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

Effective Sept. 21, 2020

Table of Contents

S*ummary of rule changes effective Sept. 21, 2020:* ..... **iv**

436-009-0001 Administration of These Rules **1**
(2) Authority for Rules 1
(3) Purpose. 1
(4) Applicability of Rules. 1

436-009-0004 Adoption of Standards **2**

436-009-0005 Definitions **4**

436-009-0008 Request for Review before the Director **9**
(1) General. 9
(2) Time Frames and Conditions. 9
(3) Form and Required Information. 11
(4) Dispute Resolution by Agreement (Alternative Dispute Resolution). 12
(5) Director Order and Reconsideration 12
(6) Hearings. 13
(7) Other Proceedings. 13

436-009-0010 Medical Billing and Payment **14**
(1) General. 14
(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.) 15
(3) Billing Forms. 15
(4) Billing Codes. 17
(5) Modifiers. 17
(6) Physician Assistants and Nurse Practitioners. 18
(7) Chart Notes. 18
(8) Challenging the Provider's Bill. 18
(9) Billing the Patient and Patient Liability. 18
(10) Disputed Claim Settlement (DCS). 19
(11) Payment Limitations. 19
(12) Excluded Treatment. 20
(13) Missed Appointment (No Show). 21

436-009-0012 Telehealth **22**
(1) Definitions. 22

(2) Scope of services. 22
(3) Distant site provider billing. 22
(4) Originating site billing. 22
(5) Payment. 23

436-009-0018 Discounts and Contracts 24
(1) Discounts. 24
(2) Fee Discount Agreements. 24
(3) Fee Discount Agreement Modifications and Terminations. 25
(4) Other Medical Providers. 25

436-009-0020 Hospitals 26
(1) Inpatient. 26
(2) Outpatient. 26
(3) Specific Circumstances. 27
(4) Out-of-State Hospitals. 27
(5) Calculation of Cost-to-Charge Ratio Published in Bulletin 290. 28

436-009-0023 Ambulatory Surgery Center (ASC) 30
(1) Billing Form. 30
(2) ASC Facility Fee. 30
(3) ASC Billing. 30
(4) ASC Payment. 31

436-009-0025 Worker Reimbursement 33
(1) General. 33
(2) Timeframes. 34
(3) Meal and Lodging Reimbursement. 35
(4) Travel Reimbursement. 35
(5) Other Reimbursements. 36
(6) Advancement Request. 36

436-009-0030 Insurer's Duties and Responsibilities 37
(1) General. 37
(2) Bill Processing. 37
(3) Payment Requirements. 38
(4) Electronic Payment. 39
(5) Communication with Providers. 40
(6) EDI Reporting. 40

436-009-0035 Interim Medical Benefits 40
(1) General. 40
(2) Claim Acceptance. 41
(3) Claim Denial. 41

436-009-0040 Fee Schedule 42
(1) Fee Schedule Table. 42
(2) Anesthesia. 42
(3) Surgery. 43

(4) Radiology Services. 46
(5) Pathology and Laboratory Services. 46
(6) Physical Medicine and Rehabilitation Services. 47
(7) Reports. 47
(8) Nurse Practitioners and Physician Assistants. 48

436-009-0060 Oregon Specific Codes 48
(1) Multidisciplinary Services. 48
(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.) 48
(3) CARF / JCAHO Accredited Programs. 53

436-009-0080 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) 54

436-009-0090 Pharmaceutical 58
(1) General. 58
(2) Pharmaceutical Billing and Payment. 58
(3) Clinical Justification Form 4909. 59
(4) Dispensing by Medical Service Providers. 60

436-009-0110 Interpreters 60
(1) Choosing an Interpreter. 60
(2) Billing. 61
(3) Billing and Payment Limitations. 61
(4) Billing Timelines. 62
(5) Billing Form. 62
(6) Payment Calculations. 64
(7) Payment Requirements. 65

436-009-0998 Sanctions and Civil Penalties 67

Appendix A Matrix for health care provider types 68

Appendices B through E 69

Historical rules: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

Summary of rule changes effective Sept. 21, 2020:

- Amended rule 0004 adopts new CPT® codes for COVID-19 testing.
- Amended rule 0010 allows providers to use the new CPT® codes to bill for COVID-19 testing.
- Amended rule 0012:
  - Defines "telehealth";
  - States that all services must be appropriate, and the form of communication must be appropriate for the service provided;
  - Clarifies that medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2020; and
  - Explains that when billing for telehealth services other than telemedicine services, a distant-site provider must use the place-of-service code "02," and may not use modifier 95.
- Amended rule 0040 and its Appendix B, the physician fee schedule:
  - Increase maximum allowable payments for certain telephone and digital evaluation and management services;
  - Add HCPCS code T1014 with a payment amount of $0.00 to Appendix B; and
  - Set payment amounts for new COVID-19 testing CPT® codes (86328, 86769, 86408, 86409, 87426, 87635, 0202U, 0223U, 0224U, 0225U, and 0226U) at 80% of billed.

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

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 standards 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 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2020 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2020, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumberg, IL 60173, 847-825-5586, or www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2020), Fourth Edition Revised, 2019, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 2020 govern 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 the following CPT® codes not listed in CPT® 2020 for billing by medical providers: 86328, 86408, 86409, 86769, 87426, 87635, 0202U, 0223U, 0224U, 0225U, and 0226U.

(4) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 29, Issue 12, 2019. If there is a conflict between CPT® 2020 and the CPT® Assistant, CPT® 2020 is the controlling resource.

(5) To get a copy of the CPT® 2020 or the CPT® Assistant, contact the American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, 800-621-8335, or www.ama-assn.org.

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

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

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

(7) The director adopts, by reference, CDT 2020: 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 www.ada.org.

(8) The director adopts, by reference, the 02/12 1500 Claim Form and Version 7.0 7/19 (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, PO Box 74008935, Chicago, IL 60674-8935, or www.nucc.org.

(9) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2020 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606, 312-422-3000, or www.nubc.org.

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

(11) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2020, CPT® 2020, CPT® Assistant, HCPCS 2020, CDT 2020, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(12) 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.

Stat Auth: ORS 656.248, 656.726(4)
Stats Implemented: ORS 656.248
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 7/10/20 as Admin. Order 20-059, eff. 7/13/20 (temp)
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/2020
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/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) CMS means Centers for Medicare & Medicaid Services.

(b) CPT® means Current Procedural Terminology published by the American Medical Association.

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

(d) EDI means electronic data interchange.

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

(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.

(g) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.

(h) MCO means managed care organization certified by the director.

(i) NPI means national provider identifier.

(j) OSC means Oregon specific code.

(k) PCE means physical capacity evaluation.

(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" or "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

(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 A, "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®" 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.

(14) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(15) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(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.

(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.

(18) "Good Cause" means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.

(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.

(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.

(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.

(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.

(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.

(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.

(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 division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

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

(27) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(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.

(29) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.

(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.

(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.

(32) "Patient" means the same as worker as defined in ORS 656.005(30).

(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.

(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.

(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.

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

(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.

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

(39) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B). See Appendix A, "Matrix for Health Care Provider Types."

(40) "Usual fee" means the medical provider's fee charged to the general public for a given service.

(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.

(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 3/7/16 as Admin. Order 16-050, eff. 4/1/16
Amended 3/13/18 as Admin. Order 18-053, eff. 4/1/18
Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0008 Request for Review before the Director

(1) General.

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, nonpayment 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) As provided in ORS 656.704(3)(b), the following disputes are in the jurisdiction of the board and will be transferred:

(A) A dispute that requires a determination of the compensability of the medical condition for which medical services are proposed; and

(B) A dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim.

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

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

(e) A request for administrative review under this rule may also be filed as prescribed in OAR 438-005.

(2) Time Frames and Conditions.

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 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 insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

When a party mistakenly sends an appeal of an MCO action or decision to the division, the division will forward the appeal to the MCO. The MCO must use the original mailing date of the appeal mistakenly sent to the division when determining timeliness of the appeal.

(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 had given written notice of representation to the insurer at the time the MCO issued its decision, the 60-day time frame begins when the MCO issues its final decision to the attorney. 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:

(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.

(d) 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.

(e) 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 under subsection (1)(b) of this rule.

(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:

(A) The packet must include a complete 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. 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 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 issued by the director under ORS 656.254 or 656.745 may request a hearing by the board as follows:

(A) A written request for a hearing must be mailed or submitted to the division. The request must specify the grounds upon which the proposed order or assessment is contested.

(B) The request must be mailed or submitted 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 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 3/11/19 as Admin. Order 19-051, eff. 4/1/19
Amended 12/17/19 as Admin. Order 19-060, eff. 1/1/20
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/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 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.

(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.

(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.

(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)(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.

(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	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2020 or in OAR 436-009-0004(3); • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2020 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the nonshaded area of box 24J, the shaded area of box 24I and 24J may be left blank. 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.
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	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.

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2020 or in OAR 436-009-0004(3), or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

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

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2020 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® 2020, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

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

(A) Unusually lengthy procedure;

(B) Excessive blood loss during the procedure;

(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);

(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or

(F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must 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 and 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, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:

(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 nonattending 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.

(c) A provider may bill a patient for a missed appointment under section (13) of this rule.

(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;

(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;

(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).

(a) 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.

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:

(A) The provider has a written missed-appointment policy that applies not only to workers' compensation patients, but to all patients;

(B) The provider routinely notifies all patients of the missed-appointment policy;

(C) The provider's written missed-appointment policy shows the cost to the patient; and

(D) The patient has signed the missed-appointment policy.

(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.

Stat. Auth.: ORS 656.726(4), 656.245, 656.248, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 7/10/20 as Admin. Order 20-059, eff. 7/13/20 (temp)
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/2020
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0012 Telehealth

(1) Definitions.

(a) For the purpose of this rule, "**telehealth**" means providing healthcare remotely by means of telecommunications technology, including but not limited to telemedicine and telephonic or online digital services.

(b) For the purpose of this rule, "**telemedicine**" means synchronous medical services provided via a real-time interactive audio and video telecommunications system between a patient at an originating site and a provider at a distant site.

(c) "**Distant site**" means the place where the provider providing medical services to a patient through telehealth is located.

(d) "**Originating site**" means the place where the patient receiving medical services through telehealth is located.

(2) Scope of services.

(a) All services must be appropriate, and the form of communication must be appropriate for the service provided.

(b) Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2020.

(3) Distant site provider billing.

(a) When billing for telemedicine services, the distant site provider must:

(A) Use the place of service (POS) code "02"; and

(B) Use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.

(b) When billing for telehealth services other than telemedicine services, the distant site provider:

(A) Must use the POS code "02"; and

(B) May not use modifier 95.

(4) Originating site billing.

When billing for telehealth services, the originating site may charge a facility fee using HCPCS code Q3014, if the site is:

(a) The office of a physician or practitioner; or

(b) A health care facility including but not limited to a hospital, rural health clinic, skilled nursing facility, or community mental health center.

(5) Payment.

(a) Insurers must pay distant site providers at the non-facility rate.

(b) Equipment or supplies at the distant site are not separately payable.

(c) The payment amount for code Q3014 is $35.00 per unit or the provider's usual fee, whichever is lower. In calculating the units of time, 15 minutes, or any portion of 15 minutes, equals one unit.

(d) Professional fees of supporting providers at the originating site are not separately payable.

(e) Insurers are not required to pay a telehealth transmission fee (HCPCS code T1014).

Stat. Auth.: ORS 726(4), 656.245, 656.248, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254
Hist: Filed 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/20

436-009-0018 Discounts and Contracts

(1) 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.

(2) 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 (2)(a) of this rule are included in the signed fee discount agreement.

(3) Fee Discount Agreement Modifications and Terminations.

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

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

(A) The insurer's name;

(B) The medical service provider's or clinic's name; and

(C) The termination date of the agreement.

(4) 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
Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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:

(i) Bills from critical access hospitals, (See Bulletin 290); 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® codes and HCPCS codes; and

(D) The hospital's NPI.

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

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

(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.

(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 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.

(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 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 yearly.

(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) and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for all Oregon critical access hospitals 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 3/7/16 as Admin. Order 16-050, eff. 4/1/16
Amended 3/6/17 as Admin. Order 17-050, eff. 4/1/17
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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.

(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.

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

(e) When the ASC's cost of an implant is $100 or more, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale 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 3/11/19 as Admin. Order 19-051, eff. 4/1/19
Amended 12/16/19 as Admin. Order 19-056, eff. 1/1/20 (temp)
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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 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 wcd.oregon.gov or call 503-947-7606.";

(E) Space for the worker's signature and date; and

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

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. 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(4), 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) The insurer may disapprove the reimbursement request if the worker requests reimbursement after two years as listed in subsection (a).

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request.

(B) 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 disapprove the request.

(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, the insurer must, within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day or 14-day time frame for the insurer to issue reimbursement or disapprove the request.

(e) When any action, other than those listed in subsections (c) and (d) of this section, causes the reimbursement request to be payable, the insurer must reimburse the worker within 14 days of the action.

(f) 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.

(g) 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 3/13/18 as Admin. Order 18-053, eff. 4/1/18
Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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), (3), and (7) 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.

(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)(b), and insurer action, for any nonpayment 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 within 45 days of receipt of the bill. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).

(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 nonpayment, 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 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 or call 503-947-7606.";

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

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

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

request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

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

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

(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment 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.

(4) Electronic Payment.

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

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

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

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

(b) Cardholder agreement for ATM or debit cards.

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

(c) Instrument of payment.

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

(5) Communication with Providers.

(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within 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.

(6) 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 3/6/17 as Admin. Order 17-050, eff. 4/1/17
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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.

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

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

(2) Anesthesia.

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

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

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

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

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

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $59.74.

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.

(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.

(3) Surgery.

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

(a) One surgeon

Procedures	**Appendix B lists:**	**The payment amount is:**	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The billed amount
	80% of billed amount	80% of billed amount	
Any additional procedures* including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The 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 ZZZ.			

(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: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	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
	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)	

(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 nonelective, 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® codes must be billed and paid per code according to this table:

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

(b) Except for CPT® codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code. When a provider bills for more than three separate CPT®-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.

(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.

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

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

(8) Nurse Practitioners and Physician Assistants.

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

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/25/20 as Admin. Order 20-055, eff. 3/25/20 (temp)
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 4/1/20 as Admin. Order 20-056, eff. 4/1/20 (temp)
Amended 7/10/20 as Admin. Order 20-059, eff. 7/13/20 (temp)
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0060 Oregon Specific Codes

(1) Multidisciplinary Services.

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

(b) 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
Addictionologist consultant services: Services requested by a managed care organization consisting of an extensive records review, a physical exam, reports, responses to letters, and urine drug screening.	D0091
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR004

Service	OSC
Arbiter file review - level 1: A file review of a limited record.	AR021
Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002

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

Service	OSC
Interpreter services - provided by a health care interpreter certified by the Oregon Health Authority, excluding American Sign Language	D0006
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE 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

Service	OSC
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE 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
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Records review: Review of medical records on an MCO-enrolled claim by a nontreating physician requested by an insurer or a managed care organization.	RECRW
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Video Review: Review of video requested by an insurer or a managed care organization.	VIDEO
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662

Service	OSC
Vocational evaluation - each additional 15 minutes	97663
WCE (work capacity evaluation): 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: •The ability to perform essential physical functions of the job based on a specific job; •Analysis as related to the accepted condition; •The ability to sustain activity over time; and •The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam and report.	W0001

(3) CARF / JCAHO Accredited Programs.

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program 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 3/13/18 as Admin. Order 18-053, eff. 4/1/18
Amended 12/17/19 as Admin. Order 19-060, eff. 1/1/20
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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.

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

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

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

(a) NU for purchased, new equipment;

(b) UE for purchased, used equipment; and

(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:

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

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

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

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

(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 $7000 for a pair of hearing aids, or $3500 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.

(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 3/11/19 as Admin. Order 19-051, eff. 4/1/19
Amended 12/16/19 as Admin. Order 19-056, eff. 1/1/20 (temp)
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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 by ingredient, listing each ingredient's 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.

(d) Unless directly purchased by the worker (see OAR 436-009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

If the drug dispensed is:	Then the maximum allowable fee is:
A generic drug	83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee
A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent	83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee
A brand name drug with a generic equivalent and the prescribing provider has not prohibited substitution	83.5 % of the average AWP for the class of generic drugs plus a $2.00 dispensing fee
A compound drug	83.5 % of the AWP for each individual ingredient plus a single compounding fee of $10.00 (The compounding fee includes the dispensing fee.)

(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., RED BOOK or Medi-Span.

(3) Clinical Justification Form 4909.

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

(A) Celebrex®,

(B) Cymbalta®,

(C) Fentora®,

(D) Kadian®,

(E) Lidoderm®,

(F) Lyrica®, or

(G) OxyContin®.

(b) Insurers may not challenge the adequacy of the clinical justification. However, they 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 3/12/15 as Admin. Order 15-058, eff. 4/1/15
Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0110 Interpreters

(1) Choosing an Interpreter.

(a) 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. However, a representative of the worker's employer may not provide interpreter services. 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.

(b) When a worker asks an insurer to arrange for interpreter services, the insurer must use a certified or qualified health care interpreter listed on the Oregon Health Care Interpreter Registry of the Oregon Health Authority available at: http://www.oregon.gov/OHA/OEI/Pages/HCI-Program.aspx. The interpreter's certification or qualification must be in effect on the date the interpreter services are provided. If no certified or qualified health care interpreter is available, the insurer may schedule an interpreter of its choice subject to the limits in subsection (a) of this section.

(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 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 the provider cancels or reschedules the appointment.

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, an interpreter may bill a workers' compensation client if the client fails to attend the appointment and if:

(A) The interpreter has a written missed-appointment policy that applies not only to workers' compensation clients, but to all clients;

(B) The interpreter routinely notifies all clients of the missed-appointment policy;

(C) The interpreter's written missed-appointment policy shows the cost to the client; and

(D) The client has signed the missed-appointment policy.

(c) The implementation and enforcement of subsection (b) of this section is a matter between the interpreter and the client. The division is not responsible for the implementation or enforcement of the interpreter's policy.

(d) 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.

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

(5) Billing Form.

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

(A) D0004 for interpreter services, excluding American Sign Language interpreter services, provided by noncertified interpreters;

(B) D0005 for American Sign Language interpreter services;

(C) D0006 for interpreter services, excluding American Sign Language interpreter services, provided by a health care interpreter certified by the Oregon Health Authority; and

(D) 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, D0006, 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.

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

For:	The maximum payment is:
Interpreter services provided by a noncertified interpreter of an hour or less	$60.00
Interpreter service of an hour or less provided by health care interpreters certified by the Oregon Health Authority[1]	$70.00
American sign language interpreter services of an hour or less	$70.00
Interpreter services provided by a noncertified interpreter 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.
Interpreter service of more than one hour provided by health care interpreters certified by the Oregon Health Authority[1]	$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.
American sign language 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	The private vehicle mileage rate published in Bulletin 112
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

[1] A list of certified health care interpreters can be found online under the Health Care Interpreter Registry at http://www.oregon.gov/oha/oei/Pages/HCI-Program.aspx .

(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.

(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 nonpayment 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 nonpayment, 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 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 or call 503-947-7606";

(E) Space for a signature and date; and

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

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

(j) The insurer or its representative must respond to an interpreter's inquiry about payment within 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 3/13/18 as Admin. Order 18-053, eff. 4/1/18
Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/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://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Appendix A - Matrix for health care provider types* See OAR 436-009-0005 and 436-010-0210

	Attending physician status (primarily responsible for treatment of a patient)	Provide compensable medical services for initial injury or illness	Authorize payment of 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 osteopathic medicine 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. (Note: physician assistants are not required to have a written treatment plan)	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by attending physician and under a written treatment plan (Note: physician assistants are not required to have a written treatment plan)
Emergency room physicians	No, if the physician refers the patient to a primary care physician	Yes	An ER physician who is not authorized to serve as attending physician under ORS 656.005(12)(c) may authorize temporary disability for up to 14 days, 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 with any authorized nurse practitioner 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 September 21, 2020]

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, 2020]

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, 2020]

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, 2020]

Note: If the above links do not connect you to the division's website, click:
http://wcd.oregon.gov/medical/Pages/disclaimer.aspx
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 2019/2020 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.

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Link to the Maximum Allowable Payment Tables: http://wcd.oregon.gov/medical/Pages/disclaimer.aspx

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