending physician, other than a chiropractic physician, must refer the worker to a type A attending physician for a closing exam.

(8) The closing report must include all of the following:

(a) Findings of permanent impairment.

(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

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**(D)** In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an accepted occupational disease.

**(b)** Findings documenting permanent work restrictions.

**(A)** If the worker has no permanent work restriction, the closing report must include a statement indicating that:

**(i)** The worker has no permanent work restriction; or

**(ii)** The worker is released, without restriction, to the job held at the time of injury.

**(B)** In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:

**(i)** Prevents the worker from returning to the job held at the time of injury; and

**(ii)** Is caused in any part by an accepted condition, a direct medical sequela of an accepted condition, or a condition directly resulting from the work injury.

**(C)** In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:

**(i)** Prevents the worker from returning to the job held at the time of injury; and

**(ii)** Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.

**(D)** In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:

**(i)** Prevents the worker from returning to the job held at the time of injury; and

**(ii)** Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.

**(E)** In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:

**(i)** Prevents the worker from returning to the job held at the time of injury; and

**(ii)** Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.

**(c)** A statement regarding the validity of an impairment finding is required in the following circumstances:

**(A)** If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the

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determination that the finding is invalid.

(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.

(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.

**Stat. Auth:** ORS 656.726(4), 656.245(2)(b)

**Stats. Implemented:** ORS 656.245, 656.252

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0290    Medical Care After Medically Stationary**

(1) A worker is found medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Medical services after a worker's condition is medically stationary are compensable only when services are:

- (a) Palliative care under section (2) of this rule;
  
- (b) Curative care under sections (3) and (4) of this rule;
  
- (c) Provided to a worker who has been determined permanently and totally disabled;
  
- (d) Prescription medications;
  
- (e) Necessary to administer or monitor administration of prescription medications;
  
- (f) Prosthetic devices, braces, or supports;
  
- (g) To monitor the status of, to replace, or to repair prosthetic devices, braces, and supports;
  
- (h) Provided under an accepted claim for aggravation;
  
- (i) Provided under Board's Own Motion;
  
- (j) Necessary to diagnose the worker's condition; or
  
- (k) Life-preserving modalities similar to insulin therapy, dialysis, and transfusions.

### **(2) Palliative Care.**

(a) Palliative care means that medical services are provided to temporarily reduce or moderate the intensity of an otherwise stable medical condition. It does not include those

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medical services provided to diagnose, heal, or permanently alleviate or eliminate a medical condition. Palliative care is compensable when the attending physician prescribes it and it is necessary to enable the worker to continue current employment or a vocational training program. Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must:

- (A) Describe any objective findings;
- (B) Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis;
- (C) Detail a treatment plan which includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days;
- (D) Explain how the requested care is related to the compensable condition; and
- (E) Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved.

(b) Palliative care may begin after the attending physician submits the request to the insurer. If the insurer approves the request, palliative care services are payable from the date service begins. However, if the request is ultimately disapproved, the insurer is not liable for payment of the palliative care services.

(c) Insurers must date stamp all palliative care requests upon receipt. Within 30 days of receiving the request, the insurer must send written notice to the attending physician, worker, and worker's attorney approving or disapproving the request.

(d) If the insurer disapproves the request, the insurer must explain the reason why in writing. Reasons to disapprove a palliative care request may include:

- (A) The palliative care services are not related to the accepted condition(s);
- (B) The palliative care services are excessive, inappropriate, or ineffectual; or
- (C) The palliative care services will not enable the worker to continue current employment or a current vocational training program.

(e) When the insurer disapproves the palliative care request, the attending physician or the worker may request administrative review before the director under OAR 436-010-0008. The request for review must be within 90 days from the date of the insurer's disapproval notice. In addition to information required by OAR 436-010-0008, if the request is from the attending physician, it must include:

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- (A) A copy of the original request to the insurer; and
- (B) A copy of the insurer's response.

(f) If the insurer fails to respond to the request in writing within 30 days, the attending physician or worker may request approval from the director within 120 days from the date the request was first submitted to the insurer. When the attending physician requests approval from the director, the physician must include a copy of the original request and may include any other supporting information.

(g) Subsequent requests for palliative care are subject to the same process as the initial request; however, the insurer may waive the requirement that the attending physician submit a supplemental palliative care request.

### **(3) Curative Care.**

Curative medical care is compensable when the care is provided to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

### **(4) Advances in Medical Science.**

The director must approve curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. When the attending physician believes that curative care is appropriate, the physician must submit a written request for approval to the director. The request must:

- (a) Describe any objective findings;
- (b) Identify the appropriate ICD diagnosis (the medical condition for which the care is requested);
- (c) Describe in detail the advance in medical science that has occurred since the worker's claim was closed that is highly likely to improve the worker's condition;
- (d) Provide an explanation, based on sound medical principles, as to how and why the care will improve the worker's condition; and

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(e) Describe why the care is otherwise justified by the circumstances of the claim.

Stat. Auth: ORS 656.726

Stats. Implemented: ORS 656.245

Hist: Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the Index to Rule History: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0300 Requesting Exclusion of Medical Treatment from Compensability**

If a worker or insurer believes that any medical treatment is unscientific, unproven as to its effectiveness, outmoded, or experimental, either party may initiate a request for exclusion of the medical treatment from compensability under ORS 656.245(3). The request must include documentation on why the medical treatment should be excluded from compensability for workers' compensation claims. The director will request advice from the licensing boards of practitioners that might be affected and the Medical Advisory Committee. The director will issue an order and may adopt a rule declaring the treatment to be noncompensable. The decision of the director is appealable under ORS 656.704. Request for administrative review of an individual worker's treatment under ORS 656.327 does not initiate review under this process. Excluded treatments are listed in OAR 436-009-0010.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.245

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## 436-010-0330    **Medical Arbiters and Physician Reviewers**

(1) The director will establish and maintain a list of arbiters. The director will appoint a medical arbiter or a panel of medical arbiters from this list under ORS 656.268.

(2) The director will establish and maintain a list of physician reviewers. The director will appoint an appropriate physician or a panel of physicians from this list to review medical treatment or medical services disputes under ORS 656.245, ~~656.260~~, and 656.327.

(3) When a worker is required to attend an examination under this rule, the director will provide notice of the examination to the worker and all affected parties. The notice will inform all parties of the time, date, location, and purpose of the examination. Examinations will be at a place reasonably convenient to the worker, if possible.

**Stat. Auth:** ORS 656.726(4)

**Stats. Implemented:** ORS 656.268, 656.325, 656.327

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0335      Monitoring and Auditing Medical Providers**

(1) The director may monitor and conduct periodic audits of medical providers to ensure compliance with ORS chapter 656 and chapter 436 of the administrative rules.

(2) All records maintained or required to be maintained must be disclosed upon request of the director.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.245, 656.254, 656.745

Hist: Amended and renumbered from OAR 436-010-0260 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the Index to Rule History: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

## **436-010-0340     Sanctions and Civil Penalties**

(1) If the director finds any medical provider in violation of the medical reporting requirements established under ORS 656.245, 656.252, 656.254(1), or 656.325, or OAR 436-009 or 436-010, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Non-payment, reduction, or recovery of fees in part or whole for medical services provided;

(c) Referral to the appropriate licensing board;

(d) Civil penalty not to exceed \$1,000 for each occurrence. In determining the amount of penalty to be assessed, the director will consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations; or

(e) A penalty of \$100 for each violation of ORS 656.325(1)(c)(C).

(2) If the medical provider fails to provide information under OAR 436-010-0240 within fourteen days of receiving a request sent by certified mail or fax, penalties under this rule or OAR 436-015-0120 may be imposed.

(3) The director may impose a penalty of forfeiture of fees and a fine not to exceed \$1,000 for each occurrence on any medical service provider who, under ORS 656.254, and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(b) Provide medical services that are excessive, inappropriate, or ineffectual; or

(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a

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worker.

(4) If the conduct as described in section (3) of this rule is found to be repeated and willful, the director may declare the medical provider ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years.

(5) A medical provider whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation patients for a period not to exceed three years. A certified copy of the revocation or suspension order will be prima facie justification for the director's order.

(6) If a financial penalty is imposed on the medical provider for violation of these rules, the provider may not seek recovery of the penalty fees from the worker.

(7) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are ~~not~~ appropriate, either may submit a complaint in writing to the director.

(8) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical services, the director may order the insurer to reimburse any affected medical providers for services provided until the insurer complies with the notification requirement. Any penalty will be limited to the amounts listed in section (9) of this rule.

(9) If the director finds any insurer in violation of statute, OAR 436-009, OAR 436-010, or an order of the director, the insurer may be subject to penalties under ORS 656.745 of not more than \$2,000 for each violation or \$10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, will be considered a separate violation.

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**(10)** The director may subject a worker who fails to meet the requirements in OAR 436-010-0265(9) to a \$100 penalty per occurrence under ORS 656.325, to be deducted from future benefits.

**Stat. Auth:** ORS 656.726(4)

**Stat. Implemented:** ORS 656.245, 656.254, 656.745

**Hist:** Amended 8/20/15 as Admin. Order 15-060, eff. 10/1/15

See also the *Index to Rule History*: [http://www.cbs.state.or.us/wcd/policy/rules/436\\_history.pdf](http://www.cbs.state.or.us/wcd/policy/rules/436_history.pdf).

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**Appendix A - Matrix for health care provider types \***

See OAR 436-010-0005

	Attending physician status (primarily responsible for treatment of a patient's injury)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (temporary disability) and release the patient 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 physician Naturopathic physician 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. <u>(Note: physician assistants are not required to have a written treatment plan)</u>	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 physicians	No, if the physician refers the patient to a primary care physician	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization	No if patient 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

**Appendix B**

**Independent Medical Examination (IME)**

**Medical Service Provider  
Training Curriculum Requirements**

A. Overview

WCD will provide the overview portion of the curriculum to vendors for use in their approved training program.

1. Why the IME training is required.

- a) The Workers' Compensation Management-Labor Advisory Committee requested a study after hearing anecdotal injured worker complaints.
- b) The Workers' Compensation Division (WCD) study found there was perceived bias in the IME system.
- c) There was no process to handle complaints about IMEs.
- d) There was concern about IME report quality.
- e) The 2005 Legislature passed Senate Bill 311 unanimously.

2. Workers' compensation system:

- a) Public policy: workers' compensation law [ORS 656.012 (2)] identifies four objectives:
  - 1) Provide, regardless of fault, sure, prompt and complete medical treatment for injured workers, and fair, adequate, and reasonable income benefits to injured workers and their dependents.
  - 2) Provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent possible, while providing for access to adequate representation for injured workers.
  - 3) Restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable.
  - 4) Encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents.

Additional items to discuss:

- Exclusive remedy.
  - The Legislature found that common law is expensive without proportionate benefit.
  - No fault versus tort.
  - The economy and the costs of injuries.
- b) Causation of work related injuries.
- Is the injury work related?
  - What are pre-existing conditions?
  - What is major contributing cause?

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- What is material contributing cause?
  
- c) The IME provider role
  - Unbiased, neutral third-party
  - Independent
  
- d) The difference between IMEs and
  - Worker Requested Medical Exams (Causation)
  - Arbitrator Exams (Reconsideration)
  - Physician Reviews (Medical disputes)
  
- B. Provider Code of Professional Conduct  
IME providers must follow a professional standard or guidelines of conduct while performing IMEs. The guidelines must be:
  1. The guidelines adopted by the appropriate health professional regulatory board, OR
  2. The "Guidelines of Conduct" published in Appendix C, if the appropriate regulatory board hasn't adopted standards for professional conduct regarding IMEs.
  
- C. Report writing
  1. The statement of accuracy must be in compliance with OAR 436-010-0265.
  2. Report content: what comprises a good IME report?
  
- D. Communication  
What is appropriate communication between claims examiners and medical providers?
  
- E. Training specific to the requirements of ORS 656.325, OAR 436-010, and 436-060 concerning:
  1. Observers
  2. Recording of exams
  3. Invasive procedures
  4. Sanctions and civil penalties
  5. Worker penalties and suspension
  6. Exam location disputes
  7. Forms
  8. Complaints.
  
- F. Sanctions of providers, up to and including removal from the list:
  1. Provider has restrictions on its license or current disciplinary actions from its health professional regulatory board.
  2. Provider has entered into a voluntary agreement with the licensing board that the director has determined to be detrimental to performing IMEs.
  3. Provider has violated the standards of professional conduct for IMEs.
  4. Provider has violated workers' compensation laws or rules.
  5. Provider has failed to attend training required by the director.

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- G. If the director removes a provider's name from the director's list, providers may appeal.
- H. Workers' Compensation Division's complaint process:
  - 1. Use of injured workers surveys about IMEs
  - 2. Complaints received by the Workers' Compensation Division.
- I. Impairment findings: The purpose of measuring impairment is vital to accurately report return-to-work status using job description, job analysis, work capacities, video of the job at injury being performed, etc.
- J. Other necessary information as determined by the director.

**OAR 436-010-0265**

**Appendix C**

**Independent Medical Examination Standards**

**As developed by the Independent Medical Examination Association**

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
  - a. Remind the examinee of the party who requested the examination.
  - b. Explain to the examinee that a physician-patient relationship will not be sought or established.
  - c. Tell the examinee the information provided during the examination will be documented in a report.
  - d. Review the procedures that will be used during the examination.
  - e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
  - f. Answer the examinee's questions about the examination process.
6. During the examination:
  - a. Ensure the examinee has privacy to disrobe.
  - b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
  - c. Examine the condition being evaluated sufficient to answer the requesting party's questions.
  - d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide additional information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which the physician is qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.



## MEMORANDUM

February 4, 2016

To: Fred Bruyns, Rules Coordinator

From: Juerg Kunz, Medical Policy Analyst

Subject: Appendix C

Appendix C contains the ambulatory surgery center (ASC) fee schedule amount for surgical procedures. The second column indicates whether a surgical procedure is subject to the multiple procedure discount. If the column contains the letter "Y," it means the procedure is subject to the multiple procedure discount; if the column contains the letter "N," it means the procedure is not subject to the multiple procedure discount.

The determination whether a procedure performed at an ASC is subject to the multiple procedure discount is made according to the following:

A procedure is subject to the multiple procedure discount unless:

- The Centers for Medicare & Medicaid Services (CMS) designates the procedure as not being subject to the multiple procedure discount; or
- The payment for the procedure is packaged into the payment of another procedure.

In the proposed 4-1-16 Appendix C, many procedures that are subject to the multiple procedure discount are listed erroneously as not being subject to the multiple procedure discount.

WCD intends to correct this error in Appendix C when filing notice of the permanent OAR 436-009 with the secretary of state.

The codes affected are listed below this Memorandum.

Juerg Kunz  
Medical Policy Analyst

19020	20150	20838	21073	21194	21343	21501	22110	22630	23040	23415
19081	20200	20900	21076	21195	21344	21502	22112	22632	23044	23420
19083	20205	20902	21077	21196	21345	21510	22114	22633	23065	23430
19085	20206	20910	21079	21198	21346	21550	22116	22634	23066	23440
19100	20220	20912	21080	21199	21347	21552	22206	22800	23071	23450
19101	20225	20920	21081	21206	21348	21554	22207	22802	23073	23455
19105	20240	20922	21082	21208	21355	21555	22208	22804	23075	23460
19110	20245	20924	21083	21209	21356	21556	22210	22808	23076	23462
19112	20250	20926	21084	21210	21360	21557	22212	22810	23077	23465
19120	20251	20950	21085	21215	21365	21558	22214	22812	23078	23466
19125	20500	20955	21086	21230	21366	21600	22216	22818	23100	23470
19296	20520	20956	21087	21235	21385	21610	22220	22819	23101	23472
19298	20525	20957	21088	21240	21386	21615	22222	22830	23105	23473
19300	20526	20962	21089	21242	21387	21616	22224	22840	23106	23474
19301	20527	20969	21100	21243	21390	21620	22226	22841	23107	23480
19302	20550	20970	21120	21244	21395	21627	22305	22842	23120	23485
19303	20551	20972	21121	21245	21400	21630	22310	22843	23125	23490
19304	20552	20973	21122	21246	21401	21632	22315	22844	23130	23491
19305	20553	20974	21123	21247	21406	21685	22318	22845	23140	23500
19306	20555	20982	21125	21248	21407	21700	22319	22846	23145	23505
19307	20600	20983	21127	21249	21408	21705	22325	22847	23146	23515
19316	20604	20999	21137	21255	21421	21720	22326	22848	23150	23520
19318	20605	21010	21138	21256	21422	21725	22327	22849	23155	23525
19324	20606	21011	21139	21260	21423	21740	22328	22850	23156	23530
19325	20610	21012	21141	21261	21431	21742	22505	22852	23170	23532
19340	20611	21013	21142	21263	21432	21743	22510	22855	23172	23540
19342	20612	21014	21143	21267	21433	21750	22511	22856	23174	23545
19350	20615	21015	21145	21268	21435	21811	22513	22857	23180	23550
19355	20650	21016	21146	21270	21436	21812	22514	22858	23182	23552
19357	20660	21025	21147	21275	21440	21813	22526	22861	23184	23570
19361	20661	21026	21150	21280	21445	21820	22527	22862	23190	23575
19364	20662	21029	21151	21282	21450	21825	22532	22864	23195	23585
19366	20663	21030	21154	21295	21451	21899	22533	22865	23200	23600
19367	20664	21031	21155	21296	21452	21920	22534	22899	23210	23605
19368	20690	21032	21159	21299	21453	21925	22548	22900	23220	23615
19369	20692	21034	21160	21310	21454	21930	22551	22901	23330	23616
19370	20693	21040	21172	21315	21461	21931	22554	22902	23333	23620
19371	20696	21044	21175	21320	21462	21932	22556	22903	23334	23625
19380	20697	21045	21179	21325	21465	21933	22558	22904	23335	23630
19396	20802	21046	21180	21330	21470	21935	22585	22905	23395	23650
19499	20805	21047	21181	21335	21480	21936	22586	22999	23397	23655
20005	20808	21048	21182	21336	21485	22010	22590	23000	23400	23660
20100	20816	21049	21183	21337	21490	22015	22595	23020	23405	23665
20101	20822	21050	21184	21338	21495	22100	22600	23030	23406	23670
20102	20824	21060	21188	21339	21497	22101	22610	23031	23410	23675
20103	20827	21070	21193	21340	21499	22102	22612	23035	23412	23680

23700	24310	24579	25100	25335	25574	26020	26356	26508	26676	27035
23800	24320	24582	25101	25337	25575	26025	26357	26510	26685	27036
23802	24330	24586	25105	25350	25600	26030	26358	26516	26686	27040
23900	24331	24587	25107	25355	25605	26034	26370	26517	26700	27041
23920	24332	24600	25109	25360	25606	26035	26372	26518	26705	27043
23921	24340	24605	25110	25365	25607	26037	26373	26520	26706	27045
23929	24341	24615	25111	25370	25608	26040	26390	26525	26715	27047
23930	24342	24620	25112	25375	25609	26045	26392	26530	26720	27048
23931	24343	24635	25115	25390	25622	26055	26410	26531	26725	27049
23935	24344	24640	25116	25391	25624	26060	26412	26535	26727	27050
24000	24345	24650	25118	25392	25628	26070	26415	26536	26735	27052
24006	24346	24655	25119	25393	25630	26075	26416	26540	26740	27054
24065	24357	24665	25120	25394	25635	26080	26418	26541	26742	27057
24066	24358	24666	25125	25400	25645	26100	26420	26542	26746	27059
24071	24359	24670	25126	25405	25650	26105	26426	26545	26750	27060
24073	24360	24675	25130	25415	25651	26110	26428	26546	26755	27062
24075	24361	24685	25135	25420	25652	26111	26432	26548	26756	27065
24076	24362	24800	25136	25425	25660	26113	26433	26550	26765	27066
24077	24363	24802	25145	25426	25670	26115	26434	26551	26770	27067
24079	24365	24900	25150	25430	25671	26116	26437	26553	26776	27070
24100	24366	24920	25151	25431	25675	26117	26440	26554	26785	27071
24101	24370	24925	25170	25440	25676	26118	26442	26555	26820	27075
24102	24371	24930	25210	25441	25680	26121	26445	26556	26841	27076
24105	24400	24931	25215	25442	25685	26123	26449	26560	26842	27077
24110	24410	24935	25230	25443	25690	26130	26450	26561	26843	27078
24115	24420	24940	25240	25444	25695	26135	26455	26562	26844	27080
24116	24430	24999	25248	25445	25800	26140	26460	26565	26850	27086
24120	24435	25000	25259	25446	25805	26145	26471	26567	26852	27087
24125	24470	25001	25260	25447	25810	26160	26474	26568	26860	27090
24126	24495	25020	25263	25449	25820	26170	26476	26580	26862	27091
24130	24498	25023	25265	25450	25825	26180	26477	26587	26910	27096
24134	24500	25024	25270	25455	25830	26185	26478	26590	26951	27097
24136	24505	25025	25272	25490	25900	26200	26479	26591	26952	27098
24138	24515	25028	25274	25491	25905	26205	26480	26593	26989	27100
24140	24516	25031	25275	25492	25907	26210	26483	26596	26990	27105
24145	24530	25035	25280	25500	25909	26215	26485	26600	26991	27110
24147	24535	25040	25290	25505	25915	26230	26489	26605	26992	27111
24149	24538	25065	25295	25515	25920	26235	26490	26607	27000	27120
24150	24545	25066	25300	25520	25922	26236	26492	26608	27001	27122
24152	24546	25071	25301	25525	25924	26250	26494	26615	27003	27125
24155	24560	25073	25310	25526	25927	26260	26496	26641	27005	27130
24200	24565	25075	25312	25530	25929	26262	26497	26645	27006	27132
24201	24566	25076	25315	25535	25931	26340	26498	26650	27025	27134
24300	24575	25077	25316	25545	25999	26341	26499	26665	27027	27137
24301	24576	25078	25320	25560	26010	26350	26500	26670	27030	27138
24305	24577	25085	25332	25565	26011	26352	26502	26675	27033	27140

27146	27259	27372	27466	27566	27664	27781	28020	28160	28308	28576
27147	27265	27380	27468	27570	27665	27784	28022	28171	28309	28585
27151	27266	27381	27470	27580	27675	27786	28024	28173	28310	28600
27156	27267	27385	27472	27590	27676	27788	28035	28175	28312	28605
27158	27268	27386	27475	27591	27680	27792	28039	28190	28313	28606
27161	27269	27390	27477	27592	27681	27808	28041	28192	28315	28615
27165	27275	27391	27479	27594	27685	27810	28043	28193	28320	28630
27170	27279	27392	27485	27596	27686	27814	28045	28200	28322	28635
27175	27280	27393	27486	27598	27687	27816	28046	28202	28340	28636
27176	27282	27394	27487	27599	27690	27818	28047	28208	28341	28645
27177	27284	27395	27488	27600	27691	27822	28050	28210	28344	28660
27178	27286	27396	27495	27601	27695	27823	28052	28220	28345	28666
27179	27290	27397	27496	27602	27696	27824	28054	28222	28360	28675
27181	27295	27400	27497	27603	27698	27825	28055	28225	28400	28705
27185	27299	27403	27498	27604	27700	27826	28060	28226	28405	28715
27187	27301	27405	27499	27605	27702	27827	28062	28230	28406	28725
27193	27303	27407	27500	27606	27703	27828	28070	28232	28415	28730
27194	27305	27409	27501	27607	27705	27829	28072	28234	28420	28735
27200	27306	27412	27502	27610	27707	27830	28080	28238	28430	28737
27202	27307	27415	27503	27612	27709	27831	28086	28240	28435	28740
27215	27310	27416	27506	27613	27712	27832	28088	28250	28436	28750
27216	27323	27418	27507	27614	27715	27840	28090	28260	28445	28755
27217	27324	27420	27508	27615	27720	27842	28092	28261	28446	28760
27218	27325	27422	27509	27616	27722	27846	28100	28262	28450	28800
27220	27326	27424	27510	27618	27724	27848	28102	28264	28455	28805
27222	27327	27425	27511	27619	27725	27860	28103	28270	28456	28810
27226	27328	27427	27513	27620	27726	27870	28104	28272	28465	28820
27227	27329	27428	27514	27625	27727	27871	28106	28280	28470	28825
27228	27330	27429	27516	27626	27730	27880	28107	28285	28475	28890
27230	27331	27430	27517	27630	27732	27881	28108	28286	28476	28899
27232	27332	27435	27519	27632	27734	27882	28110	28288	28485	29799
27235	27333	27437	27520	27634	27740	27884	28111	28289	28490	29800
27236	27334	27438	27524	27635	27742	27886	28112	28290	28495	29804
27238	27335	27440	27530	27637	27745	27888	28113	28292	28496	29805
27240	27337	27441	27532	27638	27750	27889	28114	28293	28505	29806
27244	27339	27442	27535	27640	27752	27892	28116	28294	28510	29807
27245	27340	27443	27536	27641	27756	27893	28118	28296	28515	29819
27246	27345	27445	27538	27645	27758	27894	28119	28297	28525	29820
27248	27347	27446	27540	27646	27759	27899	28120	28298	28530	29821
27250	27350	27447	27550	27647	27760	28001	28122	28299	28531	29822
27252	27355	27448	27552	27650	27762	28002	28124	28300	28540	29823
27253	27356	27450	27556	27652	27766	28003	28126	28302	28545	29824
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58956	59515	60522	61458	61576	61697	62162	63017	63266	64408	64640
58957	59525	60540	61460	61580	61698	62163	63020	63267	64410	64642
58958	59610	60545	61480	61581	61700	62164	63030	63268	64413	64644
58960	59612	60600	61500	61582	61702	62165	63040	63270	64415	64646
58970	59614	60605	61501	61583	61703	62180	63042	63271	64416	64647
58974	59618	60650	61510	61584	61705	62190	63045	63272	64417	64650
58976	59620	60659	61512	61585	61708	62192	63046	63273	64418	64653
58999	59622	60699	61514	61586	61710	62194	63047	63275	64420	64680
59000	59812	61000	61516	61590	61711	62200	63050	63276	64421	64681
59001	59820	61001	61517	61591	61720	62201	63051	63277	64425	64702
59012	59821	61020	61518	61592	61735	62220	63055	63278	64430	64704
59015	59830	61026	61519	61595	61750	62223	63056	63280	64435	64708
59020	59840	61050	61520	61596	61751	62225	63064	63281	64445	64712
59025	59841	61055	61521	61597	61760	62230	63075	63282	64446	64713
59030	59850	61070	61522	61598	61770	62256	63077	63283	64447	64714
59050	59851	61105	61524	61600	61790	62258	63078	63285	64448	64716
59051	59852	61107	61526	61601	61791	62263	63081	63286	64449	64718
59070	59855	61108	61530	61605	61796	62264	63082	63287	64450	64719
59072	59856	61120	61531	61606	61797	62267	63085	63290	64455	64721
59074	59857	61140	61533	61607	61798	62268	63086	63295	64461	64722
59076	59866	61150	61534	61608	61799	62269	63087	63300	64463	64726
59100	59870	61151	61535	61610	61800	62270	63088	63301	64479	64732
59120	59897	61154	61536	61611	61850	62272	63090	63302	64483	64734
59121	59898	61156	61537	61612	61860	62273	63091	63303	64490	64736
59130	59899	61210	61538	61613	61863	62280	63101	63304	64493	64738
59135	60000	61215	61539	61615	61864	62281	63102	63305	64505	64740
59136	60100	61250	61540	61616	61867	62282	63103	63306	64508	64742
59140	60200	61253	61541	61618	61868	62287	63170	63307	64510	64744
59150	60210	61304	61543	61619	61870	62292	63172	63308	64517	64746
59151	60212	61305	61544	61623	62000	62294	63173	63600	64520	64755
59160	60220	61312	61545	61624	62005	62310	63180	63610	64530	64760
59200	60225	61313	61546	61626	62010	62311	63182	63615	64550	64763
59300	60240	61314	61548	61630	62100	62318	63185	63620	64566	64766
59320	60252	61315	61550	61635	62115	62319	63190	63621	64600	64771
59325	60254	61316	61552	61640	62117	62350	63191	63700	64605	64772
59350	60260	61320	61556	61641	62120	62351	63194	63702	64610	64774
59400	60270	61321	61557	61642	62121	62360	63195	63704	64611	64776
59409	60271	61322	61558	61645	62140	62361	63196	63706	64612	64782
59410	60280	61323	61559	61650	62141	62362	63197	63707	64615	64784
59412	60281	61330	61563	61651	62142	63001	63198	63709	64616	64786
59414	60300	61332	61564	61680	62143	63003	63199	63710	64617	64788
59425	60500	61333	61566	61682	62145	63005	63200	63740	64620	64790
59426	60502	61340	61567	61684	62146	63011	63250	63741	64630	64792

64795	65125	65850	66821	67229	67882	68371	69421	69717	0335T
64802	65130	65855	66825	67250	67900	68399	69433	69718	0336T
64804	65135	65860	66830	67255	67901	68400	69436	69720	0340T
64809	65140	65865	66840	67299	67902	68420	69440	69725	0377T
64818	65150	65870	66850	67311	67903	68440	69450	69740	0387T
64820	65155	65875	66852	67312	67904	68500	69501	69745	0388T
64821	65175	65880	66920	67314	67906	68505	69502	69799	0392T
64822	65235	65900	66930	67316	67908	68510	69505	69801	0402T
64823	65260	65920	66940	67318	67909	68520	69511	69805	0408T
64831	65265	65930	66982	67343	67911	68525	69530	69806	0409T
64834	65270	66020	66983	67345	67912	68530	69535	69820	0410T
64835	65272	66030	66984	67346	67914	68540	69540	69840	0411T
64836	65273	66130	66985	67399	67915	68550	69550	69905	0414T
64840	65275	66150	66986	67400	67916	68700	69552	69910	0415T
64856	65280	66155	66999	67405	67917	68705	69554	69915	0416T
64857	65285	66160	67005	67412	67921	68720	69601	69930	0419T
64858	65286	66170	67010	67413	67922	68745	69602	69949	0420T
64861	65290	66172	67015	67414	67923	68750	69603	69950	C5271
64862	65400	66174	67025	67415	67924	68760	69604	69955	C5273
64864	65410	66175	67027	67420	67930	68761	69605	69960	C5275
64865	65420	66179	67030	67430	67935	68770	69610	69970	C5277
64866	65426	66180	67031	67440	67938	68810	69620	69979	C9725
64868	65435	66183	67036	67445	67950	68811	69631	0100T	
64885	65436	66184	67039	67450	67961	68815	69632	0101T	
64886	65450	66185	67040	67500	67966	68816	69633	0102T	
64890	65600	66220	67041	67505	67971	68840	69635	0171T	
64891	65710	66225	67042	67515	67973	68899	69636	0191T	
64892	65730	66250	67043	67550	67974	69000	69637	0200T	
64893	65750	66500	67101	67560	67975	69005	69641	0201T	
64895	65755	66505	67105	67570	67999	69020	69642	0213T	
64896	65756	66600	67107	67599	68020	69090	69643	0216T	
64897	65760	66605	67108	67700	68040	69100	69644	0228T	
64898	65765	66625	67110	67710	68100	69105	69645	0230T	
64905	65767	66630	67113	67715	68110	69110	69646	0238T	
64907	65770	66635	67115	67800	68115	69120	69650	0249T	
64910	65771	66680	67120	67801	68130	69140	69660	0253T	
64911	65772	66682	67121	67805	68135	69145	69661	0274T	
64999	65775	66700	67141	67808	68320	69150	69662	0275T	
65091	65780	66710	67145	67810	68325	69155	69666	0288T	
65093	65781	66711	67208	67825	68326	69205	69667	0299T	
65101	65782	66720	67210	67830	68328	69222	69670	0301T	
65103	65785	66740	67218	67835	68330	69300	69676	0302T	
65105	65800	66761	67220	67840	68335	69310	69700	0303T	
65110	65810	66762	67221	67850	68340	69320	69710	0304T	
65112	65815	66770	67227	67875	68360	69399	69714	0308T	
65114	65820	66820	67228	67880	68362	69420	69715	0313T	

**BRUYNS Fred H \* DCBS**

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**From:** Joe Martinez <Joe\_Martinez@concentra.com>  
**Sent:** Tuesday, February 09, 2016 1:25 PM  
**To:** BRUYNS Fred H \* DCBS  
**Subject:** RE: CORRECTION: Proposed amendment of OAR 436-009 and 436-010

Mr. Bruyns

First we would like to thank the Division for allowing to participate in this process.

This is our brief public comment(s).

We respectfully request that the Division add a simple phrase to section 436-009-0030 under (3) Payment Requirements subsection (c) item (A).

**(A) The original amount billed and** 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;

Thank you

**Joe Martinez**  
LAX CBO-CBO Director

**Concentra**  
909-484-7701 (o) | 909-481-5318(f)  
626-512-9891 (m)  
Ontario, CA. 91764

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**From:** BRUYNS Fred H \* DCBS [<mailto:Fred.H.Bruyns@oregon.gov>]  
**Sent:** Friday, January 15, 2016 9:32 AM  
**To:** BRUYNS Fred H \* DCBS  
**Cc:** WADSWORTH Amy D \* DCBS; AICHLMAYR Myra K \* DCBS; JOHNSTON Nanci J \* DCBS; KUNZ Juerg \* DCBS  
**Subject:** CORRECTION: Proposed amendment of OAR 436-009 and 436-010

Good morning again,

We discovered an error in the Proposed Physician Fee Schedule, Appendix B, first posted Thursday afternoon, Jan. 14. Corrected copies (PDF and Excel) have been posted. If you reviewed or downloaded this schedule before 9:30 today, Jan. 15, please refer to the corrected schedule, available now:

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

I apologize for any inconvenience this has caused you or your organization.

Please feel free to contact me at any time.

Fred Bruyns, policy analyst/rules coordinator

Department of Consumer and Business Services  
Workers' Compensation Division  
503-947-7717; fax 503-947-7514  
Email: [fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov)



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**From:** BRUYNS Fred H \* DCBS  
**Sent:** Friday, January 15, 2016 8:30 AM  
**To:** BRUYNS Fred H \* DCBS  
**Cc:** WADSWORTH Amy D \* DCBS; AICHLMAYR Myra K \* DCBS; JOHNSTON Nanci J \* DCBS; KUNZ Juerg \* DCBS  
**Subject:** Proposed amendment of OAR 436-009 and 436-010

Regarding: Amendment of rules governing workers' compensation medical services and medical billing and payment

Dear committee members and additional interested people,

The Workers' Compensation Division has published proposed OAR 436-009, Oregon Medical Fee and Payment Rules, and OAR 436-010, Medical Services, to its website:

[http://www.cbs.state.or.us/wcd/policy/rules/div\\_009/9\\_10\\_16XXXp.pdf](http://www.cbs.state.or.us/wcd/policy/rules/div_009/9_10_16XXXp.pdf).

A public rulemaking hearing is scheduled for Feb. 22, 2016, 9 a.m.

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

You may attend the hearing and speak, send written comments, or do both.

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

Send written comments to:

Email – [fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov)

Fred Bruyns, rules coordinator, Workers' Compensation Division

350 Winter Street NE (for courier or in-person delivery)

PO Box 14480 (for regular mail)

Salem, OR 97309-0405

Fax – 503-947-7514

The closing date for written comments is Feb. 25, 2016.

I have included a summary of the proposed amendments at the bottom of this message.

Please let me know if you have questions. Thank you!

Fred Bruyns, policy analyst/rules coordinator  
Department of Consumer and Business Services  
Workers' Compensation Division  
503-947-7717; fax 503-947-7514  
Email: [fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov)



**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;
- Increase maximum allowable payment rates by three percent for physician services except for physical therapy services;
- Replace two laboratory HCPCS codes with seven new codes assigned by the Centers for Medicare and Medicaid Services (CMS): replace G0431 with G0480, G0481, G0482, and G0483; replace G0434 with G0477, G0478, and G0479;
- Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
- Specify how providers must complete boxes 32 and 32a on the National Uniform Claim Committee 1500 Claim Form;
- Exclude platelet rich plasma injections from compensability;
- Eliminate the list of hospitals subject to including Medicare Severity Diagnosis Related Group (MS-DRG) codes on their bills, in favor of a general requirement to include the MS-DRG codes, unless the hospital is a critical access hospital or if the bill contains revenue code 002x.
- Replace the requirement for an insurer or insurer's representative to respond to a question from a provider or a worker about reimbursement within 48 hours with a requirement to do so within two days; require that explanations to workers about out-of-pocket expenses and explanations of benefits sent to health care providers specify two days instead of 48 hours to respond to questions;
- Remove a redundant requirement for health care providers to send multidisciplinary treatment programs to insurers – already in OAR 436-010;
- Establish new Oregon Specific (billing) Codes and associated fees for closing medical examinations of three levels of complexity, and for related closing reports;
- Increase the maximum payable for hearing aids, without approval by the insurer or director, from \$5000 to \$7000 for a pair and from \$2500 to \$3500 for a single hearing aid;
- Allow a worker to upgrade a hearing aid by paying the price difference;
- Require that compounded drugs be billed at the component ingredient level, listing each ingredient national drug code (NDC), and that ingredients without an NDC are not reimbursable;
- Set the maximum allowable fee for a non-sterile compound drug at 83.5% of the average wholesale price (AWP) for each individual component ingredient, plus a compounding fee of \$2.00 for each ingredient;
- Set the maximum allowable fee for a sterile compound drug at 83.5% of the average wholesale price (AWP) for each individual component ingredient, plus a compounding fee of \$4.00 for each ingredient;
- Replace the mileage reimbursement rate payable to interpreters, currently \$0.50 per mile, with the private vehicle mileage rate published in Bulletin 112; and
- Clarify that, in the matrix for health care provider types, when a provider is not, or is no longer, eligible to provide treatment as a Type B attending physician, if care is provided because it is authorized by an attending physician, physician assistants are not required to have a written treatment plan.

**The agency proposes to amend OAR 436-010, “Medical Services,” to:**

- Require that requests for reconsideration of administrative orders be received by the director before the order becomes final;
- Replace the requirement for an insurer to forward a copy of an independent medical exam report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report with a requirement to do so within three days; and
- Clarify that, in the matrix for health care provider types, when a provider is not, or is no longer, eligible to provide treatment as a Type B attending physician, if care is provided because it is authorized by an attending physician, physician assistants are not required to have a written treatment plan.

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## ANALYSIS OF OREGON MEDICAL FEE SCHEDULE UPDATE PROPOSED EFFECTIVE APRIL 1, 2016

NCCI estimates that the proposed changes to the Oregon Workers Compensation Medical Fee Schedule, proposed to become effective April 1, 2016, would result in an overall impact of +0.5% (\$3.0M<sup>1</sup>) on Oregon workers compensation system costs if enacted.

### Summary of Proposed Changes

The proposed changes to the Oregon Medical Fee and Payment Rules consist of the following major provisions:

- Update the physician, ambulatory surgical center (ASC), and durable medical equipment, prosthetics, orthotics and supplies fee schedules containing the maximum allowable reimbursement (MAR) amounts for such medical services. The current fee schedules have been in effect since January 1, 2016.
- Update the maximum reimbursement amount per single hearing aid from \$2,500 to \$3,500.
- Clarify reimbursement for compound drugs. Currently drugs are reimbursed at a rate of 83.5% of the Average Wholesale Price (AWP) plus a \$2 dispensing fee per prescription
  - Non-sterile compound drugs will now be billed and reimbursed at the ingredient level at a rate of 83.5% of the AWP plus a \$2 compounding fee per ingredient
  - Sterile compound drugs will now be billed and reimbursed at the ingredient level at a rate of 83.5% of the AWP plus a \$4 compounding fee per ingredient

### Actuarial Analysis

NCCI's methodology to evaluate the revision to a medical fee schedule includes three major steps:

1. Calculate the percentage change in reimbursements
  - a. Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
  - b. Calculate the weighted average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

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<sup>1</sup> Overall system costs are based on NAIC Annual Statement data. The estimated dollar impact is the percentage impact(s) displayed multiplied by 2014 written premium of \$664M from NAIC Annual Statement data for Oregon. This figure does not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be \$4M, where data on self-insurance is approximated using the National Academy of Social Insurance's August 2015 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2013."



## ANALYSIS OF OREGON MEDICAL FEE SCHEDULE UPDATE PROPOSED EFFECTIVE APRIL 1, 2016

2. Estimate the price level change as a result of the proposed fee schedule
  - a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence From 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
  - b. In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.
    - i. The assumption for the percent realized for fee schedule decreases is 50%.
  - c. In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
    - i. The formula used to determine the percent realized for fee schedule increases is  $80\% \times (1.10 + 1.20 \times (\text{price departure}))$ .
3. Determine the share of costs that are subject to the fee schedule
  - a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Oregon for Service Year 2014.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Oregon from the latest 2 policy years projected to the effective date of the benefit changes.

In some components of the analysis NCCI may rely on other data sources, which are referenced where applicable.

**Note that compound drugs could not be explicitly identified within NCCI's Medical Data Call. Any impact from the changes to the reimbursement of compounded drugs will flow through experience and be reflected in future Oregon rate filings.**

### Physician Fee Schedule Analysis

In Oregon, payments for physician services represent 53.4% of total medical payments. To calculate the percentage change in maximums for physician services, we calculate the estimated percentage change in maximums for each procedure code which are published by the Oregon Workers Compensation Division. The overall change in maximums for physician services is a weighted average of the percentage change in MAR (proposed MAR/ current MAR) by procedure code weighted by the observed payments by procedure code as reported

CONTACT: JESSICA EPLEY  
Telephone: (503) 892-8919 • Cell (360) 904-7315 • Fax: (561) 893-5704  
E-mail: [Jessica\\_Epley@ncci.com](mailto:Jessica_Epley@ncci.com)  
2/15/2016



**ANALYSIS OF OREGON MEDICAL FEE SCHEDULE UPDATE  
PROPOSED EFFECTIVE APRIL 1, 2016**

on NCCI's Medical Data Call, for Oregon for Service Year 2014. The estimated overall weighted average percentage change in MARs is +1.7%.

The estimated percentage change in reimbursements by category is shown in the table below:

<b>Physician Practice Category</b>	<b>Cost Distribution</b>	<b>Impact</b>
Anesthesia	2.8%	0.0%
Surgery	15.9%	+2.8%
Radiology	7.3%	+4.3%
Pathology	0.1%	+2.5%
Medicine	30.8%	+0.6%
Evaluation & Management	24.8%	+2.9%
Other HCPCS*	1.4%	+3.0%
Physician Payments with no specific MAR	16.9%	0.0%
<b>Total Physician Costs</b>	<b>100.0%</b>	<b>+1.7%</b>

\*Healthcare Common Procedure Coding System

Since the overall average maximum reimbursement for physician services increased, NCCI expects that 88% of the increase would be realized on physician price levels (based on an assumed price departure of 0%<sup>2</sup>). The impacts on physician payments, after the adjustment, is +1.5% (= +1.7% x 0.88).

The above estimated impact on physician payments is then multiplied by the Oregon percentage of medical costs attributed to physician payments (53.4%) to arrive at the estimated impact of +0.8% on medical costs. The resulting impact on medical costs is then multiplied by the percentage of Oregon benefit costs attributed to medical benefits (57.1%) to arrive at the estimated impact on Oregon's overall workers compensation system costs of +0.5% (\$3.0M).

**Ambulatory Surgical Center (ASC) Analysis**

In Oregon, payments for ASC services represent 3.3% of total medical payments. To calculate the estimated percentage change in maximum reimbursements for ASC services, we calculate the percentage change in MAR for each procedure code listed on the fee schedule. The overall change in maximum reimbursements for ASC services is a weighted average of the percentage change in MAR (proposed MAR/ current MAR) by procedure code weighted by the observed

<sup>2</sup> A departure of 0% implies that the ratio of actual payments to the fee schedule maximums is 1.00.

CONTACT: JESSICA EPLEY  
Telephone: (503) 892-8919 • Cell (360) 904-7315 • Fax: (561) 893-5704  
E-mail: [Jessica\\_Epley@ncci.com](mailto:Jessica_Epley@ncci.com)  
2/15/2016



## ANALYSIS OF OREGON MEDICAL FEE SCHEDULE UPDATE PROPOSED EFFECTIVE APRIL 1, 2016

payments by procedure code as reported on NCCI's Medical Data Call, for Oregon for Service Year 2014. The estimated overall weighted average percentage change in reimbursements for ASC services is -0.5%.

Since the reimbursements for ASC services decreased, NCCI expects that 50% of the decrease will be realized on ASC price levels. The estimated impact on ASC payments after applying the 50% price realization factor is -0.3%.

The above estimated impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in Oregon (3.3%) to arrive at a negligible<sup>3</sup> impact on medical costs and overall workers compensation costs.

### **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Analysis**

In Oregon, payments subject to the DMEPOS fee schedule represent 2.1% of total medical payments. To calculate the estimated percentage change in maximum reimbursements for DMEPOS, we calculate the percentage change in MAR for each procedure code listed on the fee schedule. The overall change in maximum reimbursements for DMEPOS is a weighted average of the percentage change in MAR (proposed MAR/ current MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for Oregon for Service Year 2014. The estimated overall weighted average percentage change in reimbursements for DMEPOS is -0.3%.

Since the overall average maximum reimbursement for DMEPOS decreased, NCCI expects that 50% of the decrease would be realized on DMEPOS price levels. The estimated impact on DMEPOS payments, after the adjustment, is -0.2% (= -0.3% x 0.5). The above estimated impact on DMEPOS costs is then multiplied by the percentage of medical costs attributed to DMEPOS payments in Oregon (2.1%) to arrive at a negligible impact on medical costs and overall workers compensation costs.

### **Hearing Aid Analysis**

In Oregon, payments for hearing aids represent 0.4% of total medical payments. To calculate the estimated percentage change in maximum reimbursements for hearing aids, we calculate the percentage change in MAR per hearing aid:

Current MAR per hearing aid: \$2,500  
Proposed MAR per hearing aid: \$3,500

The overall change in maximum reimbursements for hearing aids is the percentage change in MAR (proposed MAR/ current MAR). The estimated overall percentage change in reimbursements for hearing aids is +40%.

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<sup>3</sup> Negligible is defined in this document to be an impact on system costs of less than 0.1%.



**ANALYSIS OF OREGON MEDICAL FEE SCHEDULE UPDATE  
PROPOSED EFFECTIVE APRIL 1, 2016**

Since the overall average maximum reimbursement for hearing aids increased, NCCI expects that 88% of the increase would be realized on hearing aid price levels (based on an assumed price departure of 0%). The impacts on hearing aid payments, after the adjustment, is +35.2% (= +40% x 0.88).

The above estimated impact on hearing aid costs is then multiplied by the percentage of medical costs attributed to hearing aid payments in Oregon (0.4%) to arrive at an estimated impact of +0.1% medical costs. The resulting estimated impact on medical costs is then multiplied by the percentage of Oregon benefit costs attributed to medical benefits (57.1%) to arrive at the estimated impact on Oregon's overall workers compensation system costs of +0.1% (\$1.0M).

Summary of Impacts

The estimated impacts from the changes to the Oregon Medical Fee Schedules are summarized in the following table:

	<b>(A)</b>	<b>(B)</b>	<b>(C)</b>
	<b>Estimated Impact on Type of Service</b>	<b>Share of Medical Costs</b>	<b>Estimated Impact On Medical Costs (A) x (B)</b>
<b>Physician</b>	+1.5%	53.4%	+0.8%
<b>ASC</b>	-0.3%	3.3%	negligible
<b>DME</b>	-0.2%	2.1%	negligible
<b>Hearing Aid</b>	+35.2%	0.4%	+0.1%
<b>(1) Total Impact on Oregon Medical Costs</b>			<b>+0.9%</b>
<b>(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in Oregon</b>			<b>57.1%</b>
<b>(3) Total Estimated Impact on Overall Workers Compensation System Costs in Oregon = (1) x (2)</b>			<b>+0.5%</b>

CONTACT: JESSICA EPLEY  
Telephone: (503) 892-8919 • Cell (360) 904-7315 • Fax: (561) 893-5704  
E-mail: [Jessica\\_Epley@ncci.com](mailto:Jessica_Epley@ncci.com)  
2/15/2016



Re: Proposed Fee Schedule for Closing Exams

2/18/16

To Whom It May Concern,

As a provider who performs closing examinations on a regular basis, receiving referrals from physicians, MCOs, and insurers, I am concerned regarding some of the proposed reimbursement changes.

First, I would agree that changes need to be made. Some closing exams can be very basic, but others very complex. Issues that increase complexity include the number of accepted conditions or body parts that require an examination, length of the injury (and, hence, size of the file to review), and causation/appointment issues.

The majority of closing examinations are for one body part. The current proposed changes break down reimbursement by categories (1 body part, 2-3 body parts, 3+ body parts). However, the proposed reimbursement fee for one body part has plummeted from the current fee schedule (\$476 for non-AP exam and \$264 for AP exams). The new proposal would reimburse \$250 for non-AP exams (price includes report). This would pay less than what a current level 4 (99204) evaluation would be reimbursed, and yet the closing exam would require much more attention to issues not necessarily dealt with in a regular initial evaluation.

I also have the same concern for the 1 body part exam for AP exams, also paying less than what a current level 4 follow up exam pays. I have some concerns regarding the proposal for 2-3 body part exams, albeit not as much as the proposal for 1 body part exams.

If this proposal goes through as currently stated, I would no longer find it cost effective to offer to do closing exams on patients. This will likely lead to a significant increase in IME's for the purpose of claim closure, which can be costly and time delaying.

The only way I would consider the current cost proposal to be cost effective would be if the closing exam requirements were only to provide impairment measurements but no longer opinions on appointment/causation, work limitations, and future treatment. In this scenario, the chart review, no matter how large the chart, could be substantially abbreviated.

Sincerely,

Brad Lorber, MD, Physiatrist

February 19, 2016

Exhibit  
"6"

Fred Bruyns  
Rules Coordinator  
Workers' Compensation Division  
PO Box 14480  
Salem, Oregon 97309-0405

Re: Proposed Changes to OAR 436-009, Oregon Medical Fee & Payment Rules

Dear Mr. Bruyns,

Please accept the following comments in response to the Workers' Compensation Division proposed changes to OAR 436-009, "Oregon Medical Fee and Payment Rules," specifically pertaining to the calculation of the maximum allowable fee for compounded pharmaceuticals in an outpatient setting. Healthsystems is a Pharmacy and Ancillary Benefits Management company offering services to injured workers and workers' compensation carriers, third party administrators and self-insured employers in Oregon. We support the Divisions' intent to provide clarity and predictability in both the billing and reimbursement process. To that end, we have a number of recommendations on the proposed language.

The proposed language on page 67 of the draft regulation recommends the maximum allowable fee for compounded drugs as follows:

*A non-sterile compound drug - 83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$2.00 for each ingredient*

*and*

*A sterile compound drug - 83.5 % of the AWP for each individual component ingredient plus a compounding fee of \$4.00 for each ingredient*

We recommend the Division strike this language above and replace it with the following:

*All compounded drugs – 83.5% of the AWP for each individual component ingredient, plus a compounding fee of \$x.xx*

We recommend striking the initial proposal language because it will be difficult to administer and could lead to an increase in fee disputes between providers and payers. The proposal requires an "educated guess" by the payer as to the sterility of the drug and if that drug was required to be prepared in a sterile environment under the pharmacy practice act. For example, a liquid suspension or a topical crème can be prepared in a non-sterile OR a sterile environment, whereas an eye drop or an injectable drug MUST be prepared in a sterile (hooded) environment.

The pharmacy practice act defines when a compounded drug shall be prepared in a sterile environment, yet there is no clear mechanism to determine if the drug was prepared beyond the standards, in other words if the drug was made sterile when it was not required to be done in this way. It also bears mention that the variability of the dispense fee when tied to not only the sterility of the drug, but the number of

ingredients in the compound itself might incentivize providers to use more ingredients in order to artificially increase the reimbursement rate.

Data from both California and Texas demonstrated an increasing trend towards using more NDCs and higher cost NDCs in recent years. <sup>1</sup> In California, there has been an increase in the number of ingredients and the cost per ingredient. In Texas, the Division of Workers' Compensation reported in its December 2015 study that in the prior five year period, there has been a steady increase in the utilization and number of ingredients in compounds. <sup>2</sup> Both states are currently considering additional controls to address this issue.

**For all these reasons, we recommend the Division take two actions; first to require a mandatory pre-authorization for any compounded medication.** Compounds are generally not recommended as a first line of therapy and are a known cost driver in workers' compensation claims. <sup>3</sup> If a compounded medication is appropriate for the patient, a physician should be able to easily demonstrate why that drug is appropriate for the injured worker, for example if they have tried and failed with a commercially available drug, or if the patient has a known allergy to an ingredient and there are no other viable options for the patient.

**Next, we recommend the Division assign a single maximum dispense fee to all compounded drugs.** We have inserted below, a sample of maximum dispense fee for compound medications as adopted in other states' workers' compensation fee schedules. Most stakeholders find a single compounding dispense fee to be easy to implement into both PBM and bill review platforms. This information is provided as resource material for the Division to consider in designating an appropriate maximum dispense fee for compounds in Oregon.

State	Compound Dispensing Fees
AK	\$10.00
DE	\$10.00
GA	\$20.00
ID	\$7.00
SC	\$5.00
TN	\$25.00
TX	\$15.00

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<sup>1</sup> CWCI Research Notes, *Current Trends in Compound Drug Utilization and Cost in the California Workers' Compensation System*, Alex Swedlow, MHA and Eileen Auen, MBA, February 2013

<sup>2</sup> Texas Department of Insurance, *HealthCare Cost & Utilization in the Texas Workers' Compensation System 2000-2014*, published December 2015

<sup>3</sup> Business Insurance Magazine, *Rising Use & Cost of Compounded Medications in Workers Comp Sparks Concern*, July 2014

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We appreciate the opportunity to comment and offer our comments for consideration by the Oregon Workers' Compensation Division. Please do not hesitate to contact me directly with any questions or comments related to this information.

Sincerely,



Sandy Shtab  
Director, Regulatory and Legislative Affairs  
Healthsystems  
813-868-2264  
sshtab@healthsystems.com

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## TESTIMONY ON PROPOSED CHANGES TO WORKERS' COMPENSATION RULES

### CLAIM CLOSURE EXAMS

The proposed changes to the Medical Fee Schedule for closing examinations are inappropriate and short sighted which will lead to strongly negative impacts on all stakeholders.

The financial impact on providers (especially those who are most committed to the Workers' Compensation system and the injured workers it serves) is strongly negative and dis-incentivizes treating physicians from choosing to meet the requirements delineated by the Director (see Exhibit 1 and Bulletin 239) and the carriers (see Exhibit 2-Sample medically stationary letter-SAIF).

#### **Scope of the exam:**

First of all, the proposed fees appear to only reimburse for an impairment exam and a report, which is insufficient to meet the requirements for closure. This will lead to added administrative costs, either by narrative requests and phone conferences with providers, or by an increase in the number of requests for Arbiter Exams to meet the requirements for closure; all at an added expense to the carrier.

The notion that the treating physician can accurately answer the requirements of the closing exam without reviewing the chart is totally erroneous given the fact that physicians in full time practice typically have 200-300 active patients at any given time. The value of that service is bourn out by the reimbursement for Narrative Requests (\$116.28 for up to five responses / \$231.88 for over five responses). It can be argued that since the requirements for closure beyond the impairment exam and report necessitates that more than five other items be addressed then the reimbursement should reflect that.

#### **Value of the Information:**

When comparing to the tiered form of reimbursement used in the Washington L&I where the requirements are limited primarily to an impairment examination which does not necessitate the added time and effort of a file review, the treating physicians' fees are significantly more than that designated in the Oregon proposed rules (\$243.02, \$97.51, \$61.87 for Tiers 1-3 respectively).

It is also notable that each tier of arbiter examinations, which have comparatively fewer issues requiring a response, are reimbursed significantly higher than the proposed fees (\$281.80, \$424.91, \$542.62 for Tiers 1-3 respectively)

Currently, my practice "backs in" to the appropriate reimbursement by charging \$630.36 for the closing exam and \$124.07 for the report and after adjusting to 80% nets payment of \$496.29 which we feel reflects the value of exactly the same

information presented in exactly the same format using the methods required by law, based upon payments traditionally made in our region. We do not change the charge based on number of body parts. The reductions imposed by the proposed fees would impose significant losses to our practice income for the most frequently performed closing exams (\$296.29 loss, \$196.29 loss, \$53.71 gain, for Tiers 1-3 respectively). Since most claims involve one or two body parts and the negative impact on providers would be substantial.

The occasional gain for the rarely required Tier 3 closing exam would in no way come close to offsetting the significant losses from the more commonly performed Tier 1&2 exams.

The value of the information required by the Director for claim closure and resolution should be comparable no matter what format it is presented: Oregon or Washington closing exam, Oregon Narrative Response, or Oregon Arbitrator Exam. For those providers who are willing to meet this standard, they should be reimbursed appropriately. Maintaining appropriate reimbursement levels will encourage more providers to participate in the performance of closing exams and improve access to these services.

#### **Provider Choice:**

For those providers who do not provide an exam to meet the Legal standard for closing, they should not be able to successfully charge for a closing exam. They should be reimbursed with the appropriate office visit code and be required to either perform an appropriate exam or refer the patient for a closing examination.

For those providers who produce a valid closing exam that meets the standards set by the Director, they should be reimbursed under a Tiered Fee Schedule that accurately reflects the value of their work.

The Department should detail the requirements for a valid closing examination in the rules so that it is clear to providers what specific criteria must be met. Perhaps a sample template should be provided that would satisfy the criteria.

#### **Negative Impact of Current Proposed Rules:**

The proposed rule has an immediate direct and devastating financial impact on those providers who are most involved in the delivery of medical care to injured workers in Oregon. It would disincentivize the very providers that the system relies upon the most to "make the system work."

Without an appropriate incentive to provide the mandated information, the payers would see a significant increase in the need to obtain Narrative Responses, to close active claims. It would delay the time to closure in many cases with potentially negative impact on the workers and potentially negatively impact the indemnity costs incurred by the payers.

It will result in an increase in claims that are closed without meeting the letter of the law making them susceptible to disputes that would drive up indemnity costs when a higher volume of Arbiter exams and other activities are needed to resolve the claim. ).

It is noteworthy that the Department has seen fit to increase the reimbursement for this information for arbiter exams but inexplicably slashes it's value in reference to closing exams.

If the problem is that many providers are calling their final examination of a patient a "closing exam" without providing the needed information, they should not be reimbursed for an official closing exam. For those providers who are willing to comply with the rules, they should be reimbursed at an appropriate level consistent with the value reflected in other sections of the rules. I have offered a potential solution by adding in the current value of N0002 to the current proposed fees and rounding out. Something close to this would produce no negative impact on any patients or stakeholders.

This strategy shifts reimbursement away from those who are not providing a real closing exam to those that are. By not having to reimburse inadequate exams as closings, the overall financial impact on stakeholders would be neutral.

Thank you for your attention to these issues.

Sincerely,

John Di Paola, M.D.  
Occupational Orthopedics

	Wash L&I	WCD Arbiter	Current at 80%	New	N001	N002
Exam 1 Body Part	443.02	358.6	496.29	150		
Report		61.64		50	116.28	231.88
File Review		61.64				
TOTAL	443.02	481.88	496.29	200 -296.29	316.28	431.88
Exam 2-3 Body Parts	497.51	477.67	496.29	250		
Report		92.45		50	116.28	231.88
File Review		154.79				
TOTAL	497.51	724.91	496.29	300 -196.29	416.28	531.88
Exam 3+ / complex	621.87	597.44	496.29	400		
Report		123.97		150	116.28	231.88
File Review		371.21				
TOTAL	621.87	1092.62	496.29	550 53.71	666.28	781.88

Proposed Revaluation

Tier 1	450
Tier 2	550
Tier 3	700

# Workers' Compensation Examination Report – Quick Reference

Note: This is not intended to be a comprehensive reference. Please refer to *Bulletin 239* for additional information.

## Definitions

**Direct medical sequela** means a condition that is clearly established medically and originates or stems from an accepted condition.

**Impairment** means a permanent loss of use or function of a body part or system due to the compensable industrial injury or occupational disease.

**Medically stationary (MS)** means the point at which a worker's medical status is not expected to improve, either from medical treatment or the passage of time.

**Physical capacity evaluation (PCE)** is an objective, directly-observed measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator.

**Residual functional capacity (RFC)** is an individual's remaining ability to perform work-related activities.

**Regular work** means the job the worker held at the time of injury. To be released to regular work, the worker must be capable of doing all tasks and functions of the job the worker was performing at the time of injury.

## Physician responsibilities

- Determine medically stationary status of the worker. The medically stationary date must be the date of the examination and cannot be a projected date. Notify the worker, insurer, and all medical providers involved in the worker's treatment.
- Advise the worker of the date the worker is released to return to regular or modified

work and provide the insurer written notice within five days.

- Perform a closing examination and send the report to the insurer within 14 days of the medically stationary date. If the attending physician refers the worker for a closing examination, this referral must be made within eight days of the medically stationary date.
- Measure and report all findings of residual impairment. Under Oregon law, it is the department's and the insurer's responsibility to rate impairment.

## Contents of a closing report

- History
- Treatment
- Medically stationary status
- Residual impairment findings (contralateral measurement, if applicable)
- Residual functional capacity
- Work status (regular or modified)
- Apportionment (if applicable)
- Preexisting condition/estimating impairment (if applicable)
- Validity statement if finding is determined invalid, if finding is not addressed by validity criteria, or if validity criteria are disregarded (for rating impairment)
- Chronic condition
- Medical reasoning with all findings

## Reporting impairment

**Chronic condition** – Because of a permanent and chronic condition caused by the compensable injury, the worker is unable to

repetitively use a body part for more than two-thirds of a period of time.

## Upper and lower extremities

- Etiology
- Amputation – most proximal level
- Reattachment – any loss of overall length
- Active ROM – in degrees, in all appropriate directions
- Angle of fusion/ankylosis – in degrees
- Length discrepancy – in inches
- Angulation or malalignment
- Strength loss – identify affected muscle and peripheral or spinal nerve
- Dermatological/vascular conditions
- Body part – signs and symptoms

*Form 2279 – Upper Extremity Range of Motion*  
*Form 4841 – Lower Extremity Range of Motion*

## Specific to upper extremities

- Rotational deformity/lateral deviation
- Sensation – palmar surface, hand and fingers (2 pt. discrimination in mm.)
- Motor loss – brain/spinal cord damage, ability to perform: self-care and grasp/hold function

*Form 2279 – Upper Extremity Range of Motion*

# Workers' Compensation Examination Report – Quick Reference

## Specific to lower extremities

- Sensation – plantar surface, foot and toes  
Partial or total loss
- Instability/laxity
  - Knee, name ligament and grade Grade 1 (mild), Grade 2 (moderate), or Grade 3 (severe)
  - Ankle, name ligament and grade mild, moderate, or severe
- Chondromalacia -
  - Specify grade
  - Describe extent of any arthritis, DJD
- Walking or standing - permanently precluded for a total of more than 2 hours in 8-hour period  
Motor loss – brain/spinal cord damage, ability to walk or stand

*Form 4841 – Lower Extremity Range of motion*

## Hearing

- Findings
- Audiogram (500, 1000, 2000, 3000, 4000, & 6000 Hz)
- Diagnosis
- Medically stationary date
- Report to be provided by or reviewed and commented on by the attending physician
- Tinnitus – does it require job modifications

## Vision

- Near and distance acuity (best corrected)
- Lens implant
- Visual fields as measured on Goldmann perimeter with 111/4e stimulus
- Diplopia

- Ocular disturbances – stereopsis, glare (photophobia), monocular diplopia (mild, moderate, severe), and tearing

*Form 2312 – Visual Impairment*

## Spine

- Active ROM – measured by an inclinometer
- Compression fracture – percentage of compression
- Posterior element fracture – name fractured vertebra

*Form 2278C – Spinal Cervical Range of Motion*

*Form 2278T – Spinal Thoracic Range of Motion*

*Form 2278L – Spinal Lumbar Range of Motion*

## Shoulder

- Etiology
- Active ROM – in degrees, in all required directions
- Angle of fusion/ankylosis – in degrees
- Strength loss –
  - Identify affected muscles and nerves
  - Use 0 – 5/5 method
- Chronic dislocations

*Form 4842 – Shoulder Range of Motion*

## Hip

- Etiology
- Active ROM – in degrees, in all required directions
- Angle of fusion/ankylosis – in degrees
- Strength loss –
  - Identify affected muscles and nerves
  - Use 0 – 5/5 method

## Pelvis

- Fracture – displacement, if any

## Other whole person impairment

The following systems and areas of the body require specific tests to determine the extent of any impairment. These tests and specific reporting requirements are listed in Bulletin 239.

- Abdomen
- Cardiovascular
- Respiratory
- Cranial nerves and brain
- Spinal cord
- Mental illness
- Hematopoietic
- Gastrointestinal & genitourinary
- Endocrine
- Integumentary & lacrimal
- Immune

www.saif.com



January 27, 2016

John DiPaola, MD  
OCCUPATIONAL ORTHOPEDICS  
6464 SW BORLAND RD STE C4  
TUALATIN, OR 97062-8856

Fax: 503.885.7771

Worker's Name:  
Date of Birth:  
SAIF Claim No.:  
Date of Injury:

Accepted Conditions:

Dear Dr. DiPaola:

The injured worker is scheduled for a closing exam on XXX-XX-XX. The purpose of this letter is to help SAIF determine his permanent impairment award and prepare his/her claim for closure. Workers' compensation law requires very specific information, so if you have questions about what is needed, please contact me prior to performing the evaluation and completing a report. This will prevent the need for a repeat exam. If you prefer to provide a narrative report as part of the closing exam, please make sure to address all the questions in this cover letter.

As part of the closing exam, please provide the following information:

**Medically Stationary**

1. Is the work injury, including all of the accepted conditions of

\_\_\_\_\_ medically stationary?

Yes. Date: \_\_\_\_\_

No. Expected to become medically stationary approximately: \_\_\_\_\_

a. If not med stat what his your ACTIVE treatment plan for \_\_\_\_\_  
\_\_\_\_\_

b. If the worker is not medically stationary at this point in time, what circumstances are contributing to the delay or prolonging the need for treatment in this claim?

\_\_\_\_\_  
\_\_\_\_\_

SAIF Claim No:  
January 27, 2016  
Page 2

**Medications**

2. Are there any future medications anticipated for the accepted conditions?

Yes       No

Please list the medication(s) and anticipated time for ongoing usage:

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**Ongoing Need for Medical Treatment**

3. Is it medically probable that the accepted condition(s) have resolved sufficiently that you no longer anticipate the need for additional medical treatment or services in the future?

Yes       No

What future treatment or services do you anticipate?

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**Left Shoulder**

4. Please provide bilateral shoulder ROM in the table below:

	Right	Left
Flexion	____°	____°
Extension	____°	____°
Abduction	____°	____°
Adduction	____°	____°
Internal Rotation	____°	____°
External Rotation	____°	____°

Is the range of motion in the left shoulder normal for him or is there some loss of motion due to the injury?

- Normal. There is no loss of left shoulder motion due to the injury.
- There is motion loss due to the injury.

5. SAIF may compare motion in the injured joint to the uninjured joint, but only if the uninjured joint has never been injured before. Is there a history of injury or disease to the right shoulder? If so, please briefly describe it.

No.       Yes. \_\_\_\_\_

SAIF Claim No:  
January 27, 2016  
Page 3

6. Which best describes the worker's limitation in repetitive use of the left shoulder for the accepted condition(s)?

- No limitation
- Some limitation
- Significant limitation (more than 2/3 of the time)

7. Is there any left shoulder strength loss due to the accepted conditions? If so, please provide the strength grade using the 5/5 scale and identify the weakened muscles and the nerves that innervate the weakened muscles, if any.

- No strength loss. All muscles are 5/5.
- Yes.

____/5 muscle(s) _____	nerve(s) _____
____/5 muscle(s) _____	nerve(s) _____
____/5 muscle(s) _____	nerve(s) _____

8. Did your surgery include a partial resection of the acromion?

- Yes
- No.

If so, what condition necessitated the partial resection of the acromion?

\_\_\_\_\_

9. What portion of injured workers' impairment is a result of the accepted condition and what portion is due to other factors or conditions?

\_\_\_\_\_ % of the impairment is due to the accepted condition(s)

\_\_\_\_\_ % of the impairment is due to pre-existing conditions

\_\_\_\_\_ No impairment

**Work Release**

10. Can the injured worker return to his regular work as a \_\_\_\_\_ for the employer at injury?

- Yes.
- No.

10. If not released to regular work at this time, do you anticipate he will eventually be released to full duty work at his job at injury? If not, what permanent work restrictions will prohibit this?

\_\_\_\_\_

\_\_\_\_\_

SAIF Claim No:  
January 27, 2016  
Page 4

**Validity**

11. Are any of the findings you have reported invalid? If any findings are considered invalid, provide rationale and detailed reasoning; include anatomic findings if applicable.

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John DiPaola, MD

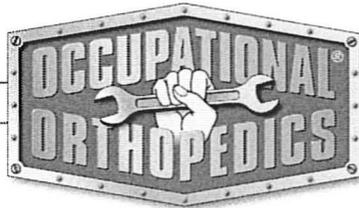
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Date

Thank you for your time.

Sincerely,

Dee Bufka, Claims Adjuster, Central Unit  
400 High Street SE  
Salem, Oregon 97312  
P: 503.315.3635, or 800.285.8525 ext. 635,  
F: 503.945.3635  
deebuf@saif.com



John Di Paola, M.D.  
Board Certified in Orthopedic Surgery

Wash Tier 1

February 11, 2016

CL#: AW74351

Hans Burger  
Case Manager  
State of Washington  
Department of Labor and Industry  
Attention: Claims Department  
P.O. Box 44269  
Olympia, Washington 99504-4269

RE: ACCT#: 8270 DOI: 03/18/2015  
DOB: CL#:

Dear Mr. Burger:

I saw this 32-year-old CNA today in claim closure examination regarding an injury occurring during the normal course of his work activities on March 18, 2015.

**MECHANISM OF INJURY:** She was helping a patient from the toilet to a wheelchair when the patient suddenly sat down resulting in a distraction injury of her right shoulder. She was seen in the emergency room and then treated in the occupational medicine department with physical therapy and anti-inflammatories. She developed increasing pain in the periscapular muscles and underwent trigger point injections which were of limited benefit. She moved to Oregon and reestablished care in our clinic. Physical therapy and an independent exercise program were effective in restoring her to her pre-injury status. She has returned to her job at injury without accommodation or restriction. She feels her range of motion, strength, and comfort are normal.

**CONDITION TREATED:** Right shoulder strain, work related

**PHYSICAL EXAMINATION:**

Physical examination today demonstrates normal appearance of the shoulder girdles. There is no tenderness. There is no atrophy about the shoulder.

**ACTIVE RANGES OF MOTION – SHOULDER** (measured by goniometer in accordance with the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition)

MOTION	RIGHT	LEFT
Forward Flexion	175 Degrees	175 Degrees
Extension	60 Degrees	60 Degrees
Abduction	170 Degrees	170 Degrees

Adduction	65 Degrees	65 Degrees
External Rotation	90 Degrees	90 Degrees
Internal Rotation	85 Degrees	85 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating and considered normal for a woman of her age, general health, and body habitus.

Her motor function is 5/5 in the shoulders, elbows, wrists, and hands including intrinsics, extrinsics, and grip. Sensation is intact in all dermatomes of the upper extremities including two-point discrimination at 5-mm on the palmar surface of all the digits of both hands.

### **IMPRESSION:**

Medically stationary

### **RECOMMENDATION:**

is advised that claim closure is in order. Its implications are explained and understood. She wishes to proceed.

She is released to any and all activity without restriction as it relates to the injury event of March 18, 2015.

There are no objective findings of impairment on physical examination today as it relates to the injury event of March 18, 2015. One hundred percent (100%) of impairment (if present) is due to the industrial injury and zero percent (0%) is due to any preexisting condition. There are no combined conditions or non-medical factors affecting the worker's objective or subjective function. There is no loss or alteration of sensation in the palmar surface of the hands.

The patient denies any injury to the contralateral left shoulder.

The worker has a zero percent (0%) upper extremity impairment relating to the work-related right shoulder strain based on the AMA Guides to the Evaluation of Permanent Impairment, 5<sup>th</sup> Edition.

The worker is not restricted in the repetitive use of the right upper extremity for more than two-thirds of her normal pre-injury workday resulting from the accepted condition(s) and/or the compensable injury of March 18, 2015. There are no permanent chronic medical conditions arising from the accepted condition(s) and/or compensable injury of March 18, 2015 that preclude the worker from repetitively using the limb. She has no impairments or disabilities and feels since she has returned to her job at injury she has been able to perform any and all activities without restrictions or accommodation.

No further medical treatment is recommended or arranged at this time as it relates to the accepted condition(s) and/or compensable injury of March 18, 2015. It is not expected that there will be periods of waxing and waning of symptoms that may result in additional medical services and/or periods of temporary disability as it relates to the accepted condition(s) and/or compensable injury. Her aggravation rights were discussed.

Please let me know if you require further information regarding the care of

Sincerely,

*John Di Paola, M.D.*

Orthopedic Surgeon

(Electronic signature – reviewed)

JD:gab/DS255022.doc/D: 02/11/16/T: 02/12/16



John Di Paola, M.D.  
Board Certified in Orthopedic Surgery

Trev I

February 16, 2016

Kathleen Straub  
Claims Adjuster  
SAIF Corporation  
400 High Street S.E.  
Salem, Oregon 97312-1000

RE: ACCT#: 8081 DOI: 06/30/2015  
DOB: CL#:

Dear Ms. Straub:

I saw this 42-year-old employee of \_\_\_\_\_ today in claim closure examination regarding an injury occurring during the normal course of his work activities on June 30, 2015.

**MECHANISM OF INJURY:** He was standing on a six-foot A-frame ladder about four feet off the ground when the ladder collapsed. He fell onto his outstretched right upper extremity striking his elbow and sustaining an axial compression injury to the right shoulder. He was seen at the emergency room where x-rays were taken and interpreted as negative. Subsequent followup by Dr. Curtis Thiessen prompted obtaining an MR arthrogram which demonstrated a large full thickness tear through the distal supraspinatus tendon. There was also evidence of labral injury. Orthopedic consultation was obtained.

On August 5, 2015 he was taken to the operating room where he underwent:

1. Right shoulder arthroscopic extensive debridement
2. Right shoulder arthroscopic rotator cuff repair
3. Right shoulder arthroscopic acromioplasty
4. Right shoulder mini open subpectoral biceps tenodesis

He has successfully completed a supervised and independent rehabilitative exercise program using an exercise kit and has recovered full comfort and function and has returned to his full duty activities without restriction or accommodation. He does note some slight stiffness of the right shoulder and occasionally some popping with intermittent pain from the surgical site.

**CONDITIONS TREATED:**

1. Right shoulder rotator cuff tear, work related
2. Right shoulder subacromial impingement, acute, work related
3. Right shoulder biceps instability, acute, work related
4. Right shoulder type I labral tear, anterior superior, preexisting, non-work related

**PHYSICAL EXAMINATION:**

Physical examination today demonstrates normal appearance of the shoulder girdles. There is no tenderness. There is no atrophy about the shoulder.

ACTIVE RANGES OF MOTION – SHOULDERS measured with a goniometer

MOTION	RIGHT	LEFT
Forward Flexion	160 Degrees	170 Degrees
Extension	50 Degrees	55 Degrees
Abduction	165 Degrees	165 Degrees
Adduction	30 Degrees	35 Degrees
External Rotation	100 Degrees	100 Degrees
Internal Rotation	60 Degrees	70 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating, but not considered normal for a gentleman of his age, general health, and body habitus.

His motor function is 5/5 in the shoulders, elbows, wrists, and hands including intrinsics, extrinsics, and grip. Sensation is intact in all dermatomes of the upper extremities including two-point discrimination at 5-mm on the palmar surface of all the digits of both hands.

**IMPRESSION:**

Medically stationary

**RECOMMENDATION:**

is advised that claim closure is in order. Its implications are explained and understood. He wishes to proceed.

He is released to any and all activity without restriction as it relates to the injury event of June 30, 2015.

There are objective findings of impairment on physical examination today with restricted range of motion as it relates to the injury event of June 30, 2015. One hundred percent (100%) of impairment (if present) is due to the industrial injury and zero percent (0%) is due to any preexisting condition. There are no combined conditions or non-medical factors affecting the worker's objective or subjective function. There is no loss or alteration of sensation in the palmar surface of the hands.

Any operative procedures performed on this worker were directed toward providing the optimal outcome for the above-listed work-related condition(s).

The patient denies any injury to the contralateral left shoulder.

The worker is not restricted in the repetitive use of the right upper extremity for more than two-thirds of his normal pre-injury workday resulting from the accepted condition(s) and/or the compensable injury of June 30, 2015. There are no permanent chronic medical conditions arising from the accepted condition(s) and/or compensable injury of June 30, 2015 that preclude the worker from repetitively using the limb. He has no impairments or disabilities and feels since he has returned to his job at injury he has been able to perform any and all activities without restrictions or accommodation.

No further medical treatment is recommended or arranged at this time as it relates to the accepted condition(s) and/or compensable injury of June 30, 2015. It is not expected that there will be periods of waxing and waning of symptoms that may result in additional medical services and/or periods of temporary disability as it relates to the accepted condition(s) and/or compensable injury. His aggravation rights were discussed.

Please let me know if you require further information regarding the care of.

Sincerely,

*John Di Paola, M.D.*

Orthopedic Surgeon

(Electronic signature – reviewed)

cc: Majoris; Dr. Curtis Thiessen

JD:gab/DS255066.doc/D: 02/16/16/T: 02/18/16



John Di Paola, M.D.  
Board Certified in Orthopedic Surgery

Tier 2

March 1, 2010

Jimena Barros  
Claims Adjuster  
SAIF Corporation  
400 High Street SE  
Salem, Oregon 97312

RE: ACCT#: 3134 DOI: 07/18/2009  
CL#:

Dear Ms. Barros:

I saw this 39-year-old field worker today in claim closure examination regarding an injury occurring to the right ankle during the normal course of her work place activities on July 18, 2009. A professional Spanish language interpreter was present throughout today's interview and examination.

**MECHANISM OF INJURY:** She lost her balance and tried to catch herself from falling into a dumbwaiter machine. She sustained shoulder, back, hip, right ankle, and foot injuries. She underwent initial treatment at Providence in Newberg where an MRI confirmed tearing of the lateral ligaments of the ankle. She was appropriately placed in a walking boot and provided with crutches. She saw Dr. Thomas Croy briefly and then transferred her care to our clinic.

At the time of engagement she had isolated complaints to the ankle. The patient saw multiple physicians during the course of her treatment.

Objective findings resolved and the patient was released to full duty, but continued to complain of subjective pain. MR arthrogram did not demonstrate any ongoing acute injury that would require surgical treatment.

The patient continued to complain of a constellation of subjective pain symptoms which were not anatomic and invalid. The patient is advised she has been released to full duty for several months and that all reasonable conservative therapies have been applied toward the treatment of her injuries. She is not a surgical candidate. We can find no objective evidence to verify a pattern of subjective pain symptoms that the patient endorses.

**CONDITIONS TREATED:**

- 1. Lumbar sprain
- 2. Right ankle sprain

**PHYSICAL EXAMINATION:**

She has normal gait and station. There is no evidence of lumbosacral pain or splinting behaviors.

**ACTIVE RANGES OF MOTION – LUMBAR SPINE** measured by double inclinometer

MOTION	DEGREES
Forward Flexion	60 Degrees
Extension	25 Degrees
Right Lateral Flexion	25 Degrees
Left Lateral Flexion	25 Degrees
Straight Leg Raising-Right	75 Degrees
Straight Leg Raising-Left	75 Degrees
Seated Straight Leg Raising - Right	95 Degrees
Seated Straight Leg Raising – Left	95 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating and considered normal for a woman of her age, general health, and body habitus.

Physical examination today demonstrates normal alignment with no evidence of effusion or deformity of the ankles.

There is no tenderness about the ankles. There is no instability of the ankles to inversion and anterior drawer stress.

**ACTIVE RANGES OF MOTION – ANKLES** measured by goniometer

MOTION	RIGHT	LEFT
Dorsiflexion	25 Degrees	25 Degrees
Plantarflexion	50 Degrees	50 Degrees
Inversion	25 Degrees	25 Degrees
Eversion	10 Degrees	10 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating and considered normal for a woman of her age, general health, and body habitus.

Her motor function is 5/5 in the hips, knees, ankles, and feet. Her sensation is intact in all dermatomes including the entire plantar surface of both feet.

There is no shortening or varus/valgus deformity of the limb resulting from the compensable injury.

Her motor function is 5/5 in the hips, knees, ankles, and feet. Her sensation is intact in all dermatomes including the entire plantar surface of both feet.

The patient continues to complain of subjective symptoms relating to both the spine and the ankle with no objective findings identified today.

**IMPRESSION:**

Medically stationary.

**RECOMMENDATION:**

is advised that claim closure is in order. Its implications are explained and understood through the assistance of the professional interpreter. She wishes to proceed.

She is released to any and all activity without restriction as it relates to the injury of July 18, 2009.

There are no objective findings of impairment on physical examination today as it relates to the injury of July 18, 2009. One hundred percent (100%) of impairment is due to the industrial injury and 0 percent (0%) is due to any preexisting condition. There are no combined conditions or non-medical factors affecting the patient's objective or subjective function. There is no loss or alteration of sensation in the plantar surface of the feet.

The patient denies any injury to the contralateral left ankle or lumbar spine.

The worker is not restricted in the repetitive use of the right lower extremity or lumbar spine resulting from the accepted condition(s) of July 18, 2009. There are no permanent chronic medical conditions arising from the accepted condition(s) of July 18, 2009 that preclude the worker from repetitively using the limb or lumbar spine region.

There are no permanent chronic medical conditions that preclude the worker from repetitively using the injured body parts.

No further medical treatment is recommended or arranged at this time as it relates to the accepted condition(s) of July 18, 2009. It is not expected that there will be periods of waxing and waning of symptoms that may result in additional medical services and/or periods of temporary disability as it relates to the accepted condition(s). Her aggravation rights were discussed.

A discussion was held with the patient and her husband who request an explanation for her ongoing pain. On an objective basis I have none. It was carefully explained to the patient that she has responded in a predictable manner to reasonably apply therapy to address her objective findings which have all resolved. She has not, however, had resolution of her subjective findings which are of a pattern and nature which do not appear to be scientifically or anatomically verifiable. She is not felt to be a candidate for any surgical treatment and all conservative therapies have been exhausted. We are unable to objectively identify any injury or disease that would require placing any restrictions on her activities. She is able to commute to and from work and can drive a vehicle as it relates to her work place injury of July 18, 2009 on the basis of objective verifiable findings.

The patient is warned to engage only in those activities that are reasonably comfortable and that do not threaten her safety or that of others. She must exercise her own judgment in determining the reasonable safety and comfort of her activities including the operation of machinery and motor vehicles.

Please let me know if you require further information regarding the care of.

Sincerely,

*John Di Paola, M.D.*

Orthopedic Surgeon

(Electronic signature – reviewed)

cc: OHS

JD:gsb/JDZQ1710.doc

D: 03/05/10/T: 03/06/10

Office: 503.885.7770

Fax: 503.885.7771



John Di Paola, M.D.  
Board Certified in Orthopedic Surgery

Tur 3

June 25, 2010

Robin Meader  
Case Examiner  
Liberty Northwest Insurance  
P.O. Box 4555  
Portland, Oregon 97208-4555

RE: ACCT#: 2057 DOI: 06/24/2008  
CL#:

Dear Ms. Meader:

I saw this 48-year-old carpenter today in claim closure examination regarding an injury occurring to his right shoulder during the normal course of his work activities on June 24, 2008.

**MECHANISM OF INJURY:** He stepped on some sheetrock which was covering a hole. He fell into the hole up to his waist. He reached out to break his fall with his right arm and developed immediate onset of right shoulder, low back, and right hip pain. He was seen in the emergency room and followed up by Dr. Borman.

An MRI scan was obtained demonstrating significant internal derangement of the shoulder and orthopedic consultation was obtained.

Conservative therapies were applied for the shoulder and the patient ultimately underwent surgical treatment.

During the course of care this patient was treated for:

1. Disabling lumbar sprain.
2. Right hip strain.
3. Right shoulder strain.
4. Right biceps tendon tear.
5. Right shoulder subscapularis rotator cuff tear.
6. Left knee contusion.
7. Left knee medial meniscus tear.
8. Right carpal tunnel syndrome.

The patient underwent three surgical procedures. On October 29, 2008 he underwent right shoulder arthroscopic rotator cuff repair of the subscapularis, mini open biceps tenodesis, and mini open partial acromioplasty.

On November 25, 2009 he underwent right carpal tunnel release.

On March 3, 2010 he underwent arthroscopic partial medial and lateral meniscectomies and retropatellar articular shaving.

The patient received conservative therapies for the other listed conditions above. He has become medically stationary. Claim closure is appropriate at this time. He agrees to proceed.

**PHYSICAL EXAMINATION:**

Physical examination today demonstrates normal appearance of the shoulder girdles. There is no tenderness. There is no atrophy about the shoulder.

**ACTIVE RANGES OF MOTION – SHOULDERS** as measured by goniometer

MOTION	RIGHT	LEFT
Forward Flexion	140 Degrees	170 Degrees
Extension	50 Degrees	50 Degrees
Abduction	140 Degrees	165 Degrees
Adduction	70 Degrees	85 Degrees
External Rotation	90 Degrees	90 Degrees
Internal Rotation	60 Degrees	65 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating, but not considered normal for a gentleman of his age, general health, and body habitus.

Examination of the wrists demonstrates alignment of the wrist and hand is normal. There are no deformities or masses and no tenderness.

**ACTIVE RANGES OF MOTION – WRIST** as measured by goniometer

MOTION	RIGHT	LEFT
Dorsiflexion	50 Degrees	50 Degrees
Palmarflexion	70 Degrees	70 Degrees
Ulnar Deviation	35 Degrees	35 Degrees
Radial Deviation	20 Degrees	20 Degrees
Supination	85 Degrees	85 Degrees
Pronation	85 Degrees	85 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating and are considered normal for a gentleman of his age, general health, and body habitus.

ACTIVE RANGES OF MOTION – LUMBAR SPINE measured by double inclinometer

MOTION	DEGREES
Forward Flexion	50 Degrees
Extension	15 Degrees
Right Lateral Flexion	10 Degrees
Left Lateral Flexion	10 Degrees
Straight Leg Raising-Right	75 Degrees
Straight Leg Raising-Left	75 Degrees
Seated Straight Leg Raising-Right	90 Degrees
Seated Straight Leg Raising-Left	90 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating and considered normal for a gentleman of his age, general health, and body habitus.

ACTIVE RANGES OF MOTION – HIPS measured by goniometer

MOTION	RIGHT	LEFT
Extension	0 Degrees	0 Degrees
Maximum Flexion	22 Degrees	114 Degrees
Internal Rotation	10 Degrees	10 Degrees
External Rotation	50 Degrees	50 Degrees
Abduction	50 Degrees	50 Degrees
Adduction	25 Degrees	25 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are valid for impairment rating, but not considered normal for a gentleman of his age, general health, and body habitus.

There is no shortening or varus/valgus deformity of the limb resulting from the compensable injury.

ACTIVE RANGES OF MOTION – KNEES measured by goniometer

MOTION	RIGHT	LEFT
Hyperextension	0 Degrees	0 Degrees
Neutral	0 Degrees	0 Degrees
Maximum Flexion	115 Degrees	115 Degrees

These range of motion findings were obtained utilizing the criteria required by the Oregon Workers' Compensation Division. They are not valid for impairment rating and considered normal for a gentleman of his age, general health, and body habitus.

#### UPPER EXTREMITY MUSCLE STRENGTH

MUSCLE/ACTION	ROOT	NERVE	RIGHT	LEFT
Shoulder Forward Flexion	C5-C6	Axillary	4+/5	5/5
Shoulder Extension	C5-C6	Axillary	5/5	5/5
Shoulder Abduction	C5-C6	Suprascapular	4+/5	5/5
Shoulder Adduction	C7-C8	Thoracodorsal	5/5	5/5
Shoulder External Rotation	C5-C6	Suprascapular	5/5	5/5
Shoulder Internal Rotation	C5-C6	Subscapular	4/5	5/5
Elbow Flexion	C5-C6	Musculocutaneous	5/5	5/5
Elbow Extension	C6-C7	Radial	5/5	5/5
Wrist Dorsiflexion	C6-C7	Radial/PIN	5/5	5/5
Wrist Palmarflexion	C7	Median	5/5	5/5
Intrinsics	C8-T1	Ulnar	5/5	5/5
Extrinsics	C6-C7	Radial	5/5	5/5
Grip Strength	C8-T1	Ulnar	5/5	5/5

#### LOWER EXTREMITY MUSCLE STRENGTH

MUSCLE/ACTION	NERVE ROOT	NERVE	RIGHT	LEFT
Hip Adduction	L3	Obturator	5/5	5/5
Hip Abduction	L5	Superior Gluteal	5/5	5/5
Knee Extension	L4	Femoral	5/5	5/5
Knee Flexion	L4-S1	Sciatic	5/5	5/5
Leg Abduction	L4-S1	Superior Gluteal	5/5	5/5
Leg Adduction	L2-L4	Obturator	5/5	5/5
Ankle Plantarflexion	S1	Tibial	5/5	5/5
Ankle Dorsiflexion	L4-L5	Deep Peroneal	5/5	5/5
Ankle Inversion	L4-L5	Tibial	5/5	5/5
Ankle Eversion	L5-S1	Superficial Peroneal	5/5	5/5
Great Toe Extension	L5, S1	Deep Peroneal	5/5	5/5

Sensory examination of the hands with two-point discrimination is 5 mm bilaterally symmetrical throughout except for the first and third digits of the right hand which exhibit 9 mm of two-point discrimination.

Sensation is intact in all dermatomes of the lower extremities including intact light touch sensation on the entire plantar surface of both feet.

**IMPRESSION:**

Medically stationary.

**RECOMMENDATION:**

is advised that claim closure is in order. Its implications are explained and understood. He wishes to proceed.

He has permanent activity restrictions related to his accepted conditions as noted in our work release today. He cannot return to his full duty activities performed on the date of injury. The worker is significantly limited in the repetitive use of the right hand secondary to residual numbness and dysesthesia resulting from his accepted carpal tunnel syndrome.

On May 25, 2010 he was released to full duty as it relates to his left medial meniscus tear, but that should not be construed as a full duty release related to all of his accepted conditions. Today's comprehensive light duty restrictions were in effect on May 25, 2010 and are stated in our work release today which is retro-dated to May 25, 2010.

He is significantly limited in the repetitive use of the right shoulder due to his right shoulder accepted conditions.

There are objective findings of impairment on physical examination today as it relates to the injury of June 24, 2008. One hundred percent (100%) of impairment is due to the industrial injury and 0 percent (0%) is due to any preexisting condition. There are no combined conditions or non-medical factors affecting the patient's objective or subjective function. There is no loss or alteration of sensation in the plantar surface of the feet.

There are no permanent chronic medical conditions arising from the accepted condition(s) of June 24, 2008 that preclude the worker from repetitively using the involved limbs or spinal region.

No further medical treatment is recommended or arranged at this time as it relates to the accepted condition(s) of June 24, 2008. It is not expected that there will be periods of waxing and waning of symptoms that may result in additional medical services and/or periods of temporary disability as it relates to the accepted condition(s). His aggravation rights were discussed.

Please let me know if you require further information regarding the care of.

Sincerely,

*John Di Paola, M.D.*

Orthopedic Surgeon

(Electronic signature – reviewed)

cc: Dr. Nancy Borman

JD:gab/JDZQ2432.doc

D: 06/25/10/T: 06/27/10

February 22, 2016

Fred Bruyns, rules coordinator  
Workers' Compensation Division

Via email: [fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov)

**Re: Helios Comments on Proposed Changes to OAR 436-009, Oregon Medical Fee and Payment Rules**

Helios appreciates this opportunity to comment on proposed changes to OAR 436-009 (Oregon Medical Fee and Payment Rules). Our comments are specifically focused on rule provisions related to pharmacy. As part of the advisory committee that provided recommendations for this rule-making, we support the proposed addition of rule language requiring billing and reimbursement of compounded medications at the individual component ingredient level. Based upon our knowledge of the national pharmacy billing standards adopted by the Division and experience in other jurisdictions, we also recommend some modifications to the proposed language along with an update to references made to the National Council for Prescription Drug Programs (NCPDP) paper billing instructions manual.

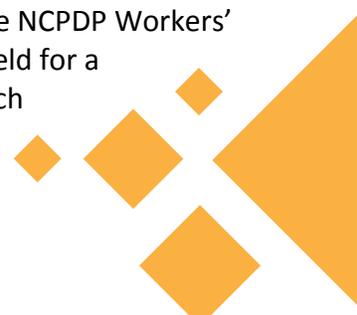
***Compound Individual Ingredient Billing & Reimbursement***

As part of the advisory committee leading up to this rule-making, Helios recommended additions to 436-009 regarding the billing and reimbursement for compounded medications – one specifically to require billing and reimbursement at the component ingredient level. As such, we are grateful to the Workers' Compensation Division for now including our recommendation in these proposed changes under 436-009-0090(2). As we noted in our original recommendation, this will add needed clarity and transparency to the process while also aligning with national pharmacy billing and processing standards already adopted by the Division. Helios also believes this may alleviate disputes between providers and payers as to the proper reimbursement for these unique products.

***Separate Compounding Fees for Each Individual Ingredient Based on "Sterile" v. "Non-Sterile"***

The Division's proposed language in the table under 436-009-0090(2)(d) also would require reimbursing providers a separate "compounding fee" for each individual ingredient included in the compound, in addition to distinguishing the applicable compounding fee amounts based on whether the compound is "sterile" or "non-sterile." Helios recommends not including either of these provisions in the final adopted rules for three reasons.

The first reason is that the national pharmacy billing standards (NCPDP) previously adopted by the Division for both paper and electronic billing, and used by stakeholders across the country, do not facilitate the submission of a separate compounding fee for each ingredient within a compound. For example, the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) only allots one field for a "dispensing fee submitted" and only one other field for "other amount submitted" (which



may be used to submit a compounding fee). This is the case because there has never been an evident need to accommodate a separate fee for every single ingredient which may be included in a compound. NCPDP’s electronic billing standard actually permits up to 25 individual ingredients and their related ingredient charges to be submitted as part of one compound, but not a separate compounding fee for each of those ingredients.

The second reason is that we fear this may unintentionally incentivize some providers to include unnecessary ingredients in the compound as a means to gain greater reimbursement. While we believe most providers are honest and will not do so, it is often the outliers that disrupt the system with questionable practices like this.

The third reason we recommend removing this language is that we are not aware of a sure, objective way to determine in a given pharmacy billing transaction whether the compound is “sterile” or “non-sterile.” There are no fields that specifically indicate this in either the NCPDP paper or electronic standards. The closest possible way to ‘back in’ to this is to review the codes submitted in the “route of administration” field, which indicates the route of administration of the complete compound mixture (examples: injection, topical, nasal); however, that is not purely objective and does not specifically get to the distinction between “sterile” and “non-sterile.” We are concerned that this level of subjectivity may lead to disagreements and potential disputes between providers and payers as to what the appropriate reimbursement should be for a dispensed compound.

Instead, Helios recommends including only a single, per-compound “compounding fee” in the table under 436-009-0090(2)(d). We are not committed to any particular dollar amount for this single fee, but recommend the Division review the dollar amounts adopted by other jurisdictions for this purpose in making its decision as to what fee would be reasonable. Our suggested language for this table is included below (underlined to indicate recommended added language to the existing table) – leaving out the specific compounding fee amount:

<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
<u>A compound drug</u>	<u>83.5 % of the AWP for each individual component ingredient plus a single compounding fee of \$#.##</u>



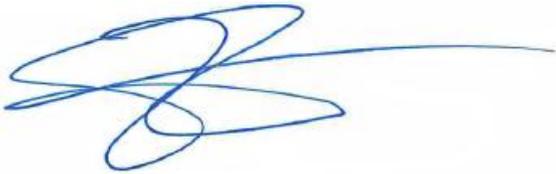
### ***Updated NCPDP Manual***

Finally, Helios would like to take this opportunity to recommend the Division update references to the NCPDP Manual Claim Forms Reference Implementation Guide in the rules to the most current version published by NCPDP – which is version 1.4 (July 2015). Of particular note for this rule-making is that this latest version of the NCPDP implementation guide added instructions for how to bill a compound medication with more than seven ingredients (along with several other editorial changes). OAR 436-009 currently refers to version 1.2 after the table of contents describing where to order the implementation guide and version 1.3 in the actual adoption of standards under 436-009-0004. We recommend the Division update both of these parts of the rules to reference version 1.4 of the implementation guide.

### ***Conclusion***

Thank you for your initial inclusion of Helios in the advisory committee leading up to this rule-making and for taking the time to consider our comments during this formal rule-making period. We look forward to working with the Division on this and other rule developments in the future. Please let me or our team know if you have any questions or require any additional information related to our comments.

Sincerely,



Kevin C. Tribout  
Executive Director of Government Affairs  
Helios  
[Kevin.Tribout@helioscomp.com](mailto:Kevin.Tribout@helioscomp.com)



**BRUYNS Fred H \* DCBS**

---

**From:** Kevin Kane <drkane@pdxir.com>  
**Sent:** Tuesday, February 23, 2016 7:53 AM  
**To:** BRUYNS Fred H \* DCBS  
**Subject:** Closing exam rule changes

Dear Mr. Bruyns,

I am writing to endorse the testimony recently provided by John Di Paola MD, relating to closing examination reimbursement.

Please add my support as a provider to the advocacy relating to this matter.

Thank you for your service to Oregon workers.

Sincerely,

**Kevin Kane D.O.**  
**Integrated Rehabilitation Inc**

10340 SE Division St.  
Portland, OR 97266  
Voice 503 232-1000  
Fax 503 232-1143  
[drkane@pdxir.com](mailto:drkane@pdxir.com)

**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 436-010, Medical Services	) ) ) )	TRANSCRIPT OF TESTIMONY
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The proposed amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated February 2016. On Feb.22, 2016, 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. 25, 2016.

**INDEX OF WITNESSES**

<b>Witnesses</b>	<b>Page</b>
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B. <a href="#">Sandy Shtab, Healthsystems</a> .....	<u>3</u>
C. <a href="#">Kevin Tribout, Helios</a> .....	<u>5</u>
D. <a href="#">John Di Paola, M.D, Occupational Orthopedics</a> .....	<u>6</u>

**TRANSCRIPT OF PROCEEDINGS**

Hearing officer:

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 9:03 a.m. on Monday, February the 22<sup>nd</sup>, 2016. We are in Room “F” of the Labor & Industries Building, at 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, or if you are testifying by telephone, I will sign-in for you.

The Department of Consumer and Business Services, Workers’ Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically, division 009, Oregon Medical Fee and Payment Rules, and division 010, the rules governing Medical Services. The department has summarized the proposed rule 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.

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. 12, 2016; 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 2016 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. 25, 2016, 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.

Workers' Compensation Division testimony:

And now, I'm going to read some Workers' Compensation Division testimony into the record, and I'm providing this first, because it will give others the opportunity to comment on the division's testimony.

The testimony is dated Feb. 4, 2016, and it is exhibit "2," also posted to our website. It is addressed to Fred Bruyns – that is me – rules coordinator, from Juerg Kunz, medical policy analyst, and the subject is Appendix "C." And this is the subject matter:

Appendix C contains the ambulatory surgery center fee schedule amount for surgical procedures. The second column indicates whether a surgical procedure is subject to the multiple procedure discount. If the column contains the letter "Y," it means the procedure is subject to the multiple procedure discount; if the column contains the letter "N," it means the procedure is not subject to the multiple procedure discount. The determination whether a procedure performed at an ambulatory surgery center is subject to the multiple procedure discount is made according to the following:

A procedure is subject to the multiple procedure discount unless: the Centers for Medicare & Medicaid Services designates the procedure as not being subject to the multiple procedure discount; or the payment for the procedure is packaged into the payment of another procedure.

In the proposed 4-1-16 Appendix "C," many procedures that are subject to the multiple procedure discount are listed erroneously as not being subject to the multiple procedure discount. The Workers' Compensation Division intends to correct this error on Appendix "C" when filing notice of the permanent OAR 436-009 with the Secretary of State. The codes affected are listed below this memorandum. Signed Juerg Kunz, medical policy analyst.

And, what follows are several pages of codes. I will not read all of those into the record. Again, the information is available on the division's website, and I would encourage anyone to go and have a look at that.

At this point I'd like to ask Sandy Shtab of Healthsystems if she would like to provide some testimony.

Sandy Shtab:

Yes, I would love to. Thank you very much, Fred, for letting me go first. I will be very brief.

Really, our comments here today focus on the maximum allowable fee for compounded drugs, and I have submitted written testimony, which hopefully folks will be able to reference afterwards, which is more extensive and gives a little more explanation. But, in short, what we would like to recommend is modifying the reimbursement maximum for the compounding dispense fee, the dispensing fee component only, to tie it to a single, uniform compound dispense fee. In other words, just that one fee that is the maximum for any compounded drug, rather than what's been proposed here, which is to really have a two-pronged calculation for dispense fees on compounds. Right now, the way it reads, the processing entity would have to determine first if the medication is a sterile or non-sterile preparation, and then would also need to be able to calculate the number of ingredients that were in the compound, and discount any that don't have an NDC associated with them. And, it's really a much more complex calculation than it needs to be. There are some states who have, not this exact methodology but that have a more complex methodology than just setting a maximum rate, and there are challenges to doing that that have to do with determining if the drug is sterile or non-sterile preparation, and then also the multiplier for the number of ingredients. We have found that it's the most straightforward type of maximum reimbursement is just setting a single rate that's applicable whether it's sterile or non-sterile. We provided just a short table of the states that do have a single dispensing fee for compound drugs to help the division consider what that might look like. We're not making a recommendation of what it should be, just that it should be a single rate. There are the complications in really operationalizing this for either a pharmacy benefit manager or a bill reviewer are that there are two potential fields on the standardized billing format that needs to be taken into account to determine if a drug was sterile or non-sterile. The drug itself is, you cannot tell if the drug itself, the end product, the compounded drug, was prepared in a sterile environment without looking at these two different fields, and it isn't a failsafe. So, understanding that the majority of the compounded drugs that are going to be billed for outpatient use, and I'm talking only about this piece of the fee schedule on page 67, applies only to outpatient I believe? Typically those are drugs like compounded topical creams and lotions, which are not usually prepared in a sterile environment. There are some drugs that are prepared in a sterile environment, like eye drops, and of course there are things like infusion drugs, but typically those are not prepared for the patient to take home and use. So, that's the reason that we're talking about, or at least recommending strongly that the division adopt a single rate for compound fees. Does that make sense?

Hearing officer:

Yes. Yes it does.

Sandy Shtab:

Okay. Are there any questions on that before I move on to the next two remarks that I have?

Hearing officer:

Does anyone have any questions? Okay – no, that’s fine Sandy, go ahead.

Sandy Shtab:

Okay, thank you. The next thing we recommend is to have a preauthorization requirement for compounded medications. The reason is that there are studies – there’s a lot of literature out there specific to the workers’ compensation industry around compounding of medications and how they’ve been used in some circumstances inappropriately as a first line of therapy without trying other medications that are manufactured. So, we would recommend having a preauthorization requirement around that, just so that the physician can demonstrate – really it’s like a speed bump, some people I’ve heard say the word speed bump – to make sure that the physician is held accountable that that drug is the most appropriate one for the patient. Compounding of medications has been done for many, many years, and there are definitely appropriate uses for it, but we have seen a lot of medical evidence, and a lot of industry publications and research documents, which I’ve, you know, referenced here in my letter as well that talk about how they’ve been used inappropriately in workers’ comp. So, we would suggest that.

And then, finally, this is just a little thing I noticed on – I believe it is on page 67 of the proposal, and I did not include this in my written remarks, because I noticed it after the fact. There’s a reference on page 67 about insurers using a nationally published prescription pricing guide for calculating the payment to the provider. And, the examples given are First DataBank, RED BOOK, or Medi-Span. I just wanted to point out that First DataBank has stopped publishing average wholesale price data several years ago, so that citation may be – not may be, is definitely outdated and should probably be removed as an example, because they don’t publish that information that would be used under the Oregon fee schedule.

Hearing officer:

Okay – thank you.

Sandy Shtab:

And that's really – that's the crux of it. I'm happy to take any questions, if there are any.

Hearing officer:

Okay. No, I think that was pretty clear, Sandy, and really appreciate it. And, also thank you for pointing out the information about First DataBank.

Sandy Shtab:

Thank you.

Hearing officer:

Okay, and is Kevin Tribout on the line with us?

Kevin Tribout:

Yes, thank you, Fred. We appreciate the opportunity to comment. We will be filing our written comments later today. I mirror what Sandy said about the compounding issue. Our main concern on the separate dispensing fee for the compound, for, first off dealing with the existing NCPDP form and format, for both paper and electronic billing, if there is a separate dispensing fee for individual ingredients, because one may be a sterile, one may not be a sterile ingredient. That would make use of the NCPDP form very difficult, because there is not an individual compounding fee field submission for each individual ingredient.

The second reason why we're commenting is to really support a single dispensing fee – not an amount. We believe that Oregon and your group there are best able to determine what would be acceptable for providers in Oregon. But is that, if you have ingredients in a compound, you may see unintentional use of some sterile products as part of a compound simply to drive up cost. We've seen this in other states where certain ingredients are used that may not have an efficacy for the compound, but are used to [inaudible] necessarily drive up the cost of the compound. And, I think those are really the reasons why we are – we're supportive of the change that you have made. We think it's a great change. It will bring better cost control and safety to the utilization of compounds in Oregon. We just think that a single compounding fee will be better for providers and payers, and processors, especially those that use the state format and form for billing. And, we'll be filing our comments that reflect that later today.

Hearing officer:

Okay. Thank you very much Kevin. Appreciate it. Is there anyone else on the line with us who would like to testify this morning? Is there anyone hear in Salem? Given that, it's our policy to keep a hearing open, to remain here and present, for at least a half an hour in case someone does arrive late, so I'll just remind you again that the record remains

open for written testimony through and including Feb. 25, 2016. 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 USPS mail, or you may hand deliver testimony to the Workers' Compensation Division Central Reception on the second floor of this building. And, on the table here by the entrance are business cards that include my contact information. It's also on the hearing notice, the Notice of Proposed Rulemaking Hearing. I will acknowledge all testimony received.

This hearing is recessed at 9:16 a.m.

The hearing is resumed at 9:19, so Dr. Di Paola, go ahead and provide whatever testimony that you would like. And we appreciate it, thank you.

John Di Paola, M.D.:

Okay. I've handed you a copy of a written statement and also a Excel spreadsheet, because I wanted to make comments on the proposed rules for changing the fees for claim closure examinations. I feel that these proposed changes are inappropriate and short sighted and that they'll lead to significantly negative impact on all stakeholders, including the patients. And, I think that the financial impact on providers, especially those that are the most committed to the workers' compensation system and are trying to do things in compliance with the rules, are going to be strongly, negatively impacted, and this proposed rule would result in disincentivizing these dedicated physicians from continuing to provide this service.

The requirements for a closing examination are outlined in Bulletin 239, which is a 47-page document. And, there's also a director's quick reference report, which is two pages of requirements for this examination. And, if you look at the contents of a closing report, there's I think 12 bullet points of information that are required in order to close the claim. So, in reviewing the proposed fees, it looks like fees only reimburse for the impairment examination and a report, which are insufficient to meet the requirements of a closure. This would lead to added administrative costs, either by narrative requests and phone conferences with providers, or by an increase in the number of requests for arbiters' exams to meet the requirements for the closure. All of this would strongly negatively impact the payers.

And then, further, on that scope of the exam concept, it's, the notion that a physician could accurately provide all of this information without reviewing the record, even though they're the treating physician, is really not consistent with reality, because most of us have two or three hundred patients in our practice at any given time, and in order to provide the information for closure, it does require that you go through, review the record, and provide accurate information.

And then, as far as the value of the information, I looked at three sources, and there's a spreadsheet here, and I've divided it along the left into the three different levels of

complexity of closing examinations. In the first column is a reflection of what Washington L&I uses as a reimbursement level to provide this body of information. And, it's my assumption that the three-tiered approach is Oregon's attempt to mirror what's going on in Washington. However, they didn't mirror the value that Washington places on the information. And the other interesting thing about Washington is that they don't have these 12 bullet points that are required for a closing. They just require a brief history and an impairment examination and a report.

And, so the next thing I looked at was arbiter examinations. And, the reimbursement for the same level of activity to provide exactly the same information is reimbursed at, starting at \$482 and ranging all the way up to almost \$1,100. And the proposed fee schedule recommends \$200, \$300, and \$550. So, if the information is valuable to stakeholders, if that body of information has a certain value in the marketplace in our region, I don't understand why providing that information on the occasion of a closing examination would devalue it by such a significant amount. And I've, in the next column, that's titled current at 80 percent, I outlined our strategy for backing into the fee schedule, in order that we might be reimbursed at the market price for the information that we're providing in order to legally close the claim. And so, what we do is, we actually charge \$636 for the exam and \$124 for the report and adjust it at 80 percent to bring the net reimbursement to what the value is in the marketplace. So, we have to kind of back into it to be certain that we're going to get reimbursed at an appropriate level because of the way the rules are currently written.

And the next column shows you that, should the new rules go into effect what the impact would be on my practice, and most of the exams involve the first two tiers. Most of the workers we see either have one or two, sometimes three body parts. It's very rare to have to do an examination of higher complexity. And, so you can see those first two tiers would impact us – a negative \$296 for a one body part exam, and negative \$196 for every two body part examination, obviously very impactful financially to my practice.

So, the value of the information is also reflected by the carriers, because in our current fee schedule, there's two fees that are charged for various levels of information – N001 to respond to five items on a narrative or less, and N002 which is to respond to more than five items in a narrative, and if you add the costs – and the director requests more than five items, so if you added the \$200 proposed fee and added the cost of the additional information, it still comes out to about \$432 for a tier one and \$532 for tier two. So, we're providing the information in various areas to satisfy the requirements of the workers' compensation division rules, and for some reason the fee schedule proposal presumes that if we provide exactly the same information that they are willing to pay for in other venues, that in a closing examination for some reason it's not worth that amount of reimbursement. This is a typical closing or medically stationary request form from SAIF Corporation, and you can see by reviewing the items in there that it goes well beyond a simple impairment examination in order to meet the requirements that the carrier expects us to meet.

I suspect the next topic would be provider choice. I would suspect that perhaps the person or persons who proposed these rules changes were frustrated by receiving chart notes from non-committed providers, that are titled closing examination, that do not fulfill the requirements of a closing examination. And, because the provider writes closing examination, does a brief impairment examination, which most likely is not done according to the requirements of the director, and then puts in the statement medically stationary, and then they charge an inflated rate for that visit, because it's a quote-unquote closing exam, but in reality it's not a closing exam. It doesn't meet the specifications. It does not satisfy the rules and should not be reimbursed as a closing examination. So, there's two groups of providers, those who are not particularly interested in working with the division and fulfilling the requirements that are imposed by the workers' compensation system, and those who are. And, I think that calling what those non-dedicated physicians are providing a closing examination does a disservice to those dedicated physicians who are trying to make the system work better by providing a communication product that fulfills the requirements of the law.

And, what I've done here is I've also have several exhibits that we have taken from my records, and redacted the patient information. One is a Washington tier one examination, and I have an Oregon tier one, tier two, and tier three examination, so that the members of the committee can see what that looks like when it is completed.

So, I think the current proposed rules need to be revisited. I went down on the bottom of this Excel sheet, and using the numbers in green on the right side where N002 was added to the impairment exam and report proposed fee and come up with three levels of fee: tier one \$450, tier two \$550, and tier three \$700, just as some sort of a ballpark estimate of being able to appropriately reimburse those providers who are correctly performing a closing examination, and that if a provider bills for something, and they bill under the code of the closing examination and it doesn't meet the requirements, they should be reimbursed under the usual CPT codes for an office visit, and not penalize those physicians who doing it. And, I think ultimately the system needs the information to close these claims, and ultimately the system is going to pay the price to close the claim. I think it saves time, energy, and money. It efficiently allows the worker's claim to be closed. And, we know the longer that that claim is open the more likely that negative things are going to impact that worker. And, so if we can't get an efficient and timely method of closing the claim and reimburse properly for it, I think ultimately it's going to impact the workers as well.

I think that pretty much covers what I wanted to say.

Hearing officer:

Thank you Dr. Di Paola, and thank you for redacting the information that you provided.

John Di Paola, M.D.:

I only have one set of those exhibits for you.

Hearing officer:

For me – okay. Well, we'll post it to our website and it will be available, probably by this afternoon.

John Di Paola, M.D.:

You probably already have that. [two-page “Workers’ Compensation Examination Report – Quick Reference”]

Hearing officer:

Well, that’s okay. We can add that in as well.

John Di Paola, M.D.:

Okay. Thank you.

Hearing officer:

Thank you Dr. Di Paola.

Hearing officer:

Is there anyone else on the telephone or here present who would like to testify this morning? Okay, hearing nothing, the time is now 9:32 a.m. Thank you for coming. This hearing is adjourned.

Transcribed from a digital audio recording by Fred Bruyns, Feb. 23, 2016.

**BRUYNS Fred H \* DCBS**

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**From:** Pam Bush <pamb@sohc.comcastbiz.net>  
**Sent:** Tuesday, February 23, 2016 9:54 AM  
**To:** BRUYNS Fred H \* DCBS  
**Subject:** proposed fee schedule for closing exams  
**Attachments:** Proposed Fee Schedule.xlsx; TESTIMONY ON PROPOSED CHANGES TO WORKERS' COMPENSATION RULES.docx

*Dr. Howard Tsang has reviewed the attached testimony of Dr. Dipaola and supports his opinion completely. If you have any questions please feel free to contact Dr. Tsang at the number below.*

**Pam Bush**  
**Client Relations Coordinator**  
**Administrative Assist.**  
**Salem Occupational Health Clinic**  
**503-362-5242**  
**503-362-6771 Fax**

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**From:** John Di Paola [<mailto:johndipaola@mac.com>]  
**Sent:** Tuesday, February 23, 2016 7:28 AM  
**To:** PamelaBush <[pamb@sohc.comcastbiz.net](mailto:pamb@sohc.comcastbiz.net)>  
**Subject:** Please bring to Howard's immediate attention

Hi Howard-

The WCD Proposed rules this year threatens to slash reimbursement for closing exams. I think this is in response to a lot of non-committed docs charging inflated prices for their last exam of the worker and titling it a "closing exam." If we don't act this week, those of us who are committed and willing to do a legitimate closing will be penalized.

I went down to Salem to testify yesterday and submitted the enclosed written testimony. It may be easiest to follow if either you print them out or open the word and excel documents side by side.

Please review these and send an email to Fred Bruyns at the WCD to express your support for the testimony I submitted or submit a statement of your own. If the WCD hears from enough committed docs that the new fees would disincentivize you performing closings, they will not adopt the proposed changes. Also, please feel free to pass this along to your colleagues who might be willing to submit an email to Fred.

Fred's email is [fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov). We must respond before the end of this week so please take a few minutes to review this and send a comment to Fred.

Thanks for giving this your immediate attention.

Regards- John

	Wash L&I	WCD Arbiter	Current at 80%	New	N001	N002
Exam 1 Body Part	443.02	358.6	496.29	150		
Report		61.64		50	116.28	231.88
File Review		61.64				
TOTAL	443.02	481.88	496.29	200 -296.29	316.28	431.88
Exam 2-3 Body Parts	497.51	477.67	496.29	250		
Report		92.45		50	116.28	231.88
File Review		154.79				
TOTAL	497.51	724.91	496.29	300 -196.29	416.28	531.88
Exam 3+ / complex	621.87	597.44	496.29	400		
Report		123.97		150	116.28	231.88
File Review		371.21				
	621.87	1092.62	496.29	550 53.71	666.28	781.88

Proposed Revaluation

Tier 1	450
Tier 2	550
Tier 3	700

## TESTIMONY ON PROPOSED CHANGES TO WORKERS' COMPENSATION RULES

### CLAIM CLOSURE EXAMS

The proposed changes to the Medical Fee Schedule for closing examinations are inappropriate and short sighted which will lead to strongly negative impacts on all stakeholders.

The financial impact on providers (especially those who are most committed to the Workers' Compensation system and the injured workers it serves) is strongly negative and dis-incentivizes treating physicians from choosing to meet the requirements delineated by the Director (see Exhibit 1 and Bulletin 239) and the carriers (see Exhibit 2-Sample medically stationary letter-SAIF).

#### **Scope of the exam:**

First of all, the proposed fees appear to only reimburse for an impairment exam and a report, which is insufficient to meet the requirements for closure. This will lead to added administrative costs, either by narrative requests and phone conferences with providers, or by an increase in the number of requests for Arbiter Exams to meet the requirements for closure; all at an added expense to the carrier.

The notion that the treating physician can accurately answer the requirements of the closing exam without reviewing the chart is totally erroneous given the fact that physicians in full time practice typically have 200-300 active patients at any given time. The value of that service is bourn out by the reimbursement for Narrative Requests (\$116.28 for up to five responses / \$231.88 for over five responses). It can be argued that since the requirements for closure beyond the impairment exam and report necessitates that more than five other items be addressed then the reimbursement should reflect that.

#### **Value of the Information:**

When comparing to the tiered form of reimbursement used in the Washington L&I where the requirements are limited primarily to an impairment examination which does not necessitate the added time and effort of a file review, the treating physicians' fees are significantly more than that designated in the Oregon proposed rules (\$243.02, \$97.51, \$61.87 for Tiers 1-3 respectively).

It is also notable that each tier of arbiter examinations, which have comparatively fewer issues requiring a response, are reimbursed significantly higher than the proposed fees (\$281.80, \$424.91, \$542.62 for Tiers 1-3 respectively

Currently, my practice "backs in" to the appropriate reimbursement by charging \$630.36 for the closing exam and \$124.07 for the report and after adjusting to 80% nets payment of \$496.29 which we feel reflects the value of exactly the same

information presented in exactly the same format using the methods required by law, based upon payments traditionally made in our region. We do not change the charge based on number of body parts. The reductions imposed by the proposed fees would impose significant losses to our practice income for the most frequently performed closing exams (\$296.29 loss, \$196.29 loss, \$53.71 gain, for Tiers 1-3 respectively). Since most claims involve one or two body parts and the negative impact on providers would be substantial.

The occasional gain for the rarely required Tier 3 closing exam would in no way come close to offsetting the significant losses from the more commonly performed Tier 1&2 exams.

The value of the information required by the Director for claim closure and resolution should be comparable no matter what format it is presented: Oregon or Washington closing exam, Oregon Narrative Response, or Oregon Arbitrator Exam. For those providers who are willing to meet this standard, they should be reimbursed appropriately. Maintaining appropriate reimbursement levels will encourage more providers to participate in the performance of closing exams and improve access to these services.

#### **Provider Choice:**

For those providers who do not provide an exam to meet the Legal standard for closing, they should not be able to successfully charge for a closing exam. They should be reimbursed with the appropriate office visit code and be required to either perform an appropriate exam or refer the patient for a closing examination.

For those providers who produce a valid closing exam that meets the standards set by the Director, they should be reimbursed under a Tiered Fee Schedule that accurately reflects the value of their work.

The Department should detail the requirements for a valid closing examination in the rules so that it is clear to providers what specific criteria must be met. Perhaps a sample template should be provided that would satisfy the criteria.

#### **Negative Impact of Current Proposed Rules:**

The proposed rule has an immediate direct and devastating financial impact on those providers who are most involved in the delivery of medical care to injured workers in Oregon. It would disincentivize the very providers that the system relies upon the most to “make the system work.”

Without an appropriate incentive to provide the mandated information, the payers would see a significant increase in the need to obtain Narrative Responses, to close active claims. It would delay the time to closure in many cases with potentially negative impact on the workers and potentially negatively impact the indemnity costs incurred by the payers.

It will result in an increase in claims that are closed without meeting the letter of the law making them susceptible to disputes that would drive up indemnity costs when a higher volume of Arbiter exams and other activities are needed to resolve the claim. ).

It is noteworthy that the Department has seen fit to increase the reimbursement for this information for arbiter exams but inexplicably slashes it's value in reference to closing exams.

If the problem is that many providers are calling their final examination of a patient a "closing exam" without providing the needed information, they should not be reimbursed for an official closing exam. For those providers who are willing to comply with the rules, they should be reimbursed at an appropriate level consistent with the value reflected in other sections of the rules. I have offered a potential solution by adding in the current value of N0002 to the current proposed fees and rounding out. Something close to this would produce no negative impact on any patients or stakeholders.

This strategy shifts reimbursement away from those who are not providing a real closing exam to those that are. By not having to reimburse inadequate exams as closings, the overall financial impact on stakeholders would be neutral.

Thank you for your attention to these issues.

Sincerely,

John Di Paola, M.D.  
Occupational Orthopedics

**From:** John Di Paola <jdd@occortho.com>  
**Sent:** Tuesday, February 23, 2016 1:23 PM  
**To:** Bruyns Fred H  
**Subject:** Fwd: forgot to remove name off top  
**Attachments:** CN for Dr D.pdf

Hi Fred-

Here is an example of a note from a provider that is not sufficient for a closing and does not sufficiently document to meet Directors requirements. Please include it in the exhibits.

Thanks-

John DiPaola

Sent from [Outlook Mobile](#)

----- Forwarded message -----

**From:** "Lesli Webb" <[Lesli@occortho.com](mailto:Lesli@occortho.com)>  
**Date:** Tue, Feb 23, 2016 at 1:05 PM -0800  
**Subject:** forgot to remove name off top  
**To:** "John Di Paola" <[jdd@occortho.com](mailto:jdd@occortho.com)>

**Lesli Webb**

6464 SW Borland Rd, Suite C4  
Tualatin, OR 97062  
PHN: 503-885-7770  
FAX: 503-885-7771  
Email: [lesli@occortho.com](mailto:lesli@occortho.com)



This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. Please note that any views or opinions presented in this email are solely those of the author and do not necessarily represent those of the company. Emails sent to or from our systems are not confidential to any named individual and we reserve the right to read them without prior notice. Finally, the recipient should check this email and any attachments for the presence of viruses. The company accepts no liability for any damage caused by any virus transmitted by this email.

Invoice # 83885

Date of Invoice: 11/17/2015

Page 1

[REDACTED]  
DOB: [REDACTED]  
DOS: 11/5/2015

**CHIEF COMPLAINT:** Followup of foot injury.

**SUBJECTIVE:** This gentleman continues to complain of some mild discomfort in the mid foot with stairs or climbing. Otherwise, he has returned to all of his regular work activities.

**OBJECTIVE:**

**LEFT FOOT:** There is still some mild tenderness to palpation over the mid third and fourth metatarsals. There is full range of motion of the ankle and foot without pain. He has 5/5 strength and normal sensation.

**ASSESSMENT:** Left foot 3rd, 4th and 5th metatarsal fractures.

**PLAN:** [REDACTED] is medically stationary. There is no permanent impairment. He is returned to work without restrictions. His examination is valid. I have recommended that he return for further evaluation if he develops any new, worsening or persistent complaints.

[REDACTED]  
D: 11/5/2015  
T: 11/9/2015

**Joan Takacs, DO, John Takacs, DO and Susan Schmitt, MD**

5909 SE Division Street, Portland, OR 97206

503-234-1531

February 23, 2016

Dear Mr. F. Bruyns:

The proposed changes to the Medical Fee Schedule for closing examinations are inappropriate and short sighted which will lead to strongly negative impacts on all providers.

The impact on providers who are most committed to the Workers' Compensation system and the injured workers it serves is strongly negative and dis-incentivizes treating physicians from choosing to meet the requirements delineated by the Director and the carriers .

The closing exam requires the treating physician review the chart notes so they can accurately address the requirements of the closing exam, without reviewing the chart the physician may not be able to address accurately all the information needed for the closing exam.

Without the appropriate information in the closing exam we feel there will be added administrative costs, either by narrative requests and phone conferences with providers, or by an increase in the number of requests for Arbiter Exams to meet the requirements for closure; all at an added expense to the carrier.

Currently, our practice charges \$300.00 for the closing exam and \$150.00 for the report and after adjusting to 80% nets payment of \$360.00 which we feel reflects the value of exactly the same information presented in exactly the same format using the methods required by law, based upon payments traditionally made in our region (\$150.00 loss with the new proposal). We do not change the charge based on number of body parts. The reductions imposed by the proposed fees would impose significant losses to our practice income for the most frequently performed closing exams. Since most claims involve one or two body parts and the negative impact on providers would be substantial.

The occasional gain for the rarely required Tier 3 closing exam would in no way come close to offsetting the significant losses from the more commonly performed Tier 1&2 exams.

The value of the information required by the Director for claim closure and resolution should be comparable no matter what format it is presented: Oregon or Washington closing exam, Oregon Narrative Response, or Oregon Arbiter Exam. For those providers who are willing to meet this standard, they should be reimbursed appropriately. Maintaining appropriate reimbursement levels will encourage more providers to participate in the performance of closing exams and improve access to these services.

For those providers who do not provide an exam to meet the Legal standard for closing, they should not be able to successfully charge for a closing exam. They should be reimbursed with the appropriate office visit code and be required to either perform an appropriate exam or refer the patient for a closing examination.

Providers producing a valid closing exam that meets the standards set by the Director should be reimbursed under a Tiered Fee Schedule that accurately reflects the value of their work.

The Department should detail the requirements for a valid closing examination in the rules so that it is clear to providers what specific criteria must be met. Perhaps a sample template should be provided that would satisfy the criteria.

The proposed rule has an immediate direct and devastating financial impact on those providers who are most involved in the delivery of medical care to injured workers in Oregon. It would dis-incentivize the very providers that the system relies upon the most to "make the system work."

Without an appropriate incentive to provide the mandated information, the payers would see a significant increase in the need to obtain Narrative Responses, to close active claims. It would delay the time to closure in many cases with potentially negative impact on the workers and potentially negatively impact the indemnity costs incurred by the payers.

It will result in an increase in claims that are closed without meeting the letter of the law making them susceptible to disputes that would drive up indemnity costs when a higher volume of Arbiter exams and other activities are needed to resolve the claim.

It is noteworthy that the Department has seen fit to increase the reimbursement for this information for arbiter exams but inexplicably slashes its value in reference to closing exams.

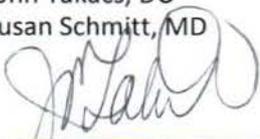
If the problem is that many providers are calling their final examination of a patient a "closing exam" without providing the needed information, they should not be reimbursed for an official closing exam. For those providers who are willing to comply with the rules, they should be reimbursed at an appropriate level consistent with the value reflected in other sections of the rules.

By not having to reimburse inadequate exams as closings, the overall financial impact on stakeholders would be neutral.

Thank you for your attention to these issues.

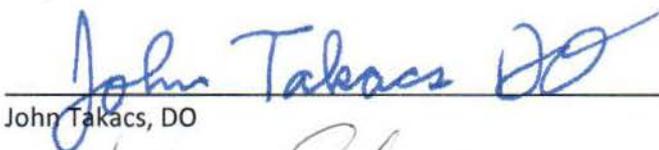
Sincerely,

Joan Takacs, DO  
John Takacs, DO  
Susan Schmitt, MD



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Joan Takacs, DO



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John Takacs, DO



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Susan Schmitt, MD



February 24, 2016

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. As always, we appreciate the opportunity to provide input on the proposed rule changes. SAIF provides the following comments for WCD's consideration:

**OAR 436-009-0010(3)(e) Instructions for Completing the CMS-1500 Form**

Rather than clarifying the instructions, it appears that the proposed Oregon specific instructions for boxes 32, 32A are inconsistent with the national standards created by the NUCC. The national standard requires payers to complete these fields if the facility is not a component or subpart of the billing provider.

**OAR 436-009-0020(1) Exclude Critical Access Hospitals from Billing DRGs,**

The proposed rule does not define "critical access hospital" (CAH). SAIF suggests WCD's rules define CAH so that the payer may properly exclude CAHs from the DRGs.

**OAR 436-009-0060(2) Oregon Specific Codes for Closing Exams**

The proposed rule creates six new codes for closing exams and 3 new codes for closing reports. We believe this creates unnecessary administrative complexity in the workers' compensation system. Closing exams are evaluation and management services for which there are appropriate national codes and a fee schedule already established. In SAIF's experience, most providers bill evaluation and management codes for these services. For administrative simplification we recommend that Oregon Specific Codes for closing exams and reports be eliminated. If WCD adopts a rule to include separate closing exam code(s), then SAIF recommends that the rule also include the requirements described in the Bulletin.

**OAR 436-009-0080(10) Increase Hearing Aid Payment from \$5,000 to \$7,000**

The proposed rules increase reimbursement for hearing aids by 40%; SAIF estimates this would increase SAIF's costs by more than \$300,000 per year. Between 7/1/14-6/30/15 SAIF paid for 157 hearing aids using the current fee schedule. We have received very few complaints about access issues, nor have providers disputed the reimbursement amount. In most instances the \$5,000 includes all related items such as fittings, batteries, supplies, accessories, examinations, molds and other related services. If a worker has a medical need for a pair of hearing aids over \$5000, then SAIF reimburses the additional amount as an exception. SAIF recommends that rather

than adopting an across the board 40% increase, WCD adopt language that allows for exceptions above the \$5000 limit per pair if medically necessary. We also recommend the rules specify that the hearing aid include all related supplies and services.

**OAR 436-009-0090(2) Reimbursement for Compound Drugs**

The proposed rules create two dispensing fees for sterile versus non-sterile ingredients. There is no guidance on how to determine whether an ingredient is sterile. This adds unnecessary administrative complexity. The dispensing fee should remain \$2.00, consistent with the fee for all other medications. Any rules adopted should be consistent with NCPDP billing requirements.

**Fee Schedule Increase for Physician Services**

The proposed fee schedule increases costs by approximately \$1.7 million. We assume WCD has thoroughly analyzed the physician reimbursement data that supports the fee schedule increase for these services.

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

**BRUYNS Fred H \* DCBS**

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**From:** KUNZ Juerg \* DCBS  
**Sent:** Wednesday, February 24, 2016 8:59 AM  
**To:** 'Mercedes Hudgins'; BRUYNS Fred H \* DCBS  
**Subject:** RE: 2016 Proposed Changes to OAR 436-009, Oregon Medical Fee & Payment Rules

Hi Mercedes,

For the fee schedule amounts of the new codes, we used WCD's fee schedule amount of G0434 and applied the multipliers suggested by CMS for the codes G0477, G0478 and G0479 as you describe. For codes G0480, G0481, G0482 and G0483, we used CMS' lab fee schedule amount for code 82542 as the basis only and then used multipliers for WCD's fee schedule amounts. Keep in mind that we have not adopted CMS' lab fee schedule per se.

We are not proposing the crosswalk of 82542 to G0431 because we generally don't tell providers what specific code they have to use. Instead, we refer them to CPT guidelines for the use of CPT codes. That means, providers may use code 82542 as a crosswalk to G0431, if code 82542 correctly describes the service provided. Our fee schedule for CPT code 82542 is 80% of billed.

Sincerely,

Juerg Kunz  
Medical Policy Analyst  
Oregon Workers' Compensation Division  
503-947-7741 / FAX 503-947-7629  
[juerg.kunz@oregon.gov](mailto:juerg.kunz@oregon.gov)



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**From:** Mercedes Hudgins [<mailto:Mercedes.Hudgins@mitchell.com>]  
**Sent:** Wednesday, February 24, 2016 7:49 AM  
**To:** BRUYNS Fred H \* DCBS  
**Cc:** KUNZ Juerg \* DCBS  
**Subject:** 2016 Proposed Changes to OAR 436-009, Oregon Medical Fee & Payment Rules

Hello Mr. Bruyns,

Regarding the proposed rule listed under the 436-009 Rule Summary:

**To Replace two laboratory HCPCS codes with seven new codes assigned by the Centers for Medicare and Medicaid Services (CMS): replace G0431 with G0480, G0481, G0482, and G0483; replace G0434 with G0477, G0478, and G0479.**

Reviewing CMS Clinical Lab Fee Schedule 2016 final determination document: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2016-CLFS-Codes-Final-Determinations.pdf>

G0434 → CMS supports New Code G0478 as a one to one crosswalk. Fees for the new codes replacing G0434 (G0477, G0478 and G0479) are derived by using multipliers of the fee for G0478.

G0431 → Does not appear to have a one to one crosswalk. Fees for the new codes replacing G0431 (G0480, G0481, G0482 and G0483) are derived by using multipliers of the fee for CPT code 82542 (Which is still valid and has its own CMS fee).

Please confirm if Oregon is proposing to accept 82542 as a crosswalk to G0431?

Respectfully,

**MERCEDES HUDGINS** | Data Analyst, Auto Casualty Solutions

**Mitchell** | (o) 858.368.7042 | (e-fax) 858.408-7290 | [mercedes.hudgins@mitchell.com](mailto:mercedes.hudgins@mitchell.com) | [www.mitchell.com](http://www.mitchell.com)



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**From:** Jaye Fraser <JAYFRA@saif.com>  
**Sent:** Thursday, February 25, 2016 10:58 AM  
**To:** BRUYNS Fred H \* DCBS  
**Cc:** Allison Morfitt; Christina Murrell; WINTERROWD Charla  
**Subject:** FW: proposed division 9 OARs

Fred – Since the rules may not be published until the third week in March, will WCD push the effective date? SAIF appreciates that WCD must consider the all the testimony it received, and may wish to amend the proposed rules. That said, SAIF is a bit concerned that there is quite a bit of programming that needs to be accomplished before the effective date for these rules. It will be tough with a mid-March publication date.

Thanks for your consideration.

---

**Jaye Caroline Fraser, J.D.** Assistant Counsel for Legal Services  
SAIF Corporation | Legal Services  
400 High St SE | Salem, Oregon 97312 | P: 503.373.8026  
P: 800.285.8525 | F: 503.584.8026 | [jayfra@saif.com](mailto:jayfra@saif.com)

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**From:** Allison Morfitt  
**Sent:** Thursday, February 25, 2016 10:51 AM  
**To:** Jaye Fraser <JAYFRA@saif.com>  
**Subject:** FW: proposed division 9 OARs

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**Allison Morfitt, CPHQ, CPMA, Medical Audit Supervisor**  
SAIF Corporation | Claims Division  
440 Church St SE | Salem, Oregon 97312 | P: 503.315.3232  
P: 800.285.8525 | F: 503.945.3232 | [allmor@saif.com](mailto:allmor@saif.com)

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**From:** BRUYNS Fred H \* DCBS [<mailto:Fred.H.Bruyns@oregon.gov>]  
**Sent:** Wednesday, February 24, 2016 4:39 PM  
**To:** Allison Morfitt <[allmor@saif.com](mailto:allmor@saif.com)>  
**Cc:** BRUYNS Fred H \* DCBS <[Fred.H.Bruyns@oregon.gov](mailto:Fred.H.Bruyns@oregon.gov)>  
**Subject:** RE: proposed division 9 OARs

Hi Allison,

We have received quite a lot of testimony, especially regarding the proposed closing exam/report fees, as well as payment criteria for compounded drugs. We will need a little time to consider what to do. However, we will likely publish during the third week in March.

Thanks you!

Fred Bruyns, policy analyst/rules coordinator  
Department of Consumer and Business Services  
Workers' Compensation Division  
503-947-7717; fax 503-947-7514  
Email: [fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov)

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**From:** Allison Morfitt [<mailto:allmor@saif.com>]  
**Sent:** Wednesday, February 24, 2016 2:37 PM  
**To:** BRUYNS Fred H \* DCBS  
**Subject:** RE: proposed division 9 OARs

I just wanted to see if there was a target date for publishing the proposed rules. thanks!

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**Allison Morfitt, CPHQ, CPMA, Medical Audit Supervisor**

SAIF Corporation | Claims Division

440 Church St SE | Salem, Oregon 97312 | P: 503.315.3232

P: 800.285.8525 | F: 503.945.3232 | [allmor@saif.com](mailto:allmor@saif.com)

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**From:** BRUYNS Fred H \* DCBS [<mailto:Fred.H.Bruyns@oregon.gov>]

**Sent:** Wednesday, February 24, 2016 1:41 PM

**To:** Allison Morfitt <[allmor@saif.com](mailto:allmor@saif.com)>

**Cc:** Jaye Fraser <[JAYFRA@saif.com](mailto:JAYFRA@saif.com)>; Krystal Smith <[KRYSMI@saif.com](mailto:KRYSMI@saif.com)>; Dan Schmelling <[dansch@saif.com](mailto:dansch@saif.com)>; Ryan McClelland <[ryamcc@saif.com](mailto:ryamcc@saif.com)>; VANNESS Jim \* DCBS <[Jim.VanNess@oregon.gov](mailto:Jim.VanNess@oregon.gov)>; PASSANTINO Steve S \* DCBS <[Steve.S.Passantino@oregon.gov](mailto:Steve.S.Passantino@oregon.gov)>; ANDERSEN Robert C \* DCBS <[Robert.C.Andersen@oregon.gov](mailto:Robert.C.Andersen@oregon.gov)>; AICHLMAYR Myra K \* DCBS <[Myra.K.Aichlmayr@oregon.gov](mailto:Myra.K.Aichlmayr@oregon.gov)>; WADSWORTH Amy D \* DCBS <[Amy.D.Wadsworth@oregon.gov](mailto:Amy.D.Wadsworth@oregon.gov)>; JOHNSTON Nanci J \* DCBS <[Nanci.J.Johnston@oregon.gov](mailto:Nanci.J.Johnston@oregon.gov)>; KUNZ Juerg \* DCBS <[Juerg.Kunz@oregon.gov](mailto:Juerg.Kunz@oregon.gov)>; KARMA Daneka A \* DCBS <[Daneka.A.Karma@oregon.gov](mailto:Daneka.A.Karma@oregon.gov)>; BRUYNS Fred H \* DCBS <[Fred.H.Bruyns@oregon.gov](mailto:Fred.H.Bruyns@oregon.gov)>

**Subject:** RE: proposed division 9 OARs

Hello Allison,

Thank you for submitting testimony. I have posted it to our website:

[http://www.cbs.state.or.us/wcd/policy/rules/Testimony\\_20160222/Exhibit\\_14\\_AMorfitt.pdf](http://www.cbs.state.or.us/wcd/policy/rules/Testimony_20160222/Exhibit_14_AMorfitt.pdf) (direct link to testimony)

[http://www.cbs.state.or.us/wcd/policy/rules/testimony\\_on\\_proposed\\_oars.html](http://www.cbs.state.or.us/wcd/policy/rules/testimony_on_proposed_oars.html) (link to testimony page)

We appreciate having your input and will give it careful consideration.

Sincerely,

Fred BruyNS, policy analyst/rules coordinator  
Department of Consumer and Business Services  
Workers' Compensation Division  
503-947-7717; fax 503-947-7514  
Email: [fred.h.bruyNS@oregon.gov](mailto:fred.h.bruyNS@oregon.gov)

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**From:** Allison Morfitt [<mailto:allmor@saif.com>]

**Sent:** Wednesday, February 24, 2016 12:36 PM

**To:** BRUYNS Fred H \* DCBS

**Cc:** Jaye Fraser; Krystal Smith; Dan Schmelling; Ryan McClelland

**Subject:** proposed division 9 OARs

Hi Fred –attached is SAIF’s written testimony on the proposed division 9 changes. Let me know if you have any questions. thanks!

Confidentiality Notice: This email may contain information that is privileged, confidential, or otherwise exempt from disclosure under applicable law. If you are not the addressee or it appears from the context or otherwise that you have received this email in error, please advise us immediately at [helpdesk@saif.com](mailto:helpdesk@saif.com), keep the contents confidential, and immediately delete the message and any attachments from your system.

**From:** Ehrlich, Kim A. (EHQ) <KAhrlich@express-scripts.com>  
**Sent:** Thursday, February 25, 2016 11:22 AM  
**To:** BRUYNS Fred H \* DCBS  
**Cc:** Ehrlich, Kim A. (EHQ)  
**Subject:** Comments: Proposed Changes to OAR 436-009, Oregon Medical Fee and Payment Rules



February 25, 2016

Express Scripts  
One Express Way  
St Louis, MO 63121

Fred Bruyns, Policy Analyst/Rules Coordinator  
Department of Consumer and Business Services  
Workers' Compensation Division  
PO Box 14480  
Salem, OR 97309-0405  
[fred.h.bruyns@oregon.gov](mailto:fred.h.bruyns@oregon.gov)

**Re: Proposed Changes to OAR 436-009, Oregon Medical Fee and Payment Rules**

Dear Fred Bruyns:

Express Scripts, Inc. would like to take the opportunity to contact you in regards to the proposed changes 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.

We appreciate the opportunity to provide input to the Division on the proposed rules. Express Scripts supports the billing efforts already made by the Division and the proposal for compound drugs to be billed at the ingredient level. With the proposed language we have noted a few suggestions and comments below:

Express Scripts suggested revisions to proposed language:

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

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide

Version 1.4 ~~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.ncdp.org](http://www.ncdp.org).

Express Scripts supports the Divisions proposal to bill compound drugs at the ingredient level; however, the NCPDP standards adopted by the Division for paper and electronic billing do not allow for the submission of a separate compounding fee for each ingredient within a compound. We recommended that the Division adopt one compounding fee for each scenario as outlined below. See the recommended changes below:

**436-009-0090 Pharmaceutical**

**(2) Pharmaceutical Billing and Payment**

A non-sterile compound drug 83.5 % of the AWP for each individual component ingredient plus a compounding fee of (\$X.XX). ~~\$2.00 for each ingredient~~

A sterile compound drug 83.5 % of the AWP for each individual component ingredient plus a compounding fee of (\$X.XX). ~~\$4.00 for each ingredient~~

Thank you for your consideration of our suggested revisions to the proposed changed to OAR 436-009, Oregon Medical Fee and Payment Rules. We look forward to working with you on this matter. Feel free to contact us with any comments, questions, or concerns.

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**Kim Ehrlich**

Director, Workers' Compensation Compliance

Office: 314.684.5063 | Cell: 314.221.5260 |

[kaehrlich@express-scripts.com](mailto:kaehrlich@express-scripts.com)

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