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

## Effective July 7, 2008

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**Amendments are marked as follows:**

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| Deleted text has a "strike-through" style, as in | ~~Deleted~~ |
| Added text is bold and underlined, as in | **Added** |

**HISTORY LINES:** These rules include only the most recent "History" lines. The history line shows when the rule was last revised (or "filed" if the rule has never been revised) and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, (503) 947-7627, or visit the division's Web site: http://www.wcd.oregon.gov/policy/rules/full_set.html

**The Workers' Compensation Division (WCD) adopts, by reference, parts of the *Centers for Medicare & Medicaid Services Medicare Resource-Based Relative Value Scale (RBRVS),* the American *Society of Anesthesiologists (ASA) Relative Value Guide,* and *Current Procedural Terminology* (CPT®). *See OAR 436-009-0004 for details and updated citations.***

- To order the **RBRVS**, contact:
  United States Government Bookstore
  www.nara.gov
  **Ask for: 72 Federal Register No. 227, November 27, 2007**

  This copy of the Federal Register is located at:

  http://www.access.gpo.gov/su_docs/fedreg/a071127c.html

- To order the ***ASA Relative Value Guide***, contact:
  American Society of Anesthesiologists
  520 N. Northwest Highway
  Park Ridge, IL 60068-2573
  Phone (847) 825-5586
  **Ask for: 2008 Relative Value Guide**

- To order the ***CPT® 2008*** *or the CPT Assistant*, contact:
  American Medical Association
  515 North State Street
  Chicago, IL 60610
  Phone (800) 621-8335

- To order the **NUBC *UB-04 Data Specifications Manual***, contact:
  National Uniform Billing Committee
  American Hospital Association
  29th Floor
  One North Franklin
  Chicago, IL 60606
  Phone (312) 422-3390
  **Ask to: Become a subscriber of the NUBC UB-04 Specifications Manual**

- To order the Healthcare Common Procedure Coding System, contact:
  National Technical Information Service
  Springfield, VA 22161
  Phone (800) 621- 8335
  www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp

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

| | | |
|---|---|---|
| In the Matter of the Amendment of OAR chapter 436, division 009: | ) | ORDER OF ADOPTION |
| | ) | OF TEMPORARY RULES |
| Oregon Medical Fee and Payment Rules | ) | No. 08-060 |

The Director of the Department of Consumer and Business Services, under rulemaking authority in ORS 656.726(4), and in accordance with the procedure in ORS 183.335(5), temporarily amends OAR chapter 436, division 009.

**EXPLANATION**

Permanent OAR 436-009, "Oregon Medical Fee and Payment Rules," requires payment at the maximum allowed under the fee schedule or the health care provider's usual fee, whichever is less.

These temporary rules provide for payment under the terms of a contact to which a health care provider is a party: Unless otherwise provided by contract, insurers must pay providers at the providers' usual fee, or the amount set by the fee schedule, whichever is less. If a provider's fee is covered by multiple contracts, the insurer may apply only one contract to discount the provider's fee. If a provider's fee is controlled by multiple contracts, and one contract is with a certified managed care organization, the fee under the managed care organization's contract must be applied when the services were provided to an enrolled worker. The insurer must provide a copy of any contract that is the basis for a fee reduction to the director or the provider upon request. The insurer must notify the provider that they may request administrative review of the insurer's action in response to a medical bill within 90 days of the insurer's decision.

**FINDINGS**

Failure to act promptly will result in serious prejudice to the public interest.

**IT IS THEREFORE ORDERED:**

(1) Temporary amendments to OAR Chapter 436, Division 009, Oregon Medical Fee and Payment Rules, are **adopted on this 7th day of July 2008, to be effective July 7, 2008**.

(2) The attached Statement of Need and Justification is incorporated by reference.

(3) The amended rules, the Certificate and Order for Filing, and the Statement of Need and Justification will be filed with the Secretary of State.

(4) The amended rules, with marked revisions, will be filed with Legislative Counsel in accordance with ORS 183.715 within ten days after filing with the Secretary of State.

**Dated this 7th day of July 2008**.

DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES

*/s/ John L. Shilts*
John L. Shilts, Administrator
Workers' Compensation Division

## Under ADA Guidelines, alternate format copies of the rules will be made available to qualified individuals upon request.

## If you have questions about these rules or need them in a different format, contact the Workers' Compensation Division at 503-947-7810.

Distribution: ID, S0, S1, S4, S7, S, U, AT, CE, EG, IA, LU, NM, CI, MR, TT, OH, DC, DO, GR, MD, ND, OT, PY

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# EXHIBIT "A"
# OREGON ADMINISTRATIVE RULES
# CHAPTER 436, DIVISION 009

## 436-009-0001 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.

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

## 436-009-0002 Purpose

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

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96

## 436-009-0003 Applicability of Rules *(Temporary Rule)*

(1) These rules apply to**:**

**(a) A**~~a~~ll **medical** services rendered on or after the effective date of these rules**; and**

**(b) All payments made under a contract with a medical provider, regardless of the date of service**.

**(2) These rules do not apply to any medical fee dispute that has been resolved by agreement or an administrative order that has become final by operation of law.**

~~(2)~~**(3)** Applicable to these rules, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 3/4/04 as Admin. Order 04-054, eff. 4/1/04
**Amended 7/7/08 as Admin. Order 08-060, eff. 7/7/08 (temporary)**

## 436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the columns titled "CPT/HCPCS," "Mod," "Physician Work RVUs," "Year 2008 Transitional Non-Facility PE RVUs," "Year 2008 Transitional Facility PE RVUs," "Malpractice RVUs," and "Global" in the Centers for Medicare & Medicaid Services (CMS) 2008 Medicare Resource-Based Relative Value Scale (RBRVS) Addendum B and Addendum C, 72 Federal Register No. 227, November 27, 2007, as the basis for the fee schedule for payment of medical service providers except as otherwise provided in these rules. The director does not adopt the definitions, status indicators, alpha codes, edits, processes, policies or philosophies of CMS, such as the National Correct Coding Initiative.

(2) The director adopts, by reference, the *American Society of Anesthesiologists ASA, Relative Value Guide* 2008 as a supplementary fee schedule for payment of anesthesia service providers except as otherwise provided in these rules for those anesthesia codes not found in the Federal Register.

(3) The director adopts, by reference, the American Medical Association's (AMA) *The Physicians' Current Procedural Terminology (CPT® 2008*), Fourth Edition Revised, 2007, for billing by medical providers except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(4) The director adopts, by reference, the AMA's *CPT® Assistant*, Volume 0, Issue 04 1990 through Volume 17, Issue 12 2007, as a supplement for determining the level of service described by the CPT® manual guidelines. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual shall be the controlling resource to determine the level of service.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS *Healthcare Common Procedure Coding System* (HCPCS)to be used when billing for services only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code. The director does not adopt the edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(6) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in Addenda B and C, 72 Federal Register, No. 227, November 27, 2007, ASA Relative Value Guide 2008, CPT® 2008, CPT® Assistant, or HCPCS 2008.

Stat Auth: ORS 656.248, 656.726(4)
Stats Implemented: ORS 656.248
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08

**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 and OAR 436-010-0005 are hereby incorporated by reference and made part of these rules.

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

(a) ANSI means the American National Standards Institute.

(b) CMS means Centers for Medicare & Medicaid Services.

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

(d) DME means durable medical equipment.

(e) DRG means diagnosis related group.

(f) EDI means electronic data interchange.

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

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

(i) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(j) MCO means managed care organization.

(k) NPI means National Provider Identifier.

(l) OSC means Oregon specific code.

(m) PCE means physical capacity evaluation.

(n) RBRVS means Medicare Resource-Based Relative Value Scale published by CMS.

(o) RVU means relative value unit.

(p) WCE means work capacity evaluation.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist: Amended 11/1/07 as WCD Admin. Order 07-055, eff. 1/1/08

**436-009-0006 Administration of Rules**

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.726(4)
Hist: Amended 3/14/06 as WCD Admin Order 06-052, eff. 4/1/06

**436-009-0008 Administrative Review Before the Director**

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical services including treatment, medical fees and non-payment of compensable medical bills. The director may, on the director's own motion, initiate a medical service review at any time. A party need not be represented to participate in the administrative review before the director.

(b) Any party may request the director provide voluntary alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, the director will put the agreement in writing; or the parties shall put any agreement in writing for approval by the director. If the dispute is not resolved through alternative dispute resolution, the director will issue an order.

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims where a party disagrees with an action or decision of the MCO, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 30 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. Administrative review by the director must be requested within 60 days of issuance of the MCO's final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO

dispute 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 fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director.

(b) For all claims not enrolled in an MCO, or for disputes which do not involve an action or decision of the MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to OAR 436-009-0030. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

(c) An insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. The insurer must make the request within 180 days of the payment date. 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.

(d) Under ORS 656.704(3)(c), when there is a formal denial of the underlying condition or a denial of the causal relationship between the medical service and the accepted condition, the issue may first be decided by the Hearings Division of the Workers' Compensation Board.

(3) Parties must submit requests for administrative review to the director in the form and format prescribed by the director. When an insurer or the worker's representative submits a request without the required information, at the director's discretion the administrative review may not be initiated until the information is submitted. Unrepresented workers may contact the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker's name, date of injury, insurer, and claim number.

(b) Specify the issues in dispute and the relief sought.

(c) Provide the specific dates of the unpaid disputed treatment or services.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original CMS bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that they have provided all involved parties a copy of:

(A) The request for review; and

(B) Any attached supporting documentation; and

(C) If known, an indication of whether or not there is an issue of causation or

compensability of the underlying claim or condition.

(4) The division will investigate the matter upon which review was requested.

(a) The investigation may include, but not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider's peers.

(b) Upon receipt of a written request for additional information, the party must respond within 14 days.

(c) A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu 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.

(5) 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 may also request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed to the director before the administrative order becomes final.

(6) Hearings before an administrative law judge: Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(7) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as described in OAR 436-010-0008(14).

(8) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (7) of this rule, according to these rules, may request administrative review by the director as follows:

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

(b) 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 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08

**436-009-0010 General Requirements for Medical Billings**

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

(2) Billings must include the worker's full name and date of injury, the employer's name and, if available, the insurer's claim number and the provider's NPI. If the NPI is not available, then the provider must provide its license number and FEIN. For provider types not licensed by the state, "999999" must be used. All medical providers must submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a completed current UB-04 (CMS 1450) or CMS 1500 form, except for:

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

(b) Pharmacy billings, which must be submitted on the most current National Council for Prescription Drug Programs (NCPDP) form; and

(c) EDI transmissions of medical bills under OAR 436-009-0030(3)(c).

(d) Computer-generated reproductions of forms referenced in subsections (2)(a) and (b) may also be used.

(3)(a) All original medical provider billings must be accompanied by legible chart notes documenting services which have been billed and identifying the person performing the service and license number of the person providing the service. Medical providers are not required to provide their license number if they are already providing a national identification number.

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) When billing for medical services, a medical service provider must use codes listed in CPT® 2008 or Oregon Specific Codes (OSC) that accurately describe the service. If there is no specific CPT® code or OSC, a medical service provider must use the appropriate HCPCS code, if available, to identify the medical supply or service. Pharmacy billings must use the National Drug Code (NDC) to identify the drug or biological billed. A "zz" modifier must be used when billing electronically for services that use an OSC.

(a) If there is no specific code for the medical service, the medical service provider shall use the appropriate unlisted code from HCPCS or the unlisted code at the end of each medical service section of CPT® 2008 and provide a description of the service provided.

(b) Any service not identifiable with a code number must be adequately described by report.

(5) Medical providers must submit billings for medical services in accordance with this section.

(a) Bills must be submitted 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) A medical service billing submitted later than the time frames in subsection(a) of this section may be payable in full if the provider establishes good cause for submitting the bill late. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(c) A bill rendered over twelve months after the date of service is not payable, except when a provision of subsection (a) of this section is the reason the billing was rendered after twelve months.

(6) When rebilling, medical providers must indicate that the charges have been previously billed.

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

(8) Medical providers shall 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.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, costs must be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but no later than 30 days following receipt of the request. Thereafter, worker copies must be furnished during the regular billing cycle.

Stat. Auth.: ORS 656.245, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08

**436-009-0015 Limitations on Medical Billings**

(1) An injured worker is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment 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 not be limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 90-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director under OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental.

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3) of this rule.

(3) The medical provider may not charge a fee for the preparation of a written treatment plan and the supplying of progress notes that document the services billed as they are integral parts of the fee for the medical service.

(4) No fee is payable for the completion of a work release form or completion of a PCE form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or for a Worker Requested Medical Examination. Except as provided in OAR 436-009-0070 (10)(d) and (11)(d), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider shall be paid at 50 percent of the examination or testing fee.

(6) Under ORS 656.245 (3), the director has excluded from compensability the following medical treatment. While these services may be provided, medical providers shall not be paid for the services or for treatment of side effects.

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET)**;**

(c) Surface EMG (electromylography) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography; and

(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 injured worker is between the age of 16 and 60;

(C) The injured worker underwent a minimum of 6 months unsuccessful exercise based rehabilitation; and

(D) The procedure is not found inappropriate under OAR 436-010-0230(13) and (14).

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

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician or authorized nurse practitioner: once near the beginning, once near the middle, and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for 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.

(9)(a) When a physician or authorized nurse practitioner provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's or authorized nurse practitioner's office, such services shall be identified by CPT® codes and paid according to the fee schedule.

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

(10) Physician assistant, authorized nurse practitioner, or out-of-state nurse practitioner fees shall be paid at the rate of 85 percent of a physician's allowable fee for a comparable service. The bills for services by these providers must be marked with modifier "-81". Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(11) Except as otherwise provided in OAR 436-009-0070, when a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, an insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT® codes such as 99080. Refer to specific code definitions in the CPT® for other applicable codes. The billing should include documentation of the actual time spent reviewing the records or reports.

Stat. Auth.: ORS 656.245, 656.252, 656.254

Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08

**436-009-0020 Hospital Fees *(Temporary Rule)***

(1) Hospital inpatient charges billed to insurers must include ICD-9-CM diagnostic and procedural codes. Hospitals must include their NPI on all bills. Unless otherwise provided for by ~~a governing MCO~~ contract, insurers must pay hospitals for inpatient services using the current adjusted cost/charge ratio (see Bulletin 290). For purposes of this rule, hospital inpatient services include, but are not limited to, those bills coded "111" through "118" in space #4 on the UB-04 billing form. The audited bill must be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers must include revenue codes, ICD-9-CM diagnostic and procedural codes, CPT® codes, HCPCS codes, and National Drug Codes (NDC), where applicable. Hospitals must include their NPI on all bills. Unless otherwise provided for by ~~a governing MCO~~ contract, insurers must pay hospitals for outpatient services according to the following: the insurer must first separate out and pay charges for services by physicians and other licensed medical service providers assigned a code under the CPT® and assigned a value in RBRVS for physician fees as identified by the revenue codes indicating professional services. These charges must be subtracted from the total bill and the adjusted cost/charge ratio applied only to the balance. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Physician work RVUs, Year 2008 transitional non-facility PE RVUs, and Malpractice RVUs columns. All other charges billed using both the hospital name and tax identification number will be paid as if provided by the hospital.

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

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

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

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

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

by the basic cost/charge ratio calculated in subsection (3)(a) to obtain the factor for bad debt and charity care.

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

(e) The factors resulting from subsections (3)(c) and (3)(d) of this rule will be added to the ratio calculated in subsection (3)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

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

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

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

(i) 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/charge ratio to reflect the data developed subsequent to the initial calculation.

(j) Notwithstanding subsections (c) through (i) of this section the payment to out-of-state hospitals, may be negotiated between the insurer and the hospital.

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

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

(C) If the insurer and the hospital are unable to reach agreement within 60 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.

(k) Notwithstanding sections (1) and (2) of this rule, the director may exclude rural

hospitals from imposition of the adjusted cost/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, as originally developed by Dr. William Cleverley. All rural hospitals having a financial flexibility index at or below the median for hospitals nationwide with a bond rating of BBB+, BBB, or BBB- will 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/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; sec. 2, ch. 771, Oregon Laws 1991; 656.252; 656.256
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08
**Amended 7/7/08 as Admin. Order 08-060, eff. 7/7/08 (temporary)**

### 436-009-0022 Ambulatory Surgical Center Fees *(Temporary Rule)*

(1) An ambulatory surgical center (ASC) is any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(a) Any ASC outside of Oregon must meet similar licensing requirements, or be certified by Medicare or a nationally recognized agency.

(b) Bills from an ASC shall be submitted on CMS 1500 form. The modifier "SG" shall be used to identify facility charges.

(2) ~~Fees shall be paid at the provider's usual fee, or in accordance with the fee schedule, whichever is less. For all MCO enrolled claims, payment of fees shall be as provided by the MCO contract, at the provider's usual fee, or according to the fee schedule, whichever is less.~~ **Unless otherwise provided by contract, insurers must pay providers at the providers' usual fee, or the amount set by the fee schedule, whichever is less.**

(3) Payment shall be made using the Medicare ASC groups, except:

(a) Arthroscopies (CPT® codes 29819 through 29898 except 29888 and 29889) are paid as Group 6.

(b) Arthroscopies (CPT® codes 29888 and 29889) are paid as Group 7.

(c) Services not listed in the Medicare ASC groups 1 through 9 shall be paid at the provider's usual rate.

(4) The ASC fee schedule is:

| | |
|---|---|
| Group 1 | $ 853.28 |
| Group 2 | $ 1,143.88 |
| Group 3 | $ 1,307.68 |
| Group 4 | $ 1,616.75 |
| Group 5 | $ 1,838.68 |

| | |
|---|---|
| Group 6 | $ 2,108.00 |
| Group 7 | $ 2,551.95 |
| Group 8 | $ 2,485.78 |
| Group 9 | $ 3,444.43 |

(5) The ASC fee includes services, such as:

(a) Nursing, technical, and related services;

(b) Use of the facility where the surgical procedure is performed;

(c) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of the surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

(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.

(6) The ASC fee does not include services, such as physicians' services, laboratory, x-ray or diagnostic procedures not directly related to the surgical procedure, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services. The insurer shall pay for prosthetic devices, orthotic devices, and DME as provided in OAR 436-009-0080.

(7) When multiple procedures are performed, the highest payment group shall be paid at 100% of the maximum allowed fee. Each additional procedure shall be paid at 50% of the maximum allowed fee.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07
**Amended 7/7/08 as Admin. Order 08-060, eff. 7/7/08 (temporary)**

### 436-009-0025 Reimbursement of Related Services Costs

(1) The insurer shall notify the worker in writing at the time of claim acceptance that claim-related services, not otherwise addressed by these rules, paid by the worker will be reimbursed by the insurer as provided in this rule. The notification must include notice to the worker of the two year time limitation to request reimbursement.

(a) The worker must request reimbursement from the insurer in writing.

(b) The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed. 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.

(c) Notwithstanding subsections (a) and (b) of this section, in deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance and shall be paid within 14 days. In a claim for aggravation or a new medical condition , reimbursement of related services is not due and payable until the aggravation or new medical condition is accepted. If the claim is denied, requests for reimbursement shall be returned to the worker within 14 days.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle shall be reimbursed as provided in this section. The maximum rate of reimbursement is limited to the rate of reimbursement for State of Oregon classified employees, as published in Bulletin 112. When a worker has documentation of the expense which includes the date of the expense, he or she may be entitled to reimbursement for:

(a) Any meal reasonably required by necessary travel to a claim-related appointment.

(b) Lodging based on the need for overnight travel to attend the appointment. Reimbursement may exceed the maximum rate where special lodging was required or where the worker was unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(c) Mileage when using a personal vehicle based on the beginning and ending addresses. Reimbursement may exceed the maximum if special transportation is required. Public transportation will be reimbursed based on actual cost.

(d) Prescriptions and other claim-related expenses will be reimbursed based on actual cost.

(3) Requests for reimbursement of claim-related services costs must be received by the insurer within two years of the date the costs were incurred or within two years of the date the claim or medical condition is finally determined compensable, whichever date is later. The insurer may disapprove requests for reimbursement received beyond the two year period as being untimely requested.

(4) Requests for reimbursement denied as unreasonable or not related to the accepted compensable injury or disease shall be returned to the worker within 30 days of the date of receipt by the insurer. The insurer shall provide the worker an explanation of the reason for nonpayment and advise the worker of the right to appeal the insurer's decision by requesting administrative review before the director, under OAR 436-009-0008.

(5) Pursuant to ORS 656.325(1)(f) and OAR 436-060-0095(5)(f), the insurer shall reimburse the worker for costs related to the worker's attendance at an independent medical examination regardless of the acceptance, deferral, or denial of the claim.

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

**436-009-0030 Insurer's Duties and Responsibilities *(Temporary Rule)***

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

(2) 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 in accordance with OAR 436-009-0070(1). 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.

(3) Insurers must date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was not paid or what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) 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(2), and insurer action, for any non-payment or fee reduction other than a fee schedule reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due. The insurer must provide the specific reason(s) for non-payment or reduced payment of the billing, in writing, to the submitting medical provider. **The insurer must provide a copy of any contract that is the basis for a fee reduction to the director or the provider upon request.**

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

(c) When a medical provider submits a bill electronically, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) 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.

(5) 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 levies such a service charge to the general public.

(6) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same

time provide specific reasons for non-payment or reduction of each medical service code. **The insurer must notify the provider that they may request administrative review of the insurer's action in response to a medical bill within 90 days of the insurer's decision.** Resolution of billing disputes, including possible overpayment disputes, must be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(7) 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 for within 45 days of receipt by the insurer even if the claim is denied.

(8) 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 shall be continuous and shall include no fewer than 10 percent of medical bills. The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(9) 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 disputed claim settlement (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.

(10) Insurers that had at least 100 accepted disabling claims in the previous calendar year, as determined by the director, are required to submit detailed medical bill payment data to the Information Management Division of the Department of Consumer and Business Services at 350 Winter St NE, Room 300, PO Box 14480, Salem OR 97309-0405. Once an insurer has reached the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. The director will notify the affected insurers when they reach the minimum. If the insurer drops below the 100 disabling claim level or encounters other significant hardships, the insurer may apply to the director for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The transmission data and format requirements are included in Appendix A of these rules and Appendix B of OAR 436-160. OAR 436-160 explains the IAIABC ANSI 837 medical bill reporting requirements. To determine which appendix applies to required reporting insurers, see below.

(b) Each insurer must continue to report according to Appendix A until successfully completing IAIABC ANSI 837 testing under OAR 436-160. Once successfully completing testing, the insurer may only report via IAIABC ANSI 837.

(c) Group 1 is all required reporting insurers who are currently reporting data via IAIABC ANSI 837 in another jurisdiction. Each insurer in Group 1 must begin testing on July 1, 2008.

(d) Group 2 is the State Accident Insurance Fund Corporation. Group 2 must begin testing on April 1, 2009.

(e) Group 3 is all other required reporting insurers. Each insurer in Group 3 must begin testing on October 1, 2009.

(11) An insurer may request, in writing, additional time to report the requested data elements according to OAR 436-160. The insurer must demonstrate that the date to begin testing creates an undue hardship. The request must include a plan to begin testing within 12 months of the group's testing date, and may not extend beyond January 1, 2010.

(12) Undue hardship is demonstrated by providing the total required expenses to begin testing; the reporting cost per bill if transmitted directly by the insurer; and the total cost per bill if reported by a vendor.

(13) If the director allows additional time, the insurer must continue to report all medical billing data under Appendix A during the testing.

(14) The director may audit an insurer's actual payments reported for individual claims. An insurer is subject to a civil penalty if an audit determines that the insurer's error rate is 15 percent or higher in any field.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08
**Amended 7/7/08 as Admin. Order 08-060, eff. 7/7/08 (temporary)**

### 436-009-0035 Interim Medical Benefits

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

(a) When the worker is enrolled in an MCO prior to claim acceptance pursuant to ORS 656.245(4)(b)(B).

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

(c) With dates of injury prior to January 1, 2002.

(2) Interim medical benefits include:

(a) Diagnostic services required to identify appropriate treatment or prevent disability.

(b) Medication required to alleviate pain.

(c) Services required to stabilize the worker's claimed condition and to prevent further disability. Examples of such services may include, but are not limited to: antibiotic or anti-inflammatory medication; physical therapy and other conservative therapies; and necessary surgical procedures.

(3) If the medical service provider has knowledge that the worker filed a work related claim, the medical service provider shall not collect health benefit plan co-payment from the worker.

(4) The medical service provider shall submit a copy of the bill to the workers' compensation insurer in accordance with OAR 436-009-0010, and the health benefit plan(s) in accordance with the plan's requirements.

(5) The insurer shall notify the medical service provider when an initial claim is denied.

(6) When the claim is denied, the medical service provider shall first bill the health benefit plan(s) with a copy of the workers' compensation denial letter.

(7) After payment is received from the health benefit plan(s), the medical service provider may bill the workers' compensation insurer, according to OAR 436-009-0010, for any remaining balance. The provider shall include a copy of the health benefit plan(s)' explanation of benefits with the bill. If the worker has no health benefit plan, the workers' compensation insurer is not required to pay for interim medical benefits.

(8) The workers' compensation insurer shall pay in accordance with the Oregon fee rules, any amount not reimbursed by the health benefit plan within 45 days of receipt of the bill with the health plan's explanation of benefits, in accordance with OAR 436-009-0030 (6).

Stat. Auth: ORS 656.245, 656.704, and 656.726(4)
Stat. Implemented: ORS 656.247
Hist: Amended 3/14/06 as WCD Admin Order 06-052, eff. 4/1/06

**436-009-0040 Calculating Medical Provider Fees *(Temporary Rule)***

(1) **Unless otherwise provided by contract, insurers must pay providers at the providers' usual fee, or the amount set by the fee schedule, whichever is less.** ~~The insurer must pay for medical services at the provider's usual fee or in accordance with the fee schedule whichever is less. Insurers must pay for medical services that have no fee schedule at the provider's usual fee. For all MCO enrolled claims, the insurer must pay for medical services at the provider's usual fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract. Where~~

**(2) If a provider's fee is covered by multiple contracts, the insurer may apply only one contract to discount the provider's fee. If a provider's fee is controlled by multiple contracts, and one contract is with a certified managed care organization for services provided to an enrolled worker, the fee under the managed care organization's contract must be applied.**

**(3) If a billed service is not covered by a contract with the provider or the fee schedule, then the insurer must pay the provider's usual fee. When** there is no maximum payment established by the fee schedule, an insurer may challenge the reasonableness of a provider's billing on a case by case basis by asking the director to review the billing 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, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances.

~~(2)~~**(4)**(a) When using RBRVS, the total RVU is determined by reference to the appropriate CPT® code and by adding the values of the Physician work RVU, Year 2008 transitional non-facility PE RVU or Year 2008 transitional facility PE RVU, and Malpractice

RVU. The PE RVU is determined by the location where the procedure is performed: If the procedure is performed inside the medical service provider's office, use Year 2008 transitional non-facility PE RVUs column; if the procedure is performed outside the medical service provider's office, use Year 2008 transitional facility PE RVUs column. Use the global column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Physician work RVUs, Year 2008 transitional non-facility PE RVUs, and Malpractice RVUs columns.

(b) When an Oregon Specific Code is assigned, the RVU for multidisciplinary program services is found in OAR 436-009-0060(5), or for other services in OAR 436-009-0070 (13).

(c) When using the *American Society of Anesthesiologists Relative Value Guide*, a basic unit value is determined by reference to the appropriate Anesthesia code. The anesthesia value includes the basic unit value, time units, and modifying units.

~~(3)~~**(5)** Payment according to the fee schedule must be determined by multiplying the assigned RVU or basic unit value by the applicable conversion factor. Where the code is designated by an RVU of "0.00" or IC (individual consideration) for Anesthesia codes, the insurer must pay at the provider's usual rate.

~~(4)~~**(6)** The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical providers.

| Service Categories | Conversion Factors |
|---|---|
| Evaluation / Management | $64.79 |
| Anesthesiology | $53.45 |
| Surgery | $86.44 |
| Radiology | $68.00 |
| Lab & Pathology | $60.00 |
| Medicine | $75.04 |
| Physical Medicine and Rehabilitation | $65.79 |
| Multidisciplinary and Other Oregon-Specific Codes | $60.00 |

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08
**Amended 7/7/08 as Admin. Order 08-060, eff. 7/7/08 (temporary)**

### 436-009-0050 CPT® Sections

Each CPT®. section has its own schedule of relative values, completely independent of and unrelated to any of the other sections. The definitions, descriptions, and guidelines found in CPT® shall be used as guides governing the descriptions of services, except as otherwise provided in these rules. The following provisions are in addition to those provided in each section of CPT®.

(1) Evaluation and Management services.

(2) Anesthesia services.

(a) 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.

(b) Anesthesia basic unit values are to be used only when the anesthesia is personally administered by either a licensed physician or certified nurse anesthetist who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

(c) When a regional anesthesia is administered by the attending surgeon, the value shall be the "basic" anesthesia value only without added value for time.

(d) When the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the modifier "NT" (no time) shall be noted on the bill.

(e) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the relative value unit for the surgical procedure.

(3) Surgery services.

(a) When a worker is scheduled for elective surgery, the pre-operative visit, in the hospital or elsewhere, necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed global value of the surgical procedure. If the procedure is not elective, the physician is entitled to payment for the initial evaluation of the worker in addition to the global fee for the surgical procedure(s) performed.

(b) When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

(c) Multiple surgical procedures performed at the same session shall be paid as follows:

(A) When multiple surgical procedures are performed by one surgeon, the principal procedure is paid at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures are paid at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid accordingly.

(B) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures paid at 50 percent of the value listed.

(C) When more than one surgeon performs surgery, each procedure shall be billed separately. The maximum allowable fee for each procedure, as listed in these rules, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation, each is entitled to an additional fee of 20 percent of the other surgeon's allowable fee as an assistant's fee. When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' allowable fees.

(D) When a surgeon performs surgery following severe trauma that requires considerable time, 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. Such a request must be

accompanied by written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(E) When a surgical procedure is performed bilaterally, the modifier "-50" shall be noted on the bill for the second side, and paid at 50% of the fee allowed for the first side.

(d) Physician assistants or nurse practitioners shall be paid at the rate of 15 percent of the surgeon's allowable fee for the surgical procedure(s). The bills for services by these providers shall be marked with a modifier "-81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The operation report shall document who assisted.

(4) Radiology services.

(a) In order to be paid, x-ray films must be of diagnostic quality and include a report of the findings. Billings for 14" x 36" lateral views shall not be paid.

(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), the technical component for the first area examined shall be paid at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent under these rules. The discount applies to multiple studies done within 2 days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days. No reduction is applied to multiple areas for the professional component.

(5) Pathology and Laboratory services.

(a) The laboratory and pathology conversion factor applies only when there is direct physician involvement.

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

(6) Medicine services.

(7) Physical Medicine and Rehabilitation services.

(a) Increments of time for a time-based CPT® code shall not be prorated.

(b) Payment for modalities and therapeutic procedures shall be limited to a total of three separate CPT®-coded services per day. CPT® codes 97001, 97002, 97003, or 97004 are not subject to this limit. An additional unit of time (15 minute increment) for the same CPT® code is not counted as a separate code.

(c) All modality codes requiring constant attendance (97032, 97033, 97034, 97035, 97036, and 97039) are time-based. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day.

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

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

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

**436-009-0060 Oregon Specific Code, Multidisciplinary Services**

(1) Services provided by multidisciplinary programs not otherwise described by CPT® codes shall be billed under Oregon Specific Codes. Electronic billings shall include a "zz" modifier as provided in OAR 436-009-0010.

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

(a) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to 6 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.

(b) Notwithstanding OAR 436-009-0010(4), 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.

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

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

(4) Billings using the multidisciplinary codes must include copies of the treatment record which specifies the type of service rendered, the medical provider who provided the service, whether treatment was individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(5) The table below lists the **Oregon Specific Codes for Multidisciplinary Services**.

| Codes | Relative Value | Description |
|---|---|---|
| 97642 | 0.91 | Physical conditioning - group - 1 hour<br>Conditioning exercises and activities, graded and progressive |
| 97643 | 0.46 | Each additional 30 minutes |
| 97644 | 1.45 | Physical conditioning – individual 1 hour<br>Conditioning exercises and activities, graded and progressive |
| 97645 | 0.73 | Each additional 30 minutes |
| 97646 | 0.91 | Work simulation - group 1 hour<br>Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors |
| 97647 | 0.46 | Each additional 30 minutes |
| 97648 | 1.50 | Work simulation - individual 1 hour<br>Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors |
| 97649 | 0.75 | Each additional 30 minutes |
| 97650 | 0.81 | Therapeutic education – individual 30 minutes<br>Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals |
| 97651 | 0.41 | Each additional 15 minutes |
| 97652 | 0.54 | Therapeutic education - group 30 minutes<br>Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals |
| 97653 | 0.28 | Each additional 15 minutes |
| 97654 | 0.41 | Professional Case Management – Individual 15 minutes<br>Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician) |
| 97655 | 0.39 | Brief Interdisciplinary Rehabilitation Conference - 10 minutes<br>A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits |

| | | |
|---|---|---|
| 97656 | 0.78 | Intermediate Interdisciplinary Rehabilitation Conferences - 20 minutes<br>A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits |
| 97657 | 1.35 | Complex Interdisciplinary Rehabilitation Conferences – 30 minutes<br>A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits |
| 97658 | 0.68 | Each additional 15 minutes Complex conference-up to 1 hour maximum |
| 97659 | 1.72 | Job site visit - 1 hour (includes travel) - must be preauthorized by insurer<br>A work site visit to identify characteristics and physical demands of specific jobs |
| 97660 | 0.86 | Each additional 30 minutes |
| 97661 | 2.32 | Ergonomic consultation - 1 hour (includes travel) - must be preauthorized by insurer<br>Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications |
| 97662 | 0.94 | Vocational evaluation - 30 minutes<br>Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options |
| 97663 | 0.47 | Each additional 15 minutes |
| 97664 | 1.27 | Nursing evaluation - 30 minutes<br>Nursing assessment of medical status and needs in relationship to rehabilitation |
| 97665 | 0.63 | Each additional 15 minutes |
| 97666 | 1.02 | Nutrition evaluation - 30 minutes<br>Evaluation of eating habits, weight and required modifications in relationship to rehabilitation |
| 97667 | 0.52 | Each additional 15 minutes |
| 97668 | 1.07 | Social worker evaluation - 30 minutes<br>Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome |
| 97669 | 0.54 | Each additional 15 minutes |

| | | |
|---|---|---|
| 97670 | 6.70 | Initial Multidisciplinary conference - up to 30 minutes |
| 97671 | 7.56 | Initial Complex Multidisciplinary conference - up to 60 minutes |

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 3/14/06 as WCD Admin Order 06-052, eff. 4/1/06

**436-009-0070 Oregon Specific Code, Other Services**

(1) Except for records required in OAR 436-009-0010(3), copies of requested medical records shall be paid under OSC-R0001.

(2) A 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 specific questions related to the attending physician's or authorized nurse practitioner's current or proposed treatment, shall be paid under OSC-N0001.

(3) A complex narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, attending physician's or authorized nurse practitioner's treatment to date, current status, impairment, prognosis, and medically stationary information, shall be paid under OSC-N0002.

(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable payment shall be as follows:

(a) FIRST LEVEL PCE: 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 requires not less than 45 minutes of actual patient contact. A first level PCE shall be paid under OSC-99196 which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(b) SECOND LEVEL PCE: 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 requires not less than two hours of actual patient contact. The second level PCE shall be paid under OSC-99197 which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(c) WCE: This is a residual functional capacity evaluation which requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE shall be paid under OSC-99198 which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g. cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report. Special

emphasis should be given to:

(A) The ability to perform essential physical functions of the job based on a specific job analysis as related to the accepted condition;

(B) The ability to sustain activity over time; and

(C) The reliability of the evaluation findings.

(5) When an attorney requires a consultation with a medical provider, the medical provider shall bill under OSC-D0001.

(6) When an insurer requires a consultation with a medical provider, the medical provider shall bill under OSC-D0030.

(7) The fee for a deposition shall be billed under OSC-D0002. This code should include time for preparation, travel and deposition. Upon request of one of the parties, the director may limit payment of the provider's hourly rate to a fee charged by similar providers.

(8) When an insurer obtains an Independent Medical Examination (IME):

(a) The medical service provider doing the IME shall bill under OSC-D0003. This code shall be used for a report, file review or examination;

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

(9) The fee for interpretive services shall be billed under OSC-D0004.

(10) Fees for all arbiters and panel of arbiters used for director reviews pursuant to OAR 436-030-0165 shall be established by the director. This fee determination will be based on the complexity of the examination, the report requirements and the extent of the record review. The level of each category is determined by the director based on the individual complexities of each case as compared to the universe of claims in the medical arbiter process. When the examination is scheduled, the director shall notify the medical arbiter and the parties of the authorized fee for that medical arbiter review based on a combination of separate components.

a) Level 1 OSC-AR001 Exam
Level 2 OSC-AR002 Exam
Level 3 OSC-AR003 Exam
Limited OSC-AR004 Exam

As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors. A limited exam generally involves a newly accepted condition, or some other partial exam.

b) Level 1 OSC-AR011 Report

Level 2 OSC-AR012 Report

Level 3 OSC-AR013 Report

As determined by the director, a level 1 report generally includes standard questions. A level 2 report generally includes questions regarding complicating factors. A level 3 report generally includes questions regarding multiple complicating factors.

c) Level 1 OSC-AR021 File Review

Level 2 OSC-AR022 File Review

Level 3 OSC-AR023 File Review

Level 4 OSC-AR024 File Review

Level 5 OSC-AR025 File Review

As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of a large record or disability evaluation without an exam. A level 4 file review generally includes an extensive record. A level 5 file review generally includes an extensive record with unique factors.

(d) The director will notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review. If a worker fails to appear for a medical arbiter examination without giving each medical arbiter at least 48 hours notice, each medical arbiter shall be paid at 50 percent of the examination or testing fee. A medical arbiter must also be paid for any file review completed prior to cancellation.

(e) If the director determines that a supplemental medical arbiter report is necessary to clarify information or address additional issues, an additional report fee may be established. The fee is based on the complexity of the supplemental report as determined by the director. The additional fees are established as follows:

Limited OSC-AR031

Complex OSC-AR032

(f) Prior to completion of the reconsideration process, the medical arbiter may request the director to redetermine the authorized fee by providing the director with rationale explaining why the physician believes the fee should be different than authorized.

(g) The director may authorize testing which shall be paid according to OAR 436-009.

(h) Should an advance of costs be necessary for the worker to attend a medical arbiter exam, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(11) A single physician selected under ORS 656.327 or 656.260, to review treatment,

perform reasonable and appropriate tests, or examine the worker, and submit a report to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under OSC-P0001 for the examination and under OSC-P0003 for the report.

(b) Physicians selected under OAR 436-010-0008, to serve on a panel of physicians shall each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. Each physician shall bill for the record review and panel examination under OSC-P0002. The panel member who prepares and submits the panel report shall receive an additional payment under OSC-P0003.

(c) The director may in a complex case requiring extensive review by a physician pre-authorize an additional fee. Complex case review shall be billed under OSC-P0004.

(d) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician shall bill under OSC-P0005. The insurer must pay the physician for the appointment time and any time spent reviewing the record completed prior to the examination time. The billing must document the physician's time spent reviewing the record.

(e) Should an advance of costs be necessary for the worker to attend an exam under ORS 656.327 or 656.260, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(12) The fee for a Worker Requested Medical Examination shall be billed under OSC-W0001. This code shall be used for a report, file review, or examination.

(13) The table below lists the Oregon Specific Codes for Other Services.

| Codes | Relative Value | Description |
|---|---|---|
| R0001 | | Copies of medical records when requested shall be paid at $10.00 for the first page and $.50 for each page thereafter and identified on billings |
| N0001 | 1.71 | Brief narrative by the attending physician or authorized nurse practitioner |
| N0002 | 3.41 | Complex narrative by the attending physician or authorized nurse practitioner |
| 99196 | 3.00 | First Level PCE |
| 99197 | 5.36 | Second Level PCE |

| | | |
|---|---|---|
| 99198 | 11.31 | WCE |
| 99193 | 0.77 | Additional 15 minutes |
| D0001 | 0.00 | Attorney consultation time |
| D0002 | 0.00 | Deposition time |
| D0003 | 0.00 | Independent Medical Examination (IME) and report |
| D0004 | 0.00 | Interpretive services |
| D0019 | 0.00 | Medical service provider review and response to IME report |
| D0030 | 0.00 | Insurer consultation time |
| AR001 | 5.12 | Level 1 arbiter exam |
| AR002 | 6.82 | Level 2 arbiter exam |
| AR003 | 8.53 | Level 3 arbiter exam |
| AR004 | 2.56 | Level 4 arbiter exam |
| AR011 | 0.88 | Level 1 arbiter report |
| AR012 | 1.32 | Level 2 arbiter report |
| AR013 | 1.77 | Level 3 arbiter report |
| AR021 | 0.88 | Level 1 arbiter file review |
| AR022 | 2.21 | Level 2 arbiter file review |
| AR023 | 5.30 | Level 3 arbiter file review |
| AR024 | 10.23 | Level 4 arbiter file review |
| AR025 | 13.65 | Level 5 arbiter file review |
| AR031 | 0.88 | Limited arbiter report |
| AR032 | 1.77 | Complex arbiter report |
| P0001 | 4.27 | Director single medical review/exam |
| P0002 | 4.27 | Director panel medical review/exam |
| P0003 | 2.17 | Director single medical review/report |
| P0004 | 5.12 | Director complex case review/exam |
| P0005 | 2.17 | Failure to appear director required examination |
| W0001 | 0.00 | Worker Requested Medical Examination and report |

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08

**436-009-0080 Durable Medical Equipment and Medical Supplies**

(1) Durable medical equipment (DME) is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and not generally useful to a person in

the absence of an illness or injury. For example: Transcutaneous Electrical Nerve Stimulation (TENS), MicroCurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc. Fees for durable medical equipment shall be paid as follows:

(a) The insurer shall pay for the purchase of all compensable DME that are ordered and approved by the physician, at 85% of the manufacturer's suggested retail price (MSRP). If no MSRP is available or the provider can demonstrate that 85% of the MSRP is less than 140% of the actual cost to the provider, the insurer shall pay the provider 140% of the actual cost to the provider for the item as documented on a receipt of sale.

(b) The DME provider is entitled to payment for any labor and reasonable expenses directly related to any subsequent modifications other than those performed at the time of purchase, or repairs. A subsequent modification is one done other than as a part of the initial set-up at the time of purchase. The insurer shall pay for labor at the provider's usual rate.

(c) The provider may offer a service agreement at an additional cost.

(d) Rental of all compensable DME shall be billed at the provider's usual rate. Within 90 days of the beginning of the rental, the insurer may purchase the DME or device at the fee provided in this rule, with a credit for rental paid up to 2 months.

(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. For example: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer shall pay the fee for a prosthetic at the provider's usual rate.

(a) Testing for hearing aids must be done by a licensed audiologist or an otolaryngologist.

(b) Based on current technology, the preferred types of hearing aids for most workers are programmable BTE, ITE, and CIC multi channel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

(c) Without approval from the insurer or director, hearing aids should not exceed $5000 for a pair of hearing aids, or $2500 for a single hearing aid.

(3) An orthosis is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. For example: brace, splint, shoe insert or modification, etc. The insurer shall pay the fee for an orthosis at the provider's usual rate.

(4) Medical 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. The insurer shall pay the fees for medical supplies at the provider's usual rate.

(5) The worker may select the service provider, except for claims enrolled in a managed care organization (MCO) where service providers are specified by the MCO contract.

(6) Except as provided in subsection (2)(c) of this rule, this rule does not apply to a worker's direct purchase of DME and medical supplies, and does not limit a worker's right to

reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(7) DME, medical supplies and other devices dispensed by a hospital (inpatient or outpatient) shall be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 5/22/07 as WCD Admin. Order 07-051, eff. 7/1/07

**436-009-0090 Pharmacy Fees *(Temporary Rule)***

(1) ~~Except for in-patient hospital charges, the insurer must pay for prescription medications at the provider's usual rate or the maximum allowable fee set by this rule, whichever is lower.~~ **Unless otherwise provided by contract, insurers must pay providers for prescription medication at the providers' usual fee, or the amount set by the fee schedule, whichever is less.**

(a) "AWP" means the Average Wholesale Price effective on the day the drug was dispensed.

(b) The maximum allowable fee 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 | 83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee |
| A brand name drug and the prescribing health care provider has not prohibited substitution | 83.5 % of the average AWP for the class of generic drugs plus a $2.00 dispensing fee |
| A brand name drug the prescribing health care 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 |

(2) All prescription medications are required medical services and do not require prior approval under the palliative care provisions of OAR 436-010-0290.

(3) Under ORS 689.515(2) licensed providers may dispense generic drugs to injured workers.

(4) Payment for Oxycontin, and COX-2 inhibitors is limited to an initial five-day supply unless the prescribing medical service provider writes a clinical justification for prescribing that drug rather than a less costly drug with a similar therapeutic effect.

(a) The clinical justification may accompany the prescription and be submitted by the pharmacist or may be given directly to the insurer by the medical provider.

(b) Clinical justification means a written document from the medical service provider

stating the reason he or she believes the drug ordered is the one the patient should have. The justification may be included on the prescription itself and may simply be a brief statement. Insurers and self-insured employers cannot challenge the adequacy of the clinical justification. However, they can challenge whether or not the medication is excessive, inappropriate, or ineffectual in accordance with ORS 656.327.

(c) An additional clinical justification is not necessary for refills of that medication.

(5) Insurers shall use the prescription pricing guide published by First DataBank Inc, Thomson Healthcare, Inc., or Facts & Comparisons (a Wolters Kluwer Health, Inc., Company) for calculating payments to the licensed provider. Insurers must update their source at least monthly.

(6) The worker may select the pharmacy, except for claims enrolled in a managed care organization (MCO) where pharmacy service providers are specified by the MCO contract.

(7) Except for sections 2, 3, 4 and 6 of this rule, this rule does not apply to a worker's direct purchase of prescription medications, and does not limit a worker's right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(8) The insurer shall pay the retail-based fee for over-the-counter medications.

(9) Drugs dispensed by a hospital (inpatient or outpatient) shall be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 6/12/08 as WCD Admin. Order 08-051, eff. 7/1/08
**Amended 7/7/08 as Admin. Order 08-060, eff. 7/7/08 (temporary)**

### 436-009-0100 Sanctions and Civil Penalties

The director may impose sanctions upon a medical provider or insurer for violation of OAR 436-009 in accordance with OAR 436-010-0340.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist: Amended 03/15/00 as Admin. Order 00-051, eff. 04/01/00

**Appendix A 436-009-0030**

Insurers are required to report medical bill payment data on all payments made during each quarter for medical services as defined in OAR 436-010-0005. Insurers must submit medical bill payment data no later than 45 days after the end of each quarter, as shown below.

| QUARTER | MONTH OF PAYMENT | DUE NEXT |
|---|---|---|
| First | January, February & March | May 15th |
| Second | April, May & June | August 14th |
| Third | July, August & September | November 14th |
| Fourth | October, November & December | February 14th |

Technical Requirements: Medical bill payment data for each quarter calendar year must be transmitted as an individual file. Insurers transmitting data for more than one insurer may batch multiple insurer data files in one transmission. Data must be transmitted in electronic text files by secure file transfer protocol (SFTP) using the secure shell (also known as SSH) protocol. Contact the Information Management Division (IMD) to arrange submission of files by SFTP. The record length must be fixed, 129 bytes, no packed fields, and in conformance with the records layout in Appendix B. Contact IMD for e-mail cover letter instructions. The cover letter must include the following: a list of all insurance companies' data included in the transmission; number of records; a contact person's name, address, and telephone number; the quarter being reported, and any known problems with the data.

Data Quality: The director will conduct electronic edits for blank or invalid data. Required reporting insurers are responsible for pre-screening the data to check that all the required information is reported. Files which have more than five percent missing or invalid data in any field, based on initial computerized edits, will be returned for correction and must be resubmitted within three weeks (21 days) from the date it was returned by the department.

Special Requirements
The medical bill payment data must include all payments made during each calendar quarter for medical services. The following apply:

Hospital Inpatient: Each hospital inpatient stay should be reported as one record summarizing all services related to the inpatient stay using provider type "HI." Report ICD-9-CM procedure code in the service code field.
Hospital Outpatient: Report at the individual service-code level using provider type "HO." A service code, whether CPT®, HCPCS or other, is required on all "HO" records in addition to the ICD-9-CM diagnostic code.
UPIN: The unique provider identifier number (UPIN), is a six-position alphanumeric identifier that is assigned to all Medicare physicians, medical groups, and non-physician practitioners. Left justify the UPIN and follow with blanks.

ICD-9-CM Diagnosis Codes: The International Classification of Diseases (ICD-9-CM) diagnosis code(s) must appear on all records where the provider type is chiropractor, hospital inpatient, hospital outpatient, medical doctor, osteopath, physician's assistant, or registered nurse practitioner. The primary code must be supplied first and, if available, the secondary code should be supplied.

Service, Drug, or Procedure Codes: Report the Physicians' Current Procedural Terminology (CPT®) code or other applicable code from the Oregon Medical Fee and Payment Rules: for example, "99201". On payments for durable medical equipment, report the appropriate HCPCS code: for example, "E0110". On payments for pharmaceuticals, report the eleven-digit National Drug Code (NDC): for example, "61392054230". On hospital inpatient services, report the ICD-9-CM procedure code: for example, "81.97". If reporting a hospital outpatient service, you may report the appropriate hospital revenue code: for example, "450". All codes must be left-justified and followed with blanks, as necessary, to comply with the required record layout format.

Modifier Codes: All adjustments to payments need to be associated with specific services.

- Use modifier 'SG' to identify ambulatory surgical center facility charges.
- Use modifier 'NT' (no time) on bills from a surgeon or attending physician administering a local or regional block for anesthesia during a procedure.
- Use modifier '50' when a surgical procedure is performed bilaterally for the second side.
- Use modifier '81' on bills for services by a physician assistant or nurse practitioner.
- Use a "zz" modifier when billing electronically for services that use Oregon Specific Codes.
- For a refund payment, repeat the record exactly as originally reported but enter payment and charge amounts as negatives (put minuses in the sign fields) and put "RF" (for refund) in the modifier code field.
- Adjustments that result in a partial refund or additional payment for a service that has already been paid should be coded with "DC" in the modifier code field.

Number of units or services: Report the number of time units paid on each time-based service such as anesthesiology and therapeutic procedures. For example, where base time unit equals 15 minutes (anesthesia, CPT® 97110, 97530, etc.), one hour of service equals "04" units. Where base time unit equals one hour (CPT® 97546), two hours of service equals "02" units. Also report the number of services if multiple, identical services to a patient are bundled into one record. For example, three whirlpool treatments (CPT® 97022) equals "03".

**Appendix A 436-009-0030**

## RECORD LAYOUT FOR ELECTRONIC DATA TRANSMISSION

| DESCRIPTION | ALPHA NUMERIC | POSITION | LENGTH | REQUIREMENT |
|---|---|---|---|---|
| Insurer's WCD number | 9 | 1 | 4 | Required |
| Insurer's claim number | X | 5 | 20 | Required |
| Claimant's SSN | 9 | 25 | 9 | Required |
| Date of injury (YYYYMMDD) | 9 | 34 | 8 | Required |
| Medical-only or disabling (M or D) | X | 42 | 1 | Optional |
| Medical provider-type | X | 43 | 2 | Required |
| Medical provider specialty | X | 45 | 3 | Required |
| Medical provider FEIN | X | 48 | 10 | Required |
| Medical provider other Federal Tax Reporting ID number or UPIN | X | 58 | 9 | Optional |
| MCO number | X | 67 | 6 | Required |
| ICD-9-CM diagnosis code | X | 73 | 6 | Required |
| Secondary ICD-9-CM diagnosis code | X | 79 | 6 | Optional |
| Service, drug, or procedure code | X | 85 | 11 | Required |
| Modifier code | X | 96 | 2 | Required |
| Date of service (YYYYMMDD) | 9 | 98 | 8 | Required |
| Date of payment (YYYYMMDD) | 9 | 106 | 8 | Required |
| Charge amount sign | X | 114 | 1 | Required |
| Charge amount | 9 | 115 | 6 | Required |
| Payment amount sign | X | 121 | 1 | Required |
| Payment amount | 9 | 122 | 6 | Required |
| Number of units or services | 9 | 128 | 2 | Required |

1. Refer to Bulletin 220 for additional special field reporting instructions.

## Appendix A 436-009-0030

## RECORD LAYOUT SPECIAL FIELD REQUIREMENTS

| DESCRIPTION | Special Field Requirements |
|---|---|
| Alpha Numeric (Table Column) | X = Character or alphanumeric data: No lower-case letters; fill empty spaces with blanks and left justify.<br>9 = Numeric data; right justify numbers including leading zeros; fill empty spaces with zeros. |
| Length (Table Column) | No compressed or packed fields. |
| Insurer's WCD number | Workers' Compensation Division insurer number National Association of Insurance Commissioners (NAIC) number, where applicable, is included for reference. |
| Date of injury (YYYYMMDD) | All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208." |
| Medical provider-type | Use code from list of provider-type codes in this appendix. |
| Medical provider specialty | Use code from list of provider specialty codes in this appendix. |
| Medical provider FEIN | Use the federal employer identification number that is used for federal tax reporting purposes. |
| Medical provider other Federal Tax Reporting ID number or UPIN | Report the nine-digit other federal tax reporting identification number that is used for federal tax reporting purposes, or the Unique Provider Identification Number of the individual providing the medical service. |
| MCO number | See instructions in Bulletin 220. |
| ICD-9-CM diagnosis code | See instructions in Bulletin 220. |
| Secondary ICD-9-CM diagnosis code | See instructions in Bulletin 220. |
| Service, drug, or procedure code | See instructions in Bulletin 220. |
| Modifier code | Optional CPT® or HCPCS modifier codes are required when needed to report a modified service. Do not report physical status modifiers for anesthesia services. See instructions in Bulletin 220 for usage of adjustment modifiers "RF" and "DC" for adjustments. See instructions in Bulletin 220 for usage of modifiers "SG", "NT", "81", "50", and "zz". |
| Date of service (YYYYMMDD) | All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208." |
| Date of payment (YYYYMMDD) | All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208." |
| Charge amount sign | If this is a refund or other negative amount, put a minus-sign in this field, otherwise fill with a blank. |
| Charge amount | Rounded to the nearest whole dollar, for example, a $300.05 payment would be shown as "000300." |
| Payment amount sign | If this is a refund or other negative amount, put a minus-sign in this field, otherwise fill with a blank. |
| Payment amount | Rounded to the nearest whole dollar, for example, a $300.05 payment would be shown as "000300." |
| Number of units or services | See instructions in Bulletin 220. |

## Appendix A 436-009-0030

## Data and Format Requirements:

**PROVIDER TYPES:** Use the following codes to describe the type of medical provider:

| TABLE OF MEDICAL PROVIDER-TYPE CODES | |
|---|---|
| **PROVIDER DESCRIPTION** | **CODE** |
| Acupuncturist | AC |
| Ambulatory Surgical Center | AS |
| Chiropractor | CH[1] |
| Dentist | DE |
| Home Health Care | HH |
| Hospital Inpatient | HI[1] |
| Hospital Outpatient | HO[1] |
| Laboratory | LA |
| Medical Doctor | MD[1] |
| Medical Supplies | MS |
| Naturopath | NA |
| Nursing Home | NH |
| Occupational Therapist | OT |
| Optometrist | OP |
| Osteopath | OS[1] |
| Pharmacy | PH |
| Physical Therapist | PT |
| Physician's Assistant | PA[1] |
| Podiatrist | PO |
| Psychologist | PS |
| Radiologist | RA |
| Registered Nurse Practitioner | NP[1] |
| Other Medical Provider | OM |

1. ICD-9-CM diagnosis codes are required on records with these types.

**PROVIDER SPECIALTY:** If the medical provider-type is "MD", use the following codes to designate the medical provider specialty:

| TABLE OF MEDICAL PROVIDER SPECIALTY CODES | |
|---|---|
| **PROVIDER SPECIALTY** | **CODE** |
| Anesthesiologist | ANE |
| Dermatologist | DER |
| Emergency Medicine | EMM |
| Family Practice | FPR |
| General Practice | GPR |
| General Surgeon | GSU |
| Internist[3] | INT |
| Neurologist | NEU |
| Neurosurgeon | NSU |
| Occupational Medicine | OCC |
| Ophthalmologist | OPH |
| Oral Surgeon | OSU |
| Orthopedist/Orthosurgeon | ORS |
| Otolaryngologist | OTO |
| Pathologist | PTH |
| Physiatrist | PMR |
| Plastic Surgeon | PSU |
| Psychiatrist | PSY |
| Radiologist | RAD |
| Urologist | URO |
| Other Surgical/non-Surgical Specialists[1] | OTH |
| Unknown Specialist[2] | UNK |
| | |

1. Indicates provider specialty does not fit any of the above categories.
2. Indicates provider specialty cannot be determined.
3. All internal medicine specialties.

**NOTE: ANSI 837 Medical Bill Reporting Requirements are described in OAR 436-160**

Secretary of State
Certificate and Order for Filing
**TEMPORARY ADMINISTRATIVE RULES**
A Statement of Need and Justification accompanies this form.

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on **7/7/2008** by the
Date prior to or same as filing date

Department of Consumer and Business Services, Workers' Compensation Division | chapter 436
Agency and Division | Administrative Rules Chapter Number

Fred Bruyns | 350 Winter Street NE, Salem OR 97301-3879, PO Box 14480, Salem OR 97309-0405 | (503) 947-7717
Rules Coordinator | Address | Telephone

to become effective **July 7, 2008** through **January 2, 2009**.
Date upon filing or later | A maximum of 180 days including the effective date.

**RULE CAPTION**

**Health care providers may contract or agree to accept fees lower than fee schedule maximums.**

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

**RULEMAKING ACTION**

List each rule number separately, 000-000-0000.
Secure approval of new rule numbers (Adopted rules) with the Administrative Rules Unit prior to filing

**AMEND**: OAR 436-009-0003, 436-009-0020, 436-009-0022, 436-009-0030, 436-009-0040, 436-009-0090

**Stat. Auth.:** ORS 656.726(4), 656.248

**Other Auth.:**

**Stats. Implemented:** ORS 656.248

**RULE SUMMARY**

Permanent OAR 436-009, "Oregon Medical Fee and Payment Rules," requires payment at the maximum allowed under the fee schedule or the health care provider's usual fee, whichever is less.

These temporary rules provide for payment under the terms of a contact to which a health care provider is a party: Unless otherwise provided by contract, insurers must pay providers at the providers' usual fee, or the amount set by the fee schedule, whichever is less. If a provider's fee is covered by multiple contracts, the insurer may apply only one contract to discount the provider's fee. If a provider's fee is controlled by multiple contracts, and one contract is with a certified managed care organization, the fee under the managed care organization's contract must be applied when the services were provided to an enrolled worker. The insurer must provide a copy of any contract that is the basis for a fee reduction to the director or the provider upon request. The insurer must notify the provider that they may request administrative review of the insurer's action in response to a medical bill within 90 days of the insurer's decision.

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; or e-mail fred.h.bruyns@state.or.us. Rules are available on the Internet: http://www.wcd.oregon.gov/policy/rules/rules.html

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630.

*/s/ John L. Shilts* | John L. Shilts | 7/7/08
Authorized Signer | Printed name | Date

*With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules.
ARC 940-2005

**STATEMENT OF NEED AND JUSTIFICATION**

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Department of Consumer and Business Services, Workers' Compensation Division 436

Agency and Division | Administrative Rules Chapter Number

**In the Matter of:** Amendment of OAR 436-009, "Oregon Medical Fee and Payment Rules"

**Rule Caption:** Health care providers may contract or agree to accept fees lower than fee schedule maximums.

**Statutory Authority:** ORS 656.726(4), 656.248

**Other Authority:**

**Stats. Implemented:** ORS 656.248

**Need for the Temporary Rule(s)**: Permanent OAR 436-009, "Oregon Medical Fee and Payment Rules," requires payment at the maximum allowed under the fee schedule or the health care provider's usual fee, whichever is less. Many health care providers have entered into agreements and contracts that require the providers to accept discounted payments. OAR 436-009 does not address such discounts. The department is promulgating temporary rules that are aligned with the common health care and insurance industry practice of contracting with providers for reduced payments.

**Documents Relied Upon, and where they are available:** Records of advisory committee meeting of June 27, 2008 and written advice from the committee members and interested parties. These documents are available for public inspection in the Administrator's Office, Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879, upon request and between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday.

**Justification of Temporary Rule(s):** Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. In recent months, many providers have disputed contractual discounts and asked the department to order increased payment up to the provider's usual fee or the fee schedule maximum. The department would be enforcing rules that may place providers in violation of their contracts. There is also potential for financial harm to preferred provider organizations and other entities that hold these contracts; because these organizations usually provide services throughout the general healthcare system, any harm caused could be widespread in its effects on Oregon's healthcare system. These temporary rules bring the "Oregon Medical Fee and Payment Rules" into alignment with common industry practices and avert the problems and risks described, while making several amendments to protect health care providers, as described in the "RULE SUMMARY" of the *Certificate and Order for Filing Temporary Administrative Rules*.

| *<u>/s/ John L. Shilts</u>* | John L. Shilts | 7/7/08 |
|---|---|---|
| Authorized Signer | Printed name | Date |

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 945-2005