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

Effective April 1, 2014

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[Effective April 1, 2014]

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[Effective April 1, 2014]

NOTE: Revisions are marked as follows:

Deleted text has a "strike-through" style, as in	~~Deleted~~
Added text is 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 and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, 503-947-7627, or visit the division's website: http://wcd.oregon.gov/policy/rules/history.html

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

To order the ***ASA Relative Value Guide***, contact:
American Society of Anesthesiologists
520 N. Northwest Highway, Park Ridge, IL 60068-2573
Phone 847-825-5586
http://www.asahq.org/
Ask for: 2014~~1~~ ***Relative Value Guide***

To order the **CPT®** 2014 or the ***CPT Assistant***, contact:
American Medical Association
515 North State Street, Chicago, IL 60610
Phone 800-621-8335
http://www.ama-assn.org/ama

To order the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.2, contact:
National Council for Prescription Drug Programs (NCPDP)
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
Phone: 480.477.1000
www.ncpdp.org

To order the **NUBC UB-04 Data Specifications Manual**, contact:
National Uniform Billing Committee

American Hospital Association
One North Franklin, 29th Floor, Chicago, IL 60606
Phone 312-422-3390
www.nubc.org
Ask to: Become a subscriber of the NUBC UB-04 Specifications Manual

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

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NOTE: OAR 436-009 has been substantially rewritten. Existing rules are marked for deletion, starting on page 75.

436-009-0001 Administration of These Rules

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

(2) Authority for Rules.

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

(3) Purpose.

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

(4) Applicability of Rules.

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

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

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

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2014 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2014, contact the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, 847-825-5586, or on the Web at: http://www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2014), Fourth Edition Revised, 2013, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® must be used as guides governing the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 23, Issue 12, 2013. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual is the controlling resource.

(4) To get a copy of the CPT® 2014 or the CPT® Assistant, contact the American Medical Association, 515 North State Street, Chicago, IL60610, 800-621-8335, or on the Web at: http://www.ama-assn.org.

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

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

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

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

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

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

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

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

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

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

436-009-0005 Definitions

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

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

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

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

(4) An **"ambulatory surgery center"** (ASC) means:

(a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or
(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.

(5) "Attending Physician" has the same meaning as described in ORS 656.005(12)(b). See "Matrix for Health Care Provider types" Appendix F.

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

(7) "Board" means the Workers' Compensation Board and includes its Hearings Division.

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

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

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

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

(12) "Days" means calendar days.

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

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

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

(16) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(17) "Hospital" means an institution licensed by the State of Oregon as a hospital.

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

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

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

(20) "Interim Medical Benefits" means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002, that are not denied within 14 days of the employer's notice of the claim.

(21) "Interpreter" means a person who:

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

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

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

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

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

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

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

(28) "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

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

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

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

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

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

(34) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.

(35) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A). See "Matrix for Health Care Provider types" Appendix F.

(36) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B). See "Matrix for Health Care Provider types" Appendix F.

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

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

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

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

436-009-0008 Request for Review by the Director

(1) General.

(a) Administrative review before the director:

(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, non-payment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review by the director.
(B) A party does not need to be represented to participate in the administrative review before the director.
(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

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

(2) Time Frames and Conditions.

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

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

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

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

(d) For claims not enrolled in an MCO, or for disputes which do not involve an action or decision of an MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 90-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

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

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

(3) Form and Required Information.

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

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

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

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

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

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

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

(A) The packet must include a complete, indexed copy of the worker's medical

record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document ten must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type: **We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).**

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

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

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

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

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

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

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

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

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

(5) Director Order and Reconsideration.

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

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

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

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

(6) Hearings.

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

(b) In the review of orders issued under ORS 656.245(3) or 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any

party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Board as follows:

(A) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.
(B) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.
(C) The division will forward the request and other pertinent information to the board.

(7) Other Proceedings.

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

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

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

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

436-009-0010 Medical Billing and Payment

(1) General.

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

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

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

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

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

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

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)

(a) Medical providers must bill within:

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

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

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

(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

(3) Billing Forms.

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

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

CMS 1500 form (Versions 08/05 or 02/12 for dates of service prior to Oct. 1, 2014; Version 02/12 for dates of service Oct. 1, 2014 or after) except for:

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

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

(C) Electronic billing transmissions of medical bills.

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

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

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2014, use ICD-9-CM codes, and on or after Oct. 1, 2014, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2014; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2014 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" to identify their services.
24I (shaded area)	See under box 24J shaded area.
24J (non-shaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the non-shaded area of box 24J, the shaded area of box 24I and 24J may be left blank.

	If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2014 or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

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

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2014 or the appropriate unlisted HCPCS code, and provide a description of the service provided.

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

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

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2014, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

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

following factors must be present:

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

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must bill using modifier "**81**" and document in the chart notes that they provided the medical service.

(7) Chart Notes.

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

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

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

(8) Challenging the Provider's Bill.

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

(9) Billing the Patient / Patient Liability.

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

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;
(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;
(C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;
(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or
(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

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

(10) Disputed Claim Settlement (DCS).

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

(11) Payment Limitations.

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

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

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing.

(12) Excluded Treatment.

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

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
(b) Intradiscal electrothermal therapy (IDET);

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

(13) Missed Appointment (No Show).

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

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

436-009-0018 Discounts and Contracts

(1) Medical Service Providers and Medical Clinics.

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

(2) Discounts.

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

(A) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or
(B) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

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

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

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

(3) Fee Discount Agreements.

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

(A) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;

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

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

(A) The insurer's name that will apply the discounts under the fee discount agreement;
(B) The medical service provider's or clinic's name;
(C) The effective date of the agreement;
(D) The end date of the agreement;
(E) The discount rate under the agreement and;
(F) An indication that all the terms required under section (3)(a) of this rule are included in the signed fee discount agreement.

(4) Fee Discount Agreement Modifications and Terminations.

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

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

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

(5) Other Medical Providers.

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

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

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

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

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

436-009-0020 Hospitals

(1) Inpatient.

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

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2014, ICD-9-CM codes, and on or after Oct. 1, 2014, ICD-10-CM codes;
(B) When applicable, procedural codes;
(C) The hospital's NPI; and
(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.

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

(2) Outpatient.

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

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

(A) Revenue codes;
(B) For dates of service prior to Oct. 1, 2014, ICD-9-CM codes, and on or after Oct. 1, 2014, ICD-10-CM and ICD-10-PCS codes;
(C) CPT® codes and HCPCS codes; and
(D) The hospital's NPI.

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

Revenue Code	**Pay Amount:**	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or The amount billed
All other revenue codes	• For hospitals listed in Bulletin 290, the amount billed multiplied by the cost to charge ratio. • For in-state hospitals not listed in Bulletin 290, 80% of the amount billed.	

(3) Specific Circumstances.

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

(4) Out-of-State Hospitals.

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

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

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

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

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

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

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

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

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

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

(e) The basic cost to charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

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

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

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

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

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

(k) Notwithstanding sections (1)(c), (2)(b), and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost to charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the

financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost to charge ratio.

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

436-009-0023 Ambulatory Surgery Center (ASC)

(1) Billing Form.

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

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

(2) ASC Facility Fee.

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

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

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

(3) ASC Billing.

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

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

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

(4) ASC Payment.

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

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

> **(A)** The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or
> **(B)** The ASC's usual fee for surgical procedures and ancillary services.

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

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

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

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

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

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

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

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

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

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

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

436-009-0025 Worker Reimbursement

(1) General.

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

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

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

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

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

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

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

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

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

(2) Timeframes.

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

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

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

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

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

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

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

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

(B) Within 14 days of claim acceptance:

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

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

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

(3) Meal and Lodging Reimbursement.

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

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

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

(4) Travel Reimbursement.

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

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

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

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

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

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

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

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

(5) Other Reimbursements.

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

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

(6) Advancement Request.

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

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

436-009-0030 Insurer's Duties and Responsibilities

(1) General.

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

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

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

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

(2) Bill Processing.

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

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

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

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

(3) Payment Requirements.

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

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

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

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

"To access information about Oregon's Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.";
(E) Space for the provider's signature and date; and
(F) A notice of right to administrative review as follows:
"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

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

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

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

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

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

(4) Communication with Providers.

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

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

(5) EDI Reporting.

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

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

436-009-0035 Interim Medical Benefits

(1) Interim medical benefits cover the patient's co-pays and deductibles for certain services on denied workers' compensation claims. These benefits only apply when the patient has a health benefit plan(s), i.e., the patient's private health insurance(s). For the purpose of this rule the Oregon Health Plan is not a health benefit plan.

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

(a) When the patient is enrolled in an MCO prior to claim acceptance under ORS 656.245(4)(b)(B); or
(b) When the insurer denies the claim within 14 days of the employer's notice.

(3) Interim medical benefits cover services provided from the date of injury to the date the insurer denies the claim and include:

(a) Diagnostic services required to identify appropriate treatment or prevent disability;
(b) Medication required to alleviate pain; and
(c) Services required to stabilize the patient'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.

(4) The medical provider must bill the workers' compensation insurer according to these rules, and the health benefit plan according to the plan's requirements.

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

(6) Once the claim is denied, the medical provider must bill the health benefit plan and include a copy of the workers' compensation denial letter.

(7) After the health benefit plan issues payment, the medical provider should bill the workers' compensation insurer, according to these rules, for the remaining balance. The

medical provider must include a copy of the health benefit plan's explanation of benefits (EOB) with the bill. For the purpose of this rule an explanation of benefits (EOB) has the same meaning as an explanation of review (EOR).

(8) If the medical provider knows that the patient filed a work related claim, the medical provider may not collect any health benefit plan co-pay from the patient.

(9) Once the workers' compensation insurer receives the bill with the health plan's explanation of benefits (EOB), they have 45 days to pay any amount not paid by the health plan up to the workers' compensation fee schedule.

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
Amended 12/15/08 as Admin. Order 08-063, eff. 1/1/09
Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14

436-009-0040 Fee Schedule

(1) Fee Schedule Table.

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

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

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

(2) Anesthesia.

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

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

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

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

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

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

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

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

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

(3) Surgery.

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

(a) One surgeon

Procedures	**Appendix B lists:**	**The payment amount is:**	
Principal procedure	A dollar amount	The lesser of:	The amount in Appendix B; or
			The amount billed
	80% of billed	80% of billed	
Any additional procedures* including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	50% of the amount in Appendix B; or
			The amount billed
	80% of billed	40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.			

(b) Two or more surgeons

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount for each surgeon is:</th></tr>
<tr><td rowspan="3">Each surgeon performs a principal procedure (and any additional procedures)

Any additional procedures including:
• diagnostic arthroscopy performed prior to open surgery
• the second side of a bilateral procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or</td></tr>
<tr><td>The amounts billed</td></tr>
<tr><td>80% of billed</td><td colspan="2">60% of the billed amount (and 30% of the amount billed for any additional procedures*)
(unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)</td></tr>
<tr><td colspan="4">*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.</td></tr>
</table>

(c) Assistant surgeons

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount is:</th></tr>
<tr><td rowspan="3">One or more surgical procedures</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>20% of the surgeon(s) fee calculated in subsections (a) or (b); or</td></tr>
<tr><td>The amount billed</td></tr>
<tr><td>80% of billed</td><td colspan="2">20% of the surgeon(s) fee calculated in subsections (a) or (b)</td></tr>
</table>

(d) Nurse practitioners or physician assistants

Procedures	**Appendix B lists:**	**The payment amount is:**	
One or more surgical procedures as the primary surgical provider	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The amount billed
	80% of billed	85% of the surgeon(s) fee calculated in subsections (a) or (b)	
One or more surgical procedures as the surgical assistant	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The amount billed
	80% of billed	15% of the surgeon(s) fee calculated in subsections (a) or (b)	
*Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.			

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

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

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

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

(4) Radiology Services.

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

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

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

(5) Pathology and Laboratory Services.

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

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

(6) Physical Medicine and Rehabilitation Services.

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

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

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

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

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

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

(7) Reports.

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

for their report or review of the records using CPT® codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.

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

(8) Nurse Practitioners and Physician Assistants.

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

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

436-009-0060 Oregon Specific Codes

(1) Multidisciplinary Services.

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

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

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

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

(2) Table of all Oregon Specific Codes

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

Service	OSC
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002
Director required medical exam or review time: Services by a physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate up to 6 hours for record review and exam.	P0001
Director required medical report:	P0003

Service	OSC
Preparation and submission of the report.	
Director required review - complex case fee: Preauthorized fee by the director for an extensive review in a complex case.	P0004
Director required exam – failure to appear: Patient fails to appear for a director required exam.	P0005
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (Independent medical exam): Report, addendum to a report, a file review, or an exam.	D0003
IME – review and response: Insurer requested review and response by treating physician; document time spent.	D0019
Interdisciplinary Rehabilitation Conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits.	97655
Interdisciplinary Rehabilitation Conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits.	97656
Interdisciplinary Rehabilitation Conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits.	97657
Interdisciplinary Rehabilitation Conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference-up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – other than ASL	D0004
Interpreter services – American Sign Language (ASL)	D0005
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671

Service	OSC
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status, and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (Physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE shall be paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.	99196
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE must be paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643

Service	OSC
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
Professional Case Management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual - each additional 30 minutes	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Vocational evaluation - 30 minutes: Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options.	97662
Vocational evaluation - each additional 15 minutes	97663
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
WCE (Work capacity evaluation): This is a residual functional capacity evaluation, which generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE must be paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety,	97646

Service	OSC
physical tolerance and work behaviors.	
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (Worker requested medical exam): Exam and report.	W0001

(3) CARF / JCAHO Accredited Programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

436-009-0090 Pharmaceutical

(1) General.

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

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

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

(2) Pharmaceutical Billing and Payment.

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

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

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

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

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

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

(3) Clinical Justification Form 4909.

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

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

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

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

(4) Dispensing by Medical Service Providers.

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

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

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

436-009-0110 Interpreters

(1) Choosing an Interpreter.

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

(2) Billing.

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

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

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

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

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

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

(3) Billing and Payment Limitations.

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

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

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

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

(4) Billing Timelines.

(a) Interpreters must bill within:
(A) 60 days of the date of service;
(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.

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

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

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

(5) Billing Form.

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

- D0004 for interpreter services except American Sign Language,
- D0005 for American Sign Language interpreter services, and
- D0041 for mileage.

(b) An interpreter's invoice must include:

(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;
(B) The patient's name;
(C) The patient's workers' compensation claim number, if known;
(D) The correct Oregon specific codes for the billed services (D0004 or D0041);
(E) The workers' compensation insurer's name and address;
(F) The date interpreter services were provided;
(G) The name and address of the medical provider that conducted the exam or provided treatment;
(H) The total amount of time interpreter services were provided; and
(I) The mileage, if the round trip was 15 or more miles.

(6) Payment Calculations.

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

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

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

(7) Payment Requirements.

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

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

(c) The insurer must pay the interpreter within:

(A) 14 days of the date of claim acceptance or any action causing the service to be payable, or 45 days of receiving the invoice, whichever is later; or
(B) 45 days of receiving the invoice for an exam required by the insurer or director.

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

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

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

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

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

(i) Electronic and written explanations must include:

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

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

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

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

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

436-009-0998 Sanctions and Civil Penalties

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

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

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

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

(5) If a prescribing provider fails to submit Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, to the insurer, in accordance with OAR 436-009-0090(3)(a), the insurer may file a complaint with the director.

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

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

	HOSPITAL NAME	NPI	ALT NPI	SECOND ALT NPI
1	Adventist Medical Center	1801887658		
2	Ashland Community Hospital*	1386644029	.	.
3	Bay Area Hospital – Coos Bay	1225016561	.	.
4	Good Samaritan Regional Medical Center - Corvallis	1962453134	.	.
5	Holy Rosary Medical Center – Ontario*	1891891792	.	.
6	Kaiser Sunnyside Medical Center	1124182902	.	.
7	Kaiser Westside	1891048807		
87	Legacy Emanuel Hospital & Health Center	1831112358	1295756898	.
98	Legacy Good Samaritan Hospital & Medical Center	1780608216	.	.
109	Legacy Meridian Park Hospital	1184647620	.	.
110	Legacy Mt. Hood Medical Center	1255354700	.	.
121	McKenzie-Willamette Medical Center – Springfield	1568413573	1528006301	.
132	Mercy Medical Center – Roseburg*	1477590198	1134161391	.
143	Mid Columbia Medical Center – The Dalles*	1306842752	.	.
154	Oregon Health & Science University Hospital	1609824010	1376873570	1548272511
165	Providence Medford Medical Center	1689755670	.	.
176	Providence Milwaukie Hospital	1366536963	.	.
187	Providence Newberg Hospital*	1952482275	.	.
198	Providence Portland Medical Center	1003991845	.	.
2019	Providence St. Vincent Medical Center	1114015971	1083866933	.
210	Rogue Valley Medical Center – Medford	1770587107	1427277086	.
221	Sacred Heart Medical Center Riverbend – Springfield	1083888515	1881928067	.
232	Sacred Heart Medical Center University Dist. – Springfield	1346237971	1164595617	.
243	Salem Hospital	1265431829	1114197894	.
254	Samaritan Albany General Hospital	1154372340	.	.
265	Santiam Memorial Hospital – Stayton*	1154302214	.	.
276	Silverton Hospital	1669424354	.	.
287	Sky Lakes Medical Center – Klamath Falls	1811130149	1659340370	.
298	St. Charles Medical Center – Bend	1982621447	1598839789	.
3029	St. Charles Medical Center – Redmond*	1225056146	.	.
310	Three Rivers Community Hospital – Grants Pass*	1801891809	1598895690	.
321	Tuality Community Hospital – Hillsboro	1275591984	1336228659	.
332	Willamette Falls Hospital – Oregon City	1639108434	.	.
343	Willamette Valley Medical Center – McMinnville *	1346269982	.	.

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

Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

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

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers. [Effective April 1, ~~2013~~2014]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective April 1, ~~2013~~2014]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective April 1, ~~2013~~2014]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, ~~2013~~2014]

Note: If the above links do not connect you to the department's website, click: http://www.cbs.state.or.us/external/wcd/policy/rules/disclaimer.html
If you have questions, call the Workers' Compensation Division, 503-947-7606.

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright ~~2012~~ 2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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

Link to the Maximum Allowable Payment Tables: http://www.cbs.state.or.us/wcd/policy/rules/disclaimer.html
Or, contact the division for a paper copy, 503-947-7717

Appendix F - Matrix for health care provider types* See OAR 436-009-0005

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

* This matrix does not apply to Managed Care Organizations

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 benefits 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
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10

436-009-0003 Applicability of Rules

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

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

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

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the *American Society of Anesthesiologists ASA, Relative Value Guide* 2013 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the *ASA Relative Value Guide 2013*, contact the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, 847-825-5586, or on the web at: http://www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) *Current Procedural Terminology (CPT®* 2013), Fourth Edition Revised, 2012, for billing by medical providers. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's *CPT® Assistant*, Volume 0, Issue 04 1990 through Volume 22, Issue 12, 2012. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual is the controlling resource.

(4) To get a copy of the *CPT® 2013* or the *CPT® Assistant*, contact the American Medical Association, 515 North State Street, Chicago, IL60610, 800-621-8335, or on the web at: http://www.ama-assn.org.

(5)The director adopts, by reference, only the alphanumeric codes from the CMS *Healthcare Common Procedure Coding System* (HCPCS) 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.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS

edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

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

(6) The director adopts, by reference, CDT 2013: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or on the web at: www.ada.org.

(7) The director adopts, by reference, *versions 8.0 7/12 and v1.1 0613 0212 of the 1500 Health Insurance Claim Form Reference Instruction Manuals* published by the National Uniform Claim Committee (NUCC). To get a copy, contact the NUCC, American Medical Association, 515 N. State St., Chicago, IL 60654, or on the web at: www.nucc.org.

(8) The director adopts, by reference, the *Official UB-04 Data Specifications Manual 2012 Edition*, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, One North Franklin, 29th Floor, Chicago, IL 60606, 312-422-3390, or on the web at: www.nubc.org.

(9) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2013, CPT® 2013, CPT® Assistant, HCPCS 2013, CDT 2013; Dental Procedure Codes, 1500 Health Insurance Claim Form Reference Instruction Manual, or Official UB-04 Data Specifications Manual 2012 Edition.

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

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

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) "Clinic" means a group practice in which several medical service providers work cooperatively.

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

(4) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; an assigned claims agent selected by the director under ORS 656.054; or, an employer or employer

group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

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

(6) 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) EDI means electronic data interchange.

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

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

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

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

(j) NPI means National Provider Identifier.

(k) OSC means Oregon specific code.

(l) PCE means physical capacity evaluation.

(m) WCE means work capacity evaluation.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.726(4)
Hist: Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11

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, 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:~~

~~(A) A worker must request administrative review by the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services.~~

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

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

~~(D) 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 12/15/08 as Admin. Order 08-063, eff. 1/1/09
Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10

436-009-0010 General Requirements for Medical Billings

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

(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 provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. All medical providers must submit bills to the insurer or, if provided by their contract for medical services, to the managed care organization. Medical providers must submit bills 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 that 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® 2013 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 or dental 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) If there is no specific code for the medical service, the medical service provider must use the appropriate unlisted code from HCPCS or the unlisted code at the end of each medical service section of CPT® 2013 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 provider must establish good cause when submitting a bill later than outlined in subsection (a) of this section. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.~~

~~(c) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing. When a provider submits a bill over 12 months after the date of service, the bill is not payable, except when a provision of subsection (a) of this section is the reason the billing was submitted after 12 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 must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.~~

~~(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 2/16/12 as Admin. Order 12-050, eff. 4/1/12~~
~~Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13~~

~~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 must 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 180-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).~~

~~(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)(e), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider must 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 (electromyography) tests;~~

~~(d) Rolfing;~~

~~(e) Prolotherapy;~~

~~(f) Thermography;~~

~~(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:~~

~~(A) The single level artificial disc replacement is between L3 and S1;~~

~~(B) The injured worker is 16 to 60 years old;~~

~~(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(14) or (15); and~~

~~(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:~~

~~(A) The single level artificial disc replacement is between C3 and C7;~~

~~(B) The injured worker is 16 to 60 years old;~~

~~(C) The injured worker underwent unsuccessful conservative treatment;~~

(D) There is intraoperative visualization of the surgical implant level; and

(E) The procedure is not found inappropriate under OAR 436-010-0230(16) or (17).

(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 must 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 must 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 must 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 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 11/12/13 as Admin. Order 13-058, eff. 1/1/14

436-009-0018 Fee Discount Agreements

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

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

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

~~(2) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule.~~

~~(3) An insurer may not apply a discount under a fee discount agreement until the medical service provider or clinic and the insurer have signed the fee discount agreement. Parties to the fee discount agreement must use Form 440-3659. The form must be reproduced on the medical service provider's or clinic's letterhead. The agreement must include the following:~~

~~(a) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;~~

~~(b) The effective and end dates of the agreement;~~

~~(c) The discount rate or rates under the agreement;~~

~~(d) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a worker receives;~~

~~(e) A statement that the agreement only applies to patients being treated for Oregon workers' compensation claims;~~

~~(f) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties.~~

~~(g) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;~~

~~(h) The name and address of the singular insurer or self-insured employer that will apply the discounts;~~

~~(i) The National Provider Identifier for the provider or clinic; and~~

~~(j) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.~~

~~(4) Once the fee discount agreement has been signed by the medical service provider or clinic and the insurer, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:~~

~~(a) The insurer's name that will apply the discounts under the fee discount agreement;~~

~~(b) The medical service provider's or clinic's name;~~

~~(c) The effective date of the agreement;~~

~~(d) The end date of the agreement;~~

~~(e) The discount rate under the agreement and;~~

~~(f) An indication that all the terms required under section (3) of this rule are included in the signed fee discount agreement.~~

~~(5) When the medical service provider or clinic and the insurer agree to changes under an existing fee discount agreement, the parties must enter into a new fee discount agreement. Bulletin 352 provides further information on the required form.~~

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

(a) The insurer's name;

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

(c) The termination date of the agreement.

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

436-009-0020 Hospital Fees

(1) For the purposes of this rule:

(a) Hospital bills for inpatient services are those bills coded "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital bills for outpatient services are those bills coded "0131" through "0138" in form locator #4 on the UB-04 billing form.

(2) Hospital inpatient bills must include:

(a) ICD-9-CM codes;

(b) When applicable, procedural codes;

(c) The hospital's NPI; and

(d) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.

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

(a) Revenue codes;

(b) ICD-9-CM diagnostic and procedural codes;

(c) CPT® codes and HCPCS codes; and

(d) The hospital's NPI.

(4) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost/charge ratio (See Bulletin 290).

(5) The insurer must pay for hospital outpatient services as follows:

(a) For services by physicians and other medical service providers assigned a code under the CPT® and identified by the revenue codes indicating professional services (0960 through 0989), pay the lesser of:

(A) The amount assigned to the CPT® in the Facility Maximum column of Appendix B; or

~~(B) The amount charged.~~

~~(b) For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology) pay the lesser of:~~

~~(A) The amount assigned to the CPT® code or the Oregon Specific Code in the Non-Facility Maximum column of Appendix B; or~~

~~(B) The amount charged.~~

~~(c) For outpatient imaging services assigned a code under the CPT® and identified by the revenue codes 0320 through 0359, 0400 through 0409, or 0610 through 0619, pay the lesser of:~~

~~(A) The amount assigned to the CPT® code in the Non-Facility Maximum column of Appendix B; or~~

~~(B) The amount charged.~~

~~(d) For hospital outpatient services not paid under subsection (5)(a), (b), or (c) of this rule, unless otherwise provided by contract, pay the amount charged multiplied by the hospital's adjusted cost/charge ratio (See Bulletin 290).~~

~~(6) If a hospital qualifies for a rural exemption under (7)(k), the insurer may only apply an MCO contract to discount the fees calculated under this rule.~~

~~(7) 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 (7)(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 (7)(c) and (7)(d) of this rule will be added to the ratio calculated in subsection (7)(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 (3), (4), and (5) 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. All rural hospitals having a financial

flexibility index at or below the median for critical access hospitals nationwide will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital 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; 656.252; 656.256
Hist: Amended 3/1/11 as Admin. Order 11-050, eff. 4/1/11
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13

436-009-0025 Reimbursement of Related Services Costs

(1) The insurer must 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 must date stamp requests for reimbursement upon receipt and must 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 must 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 must be returned to the worker within 14 days.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle must be reimbursed as provided in this section. The maximum rate of reimbursement is limited to the rate 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 must be returned to the worker within 30 days of the date of receipt by the insurer. The insurer must provide the worker an explanation of the reason for nonpayment or reduced payment 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 must 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)
Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13

436-009-0030 Insurer's Duties and Responsibilities

(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 under 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 according to 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 according to OAR 436-009-0010(2) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was 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, does 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. This includes all bills submitted to the insurer even when the insurer determines no payment is due.~~

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

~~(c) When a medical provider submits a bill electronically, it is considered "mailed" according to OAR 436-010-0005.~~

~~(4) The insurer or its representative must provide a written explanation of benefits being paid or denied. The insurer or its representative must send the explanation to the medical provider that billed for the services. All information on the explanation must be in 10 point size font or larger.~~

~~(5) The explanation of benefits must include:~~

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

~~(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;~~

~~(c) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within 48 hours, excluding weekends and legal holidays;~~

~~(d) The following notice, web link, and phone number:~~

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

~~(e) Space for a signature and date; and~~

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

~~(6) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the medical provider's inquiry. The insurer or its representative may not refer the medical provider to another~~

~~entity to obtain an answer.~~

~~(7) An insurer or its representative and a medical service provider may agree to send and receive payment information by e-mail. Electronic records sent by e-mail are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.~~

~~(8) 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.~~

~~(9) 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.~~

~~(10) 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. Resolution of billing disputes, including possible overpayment disputes, must be made under OAR 436-009-0008, 436-010-0008 and 436-015.~~

~~(11) 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.~~

~~(12) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills. The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.~~

~~(13) 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.~~

~~(14) For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.~~

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

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 (10).

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
Amended 12/15/08 as Admin. Order 08-063, eff. 1/1/09

436-009-0040 Calculating Medical Provider Fees

(1) Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay for medical services the lesser of:

(a) The maximum allowable payment amount for CPT® codes, HCPCS codes, and Oregon Specific Codes listed in Appendix B of these rules; or

(b) The provider's usual fee.

~~(2) Unless otherwise provided by contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee when:~~

~~(a) Appendix B does not establish a maximum payment amount and the code is designated "80% of billed";~~

~~(b) The fee schedule does not establish a fixed, maximum payment amount (e.g., certain medical supplies); or~~

~~(c) The service is not covered by the fee schedule.~~

~~(3) Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay 90 percent of the provider's usual fee for dental services billed with dental HCPCS codes.~~

~~(4) Unless otherwise provided by contract, the insurer must pay the provider's usual fee for ambulance services billed with the following HCPCS codes: A0425, A0426, A0427, A0428, A0429, A0433, and A0434.~~

~~(5) For services payable under section (2), (3), or (4) of this rule, for hospital outpatient charges, or for services payable "as billed," an insurer may only 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.~~

~~(6)(a) When using Appendix B for calculating payment for CPT® codes, the maximum allowable payment column is determined by the location where the procedure is performed: If the procedure is performed inside the medical service provider's office, use the Non-Facility Maximum column; if the procedure is performed outside the medical service provider's office, use the Facility Maximum column. Use the Global Days column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Non-Facility Maximum column.~~

~~(b) When an Oregon specific code is assigned, the maximum allowable payment for multidisciplinary program and other services is found at the end of Appendix B, and in OAR 436-009-0060(5) and OAR 436-009-0070(13).~~

~~(7) 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. The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $58.00.~~

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

~~(A) The maximum allowable payment amount for anesthesia codes; or~~

~~(B) The provider's usual fee.~~

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

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

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® must 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 must 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) must 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 must 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 must 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 must be billed separately. The maximum allowable fee for each procedure, as listed in these rules, must 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) The multiple surgery discount described in this subsection does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.~~

~~(F) When a surgical procedure is performed bilaterally, the modifier "50" must be noted on the bill for the second side, and paid at 50 percent of the fee allowed for the first side.~~

~~(d) When physician assistants or nurse practitioners assist a surgeon performing surgery, they must be paid at the rate of 15 percent of the surgeon's allowable fee for the surgical procedure(s). When physician assistants or nurse practitioners are the primary providers of a surgical procedure, they must be paid at the rate of 85 percent of a physician's allowable fee for a comparable service. Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.~~

~~(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician must be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The operation report must 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 must 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 maximum allowable payment amount established in Appendix B applies only when there is direct physician involvement.~~

~~(b) Laboratory fees must 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 must 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) Time-based CPT codes must be billed and paid according to this table:~~

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

~~(b) Payment for modalities and therapeutic procedures is 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 or the amount of time spent providing the treatment.~~

~~(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 one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be one charge.~~

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

~~436-009-0060~~ Oregon Specific Code (OSC), Multidisciplinary Services

~~(1) Services provided by multidisciplinary programs not otherwise described by CPT®~~

~~codes must be billed under Oregon specific codes.~~

~~(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.

OSC	Maximum Allowable Payment Amount	Description
97642	$61.88	Physical conditioning - group - 1 hour Conditioning exercises and activities, graded and progressive
97643	$31.28	Each additional 30 minutes
97644	$98.60	Physical conditioning – individual 1 hour Conditioning exercises and activities, graded and progressive
97645	$49.64	Each additional 30 minutes
97646	$61.88	Work simulation - group 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors
97647	$31.28	Each additional 30 minutes
97648	$102.00	Work simulation - individual 1 hour Real or simulated work activities addressing productivity, safety, physical tolerance and work behaviors
97649	$51.00	Each additional 30 minutes
97650	$55.08	Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals
97651	$27.88	Each additional 15 minutes
97652	$36.72	Therapeutic education - group 30 minutes Medical, psychosocial, nutritional and vocational education dependent on needs and stated goals
97653	$19.04	Each additional 15 minutes
97654	$27.88	Professional Case Management – Individual 15 minutes Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician)
97655	$26.52	Brief Interdisciplinary Rehabilitation Conference - 10 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits
97656	$53.04	Intermediate Interdisciplinary Rehabilitation Conferences - 20 minutes A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, and time frames and expected benefits
97657	$91.80	Complex Interdisciplinary Rehabilitation Conferences – 30 minutes

OSC	Maximum Allowable Payment Amount	Description
		A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames and expected benefits
97658	$46.24	Each additional 15 minutes Complex conference-up to 1 hour maximum
97659	$116.96	Job site visit - 1 hour (includes travel) - must be preauthorized by insurer A work site visit to identify characteristics and physical demands of specific jobs
97660	$58.48	Each additional 30 minutes
97661	$157.76	Ergonomic consultation - 1 hour (includes travel) - must be preauthorized by insurer Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications
97662	$63.92	Vocational evaluation - 30 minutes Evaluation of work history, education and transferable skills coupled with physical limitations in relationship to return to work options
97663	$31.96	Each additional 15 minutes
97664	$86.36	Nursing evaluation - 30 minutes Nursing assessment of medical status and needs in relationship to rehabilitation
97665	$42.84	Each additional 15 minutes
97666	$69.36	Nutrition evaluation - 30 minutes Evaluation of eating habits, weight and required modifications in relationship to rehabilitation
97667	$35.36	Each additional 15 minutes
97668	$72.76	Social worker evaluation - 30 minutes Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome
97669	$36.72	Each additional 15 minutes
97670	$455.60	Initial Multidisciplinary conference - up to 30 minutes
97671	$514.08	Initial Complex Multidisciplinary conference - up to 60 minutes

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 5/27/10 as Admin. Order 10-052, eff. 7/1/10
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0070 Oregon Specific Code, Other Services

(1) Except for records required in OAR 436-009-0010(3), copies of requested medical

~~records must be paid under OSC R0001 or R0002.~~

~~(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, must 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, must be paid under OSC N0002.~~

~~(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested and performed:~~

~~(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 generally requires 30 to 45 minutes of actual patient contact. A first level PCE shall be paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report.~~

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

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

~~(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) A closing examination is a medical evaluation to measure impairment, which occurs when the worker's condition is medically stationary.~~

~~(a) For the closing examination, bill using OSC CE001;~~

~~(b) For the closing report, use OSC CR001.~~

~~(6) When an attorney requires a consultation with a medical provider, the medical provider must bill under OSC D0001. Unless otherwise provided by contract, insurers must pay for attorney consultation time as billed.~~

~~(7) When an insurer requires a consultation with a medical provider, the medical provider must bill under OSC D0030. Unless otherwise provided by contract, insurers must pay for insurer consultation time as billed.~~

~~(8) The fee for a deposition must be billed under OSC D0002. This code should include time for preparation, travel, and deposition. Unless otherwise provided by contract, insurers must pay for deposition time as billed. 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.~~

~~(9) When an insurer obtains an Independent Medical Examination (IME):~~

~~(a) The medical service provider doing the IME must bill under OSC D0003. This code must be used for a report, addendum to a report, file review, or examination.~~

~~(b) Notwithstanding 436-009-0010(2), a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and the medical service provider.~~

~~(c) Unless otherwise provided by contract, insurers must pay for IMEs as billed.~~

~~(d) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. Billing should include documentation of time spent. Unless otherwise provided by contract, insurers must pay for medical service providers' review and response to IME reports as billed.~~

~~(10) Fees for all arbiters and panel of arbiters used for director reviews under OAR 436-030-0165 will 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 will 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 will 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 must be paid under OAR 436-009.~~

~~(h) Should an advance of costs be necessary for the worker to attend a medical arbiter exam, a request for advancement must 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 must 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, must be paid at an hourly rate up to a maximum of six 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 must 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 must each receive payment based on an hourly rate up to a maximum of six hours for record review and panel examination. Each physician must bill for the record review and panel examination under OSC P0002. The panel member who prepares and submits the panel report must 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 must be billed under OSC P0004.

(d) An insurer may not discount or reduce fees related to examinations or reviews performed by medical providers under OAR 436-010-0330.

(e) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician must 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.

(f) 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 must 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 must 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 must be billed under OSC W0001. This code must be used for a report, file review, or examination. Unless otherwise provided by contract, the insurer must pay the provider at the billed amount.

(13) The table below lists the Oregon specific codes for other services.

OSC	**Maximum Allowable Payment Amount**	**Description**
R0001		Copies of medical records when requested must be paid at $10.00 for the first page and $.50 for each page thereafter and identified on billings
R0002	$35.00	Copies of medical records in an electronic format such as a CD.

~~OSC~~	~~Maximum Allowable Payment Amount~~	~~Description~~
~~N0001~~	~~$116.28~~	~~Brief narrative by the attending physician or authorized nurse practitioner~~
~~N0002~~	~~$231.88~~	~~Complex narrative by the attending physician or authorized nurse practitioner~~
~~99196~~	~~$163.20~~	~~First Level PCE~~
~~99197~~	~~$544.00~~	~~Second Level PCE~~
~~99198~~	~~$1088.00~~	~~WCE~~
~~99193~~	~~$54.40~~	~~Additional 15 minutes~~
~~CE001~~	~~80% of billed~~	~~Closing examination~~
~~CR001~~	~~80% of billed~~	~~Closing report~~
~~D0001~~	~~as billed~~	~~Attorney consultation time~~
~~D0002~~	~~as billed~~	~~Deposition time~~
~~D0003~~	~~as billed~~	~~Independent medical examination (IME), file review, report, or addendum to report~~
~~D0019~~	~~as billed~~	~~Medical service provider review and response to IME report~~
~~D0030~~	~~as billed~~	~~Insurer consultation time~~
~~AR001~~	~~$348.16~~	~~Level 1 arbiter exam~~
~~AR002~~	~~$463.76~~	~~Level 2 arbiter exam~~
~~AR003~~	~~$580.04~~	~~Level 3 arbiter exam~~
~~AR004~~	~~$174.08~~	~~Limited arbiter exam~~
~~AR011~~	~~$59.84~~	~~Level 1 arbiter report~~
~~AR012~~	~~$89.76~~	~~Level 2 arbiter report~~
~~AR013~~	~~$120.36~~	~~Level 3 arbiter report~~
~~AR021~~	~~$59.84~~	~~Level 1 arbiter file review~~
~~AR022~~	~~$150.28~~	~~Level 2 arbiter file review~~
~~AR023~~	~~$360.40~~	~~Level 3 arbiter file review~~
~~AR024~~	~~$695.64~~	~~Level 4 arbiter file review~~
~~AR025~~	~~$928.20~~	~~Level 5 arbiter file review~~
~~AR031~~	~~$59.84~~	~~Limited arbiter report~~
~~AR032~~	~~$120.36~~	~~Complex arbiter report~~
~~P0001~~	~~$290.36~~	~~Director single medical review/exam~~
~~P0002~~	~~$290.36~~	~~Director panel medical review/exam~~
~~P0003~~	~~$290.36~~	~~Director single medical review/report~~
~~P0004~~	~~$348.16~~	~~Director complex case review/exam~~
~~P0005~~	~~$147.56~~	~~Failure to appear director required examination~~
~~W0001~~	~~as billed~~	~~Worker requested medical examination and report~~

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

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

(1) Durable medical equipment (DME) is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and 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.

(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.

(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.

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

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

(a) NU for purchased, new equipment;

(b) UE for purchased, used equipment; and

(c) RR for rented equipment

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

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

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

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

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

(a) When an item is rented on a daily basis, the maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13 month rental period, with a credit of 75 percent of the rental paid going towards the purchase.

(9) For items purchased, unless otherwise provided by contract:

(a) The 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. The insurer must pay for labor at the provider's usual rate; or

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

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

(b) Based on current technology, the preferred types of hearing aids for most workers are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (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) Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $5000 for a pair of hearing aids, or $2500 for a single hearing aid.

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

~~(12) The worker may select the service provider, except for claims enrolled in a managed care organization (MCO) when service providers are specified by the MCO contract.~~

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

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

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

~~436-009-0090~~ Pharmacy Fees

~~(1) Except for hospital charges or unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the 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 or the prescribing provider has specified that the drug may not be substituted with a generic equivalent~~	~~83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee~~
~~A brand name drug 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~~

~~(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) (a)Unless the prescription is for five days or less, the prescribing provider must submit a clinical justification for the following drugs:~~

~~(A) Celebrex®~~

~~(B) Cymbalta®~~

~~(C) Fentora®~~

~~(D) Kadian®~~

~~(E) Lidoderm®~~

~~(F) Lyrica®~~

~~(G) OxyContin®~~

~~(b) The prescribing provider must fill out the clinical justification on Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, and submit it to the insurer.~~

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

~~(d) The prescribing provider is not required to fill out an additional Form 4909 for refills of that medication.~~

~~(5) Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the requirements of the provider's licensing board.~~

~~(6) Insurers must use the prescription pricing guide First DataBank published by Hearst Corporation, RED BOOK published by Thomson Reuters, or Medi-Span published by Wolters Kluwer for calculating payments to the licensed provider. Insurers must update their source at least monthly.~~

~~(7) 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.~~

~~(8) Except for sections 2, 3, 4 and 7 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.~~

~~(9) The insurer must pay the retail-based fee for over-the-counter medications.~~

~~(10) Drugs dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.~~

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

~~436-009-0095~~ Application of Fee Discounts

~~If a medical fee is covered by multiple contracts allowed under these rules, the insurer may apply only one discount to the provider's fee. If a provider's fee is covered by multiple contracts, and one of the contracts is with a certified managed care organization for services provided to an enrolled worker, only the discount under the managed care organization's contract must be applied.~~

~~Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248~~
~~Hist: Adopted 12/15/08 as WCD Admin. Order 08-063, eff. 1/1/09~~

Interpreter Billing Procedures

436-009-0110 Definitions for OAR 436-009-0110 through 436-009-0145

(1) "Interpreter" means a person who:

(a) Provides oral or sign language translation; and

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

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

(3) "Mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location.

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

436-009-0114 Who May Choose a Person to Provide Interpreter Services?

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

Stat. Auth: ORS 656.726(4); Stats. Implemented: ORS 656.245
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/11

436-009-0115 Who Do Interpreters Bill for Providing Interpreter Services?

(1) Interpreters may only bill an insurer or, if provided by contract, a managed care organization.

(2) Interpreters may only bill a patient if the insurer denies the claim.

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

436-009-0120 What May Interpreters Bill for?

(1) Interpreters may bill for:

(a) Interpreter services; and

(b) Mileage when the round-trip mileage is 15 or more miles.

(2) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage under section (1) of this rule even if:

(a) The patient fails to attend the appointment; or

(b) The provider has to cancel or reschedule the appointment.

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

436-009-0125 When May Interpreters Not Bill?

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

(a) The patient fails to attend the appointment: or

(b) The provider cancels or reschedules the appointment.

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

436-009-0130 How Do Interpreters Bill for Interpreter Services and Mileage?

Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code D0004 for interpreter services and D0041 for mileage.

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

436-009-0135 What Must Interpreters Include On An Invoice?

An interpreter's invoice must include:

(1) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;

(2) The patient's name;

(3) The patient's workers' compensation claim number, if known;

(4) The correct Oregon specific codes for the billed services (D0004 or D0041);

(5) The workers' compensation insurer's name and address;

(6) The date interpreter services were provided;

(7) The name and address of the medical provider that conducted the exam or provided treatment;

(8) The total amount of time interpreter services were provided; and

(9) The mileage, if the round trip was 15 or more miles.

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

436-009-0140 How Much May an Interpreter Charge?

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

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

436-009-0145 When Must Interpreters Submit Their Invoice?

(1) Interpreters must send their invoice to the workers' compensation insurer within 60 days of the later of:

(a) The first date of service listed on the invoice; or

(b) The date the interpreter knew or should have known the patient filed a workers' compensation claim.

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

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

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

Interpreter Services and Mileage – Payment Calculations

436-009-0155 What are the Maximum Allowable Payment Amounts for Interpreter Services and Mileage?

Insurers must use the following table to calculate the maximum allowable payment:

For:	The maximum payment is:
Interpreter services of an hour or less	$ 60.00
Interpreter services of more than one hour	$1.00 per minute
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	$0.50 per mile
An examination required by the director or insurer which the patient fails to attend	$60.00 no show fee plus payment for mileage if 15 or more miles round trip
An examination required by the director or the insurer when the provider cancels or reschedules	$60.00 no show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage

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

Interpreter Services – Payment Requirements

436-009-0160 What Must the Insurer Pay for?

(1) When the medical exam or treatment is directed to an accepted claim or condition, the insurer must pay for:

(a) Interpreter services provided by an interpreter; and

(b) Mileage if the round-trip mileage is15 or more miles.

(2) When the patient fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay:

(a) The no-show fee; and

(b) Mileage if the round-trip mileage is 15 or more miles.

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

436-009-0165 How Much Do Insurers Have to Pay for Interpreter Services and Mileage?

Unless otherwise provided by contract, insurers must pay the lesser of:

(1) The maximum allowable payment amount; or

(2) The interpreter's usual fee.

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

436-009-0170 When Must the Insurer Pay an Interpreter?

The insurer must pay the interpreter within:

(1) 45 days of receiving the invoice for an exam required by the insurer or director; or

(2) 14 days of the date of claim acceptance, or 45 days of receiving the invoice, whichever is later.

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

436-009-0175 What If the Interpreter's Invoice Does Not Provide All the Information the Insurer Needs in Order to Process the Invoice?

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

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

436-009-0177 What If the Insurer Disagrees With the Interpreter's Invoice?

If the insurer disagrees with the amount of the interpreter's invoice, the insurer must, within 45 days, pay the undisputed portion of the invoice and at the same time provide specific reasons for non-payment or reduction of either interpreter services or mileage.

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

436-009-0180 What Must the Insurer Include on an Explanation of Benefits?

(1) The insurer must provide a written explanation for services paid or denied and must send the explanation to the interpreter that billed for the services. All the information on the explanation must be in 10 point size font or larger.

(2) The explanation must include:

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

~~(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;~~

~~(c) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within 48 hours, excluding weekends and legal holidays;~~

~~(d) The following notice, web link, and phone number:~~

~~**"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";**~~

~~(e) Space for a signature and date; and~~

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

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

~~(3) The insurer or its representative must respond to an interpreter's inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the interpreter's inquiry. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.~~

~~(4) The insurer or its representative and an interpreter may agree to send and receive payment information by e-mail. Electronic records sent by e-mail are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 and federal law.~~

~~Stat. Auth.: ORS 656.726(4)~~
~~Stats. Implemented: ORS 656.245, 656.248~~
~~Hist: Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12~~
~~Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13~~

~~436-009-0185 Does the Insurer Have to Pay for Interpreter Services That Are Not Provided By an Interpreter?~~

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

~~(1) A family member or friend of the patient; or~~

~~(2) The medical provider or medical provider's employee.~~

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

Ambulatory Surgery Center Billing Procedures

436-009-0200 Definitions for OAR 436-009-0205 through 436-009-0240

(1) An "ambulatory surgery center" (ASC) means:

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

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

(2) 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.

(3) 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.

(4) 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.

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

436-009-0205 Who Does the ASC Bill for Providing Medical Services?

The ASC must submit bills for medical services to the insurer or, if provided by contract for medical services, to the managed care organization.

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

436-009-0206 What Billing Form Must the ASC Use?

Unless the ASC submits medical bills electronically, the ASC must bill on a CMS-1500 form. Computer-generated reproductions of the CMS-1500 form may also be used.

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

436-009-0207 How Does the ASC Fill Out the CMS 1500 Form?

Unless different instructions are provided in the table below, the ASC must use the instructions provided in the *National Uniform Claim Committee 1500 Claim Form Instruction Manuals.*

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
22	May be left blank
23	Not used in Oregon workers' compensation
24D	The ASC must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® 2013; • HCPCS codes; or • Oregon Specific Codes (OSCs). If there is no specific code for the medical service: • Use an appropriate unlisted code from CPT® 2013(e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • Describe the service provided. • The ASC must add a modifier "SG" to identify the facility charges under the modifier column next to the code describing the service rendered.
24I (shaded area)	See under box 24J shaded area.
24J (non-shaded area)	Include the rendering provider's NPI.
24J (shaded area)	If the ASC includes the rendering provider's NPI in the non-shaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248; 656.252
Hist: Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13
Amended 11/12/13 as Admin. Order 13-058, eff. 1/1/14

436-009-0210 How Much Should the ASC Charge?

(1) The ASC must bill the usual fee charged to the general public.

(2) For purposes of this rule, "general public" means any person who receives medical services, unless the law requires the ASC to bill a specific amount.

(3) When a patient with two or more separate compensable claims receives treatment for more than one injury or illness, the ASC must divide the charges accordingly.

(4) If the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the ASC should include the charges for the packaged services in the surgical charges.

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

436-009-0215 What Must Accompany the ASC's Bill?

The ASC must submit legible chart notes with each bill, documenting the services that have been billed.

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

436-009-0220 What May the ASC Not Bill for?

The ASC may not bill for:

(1) Providing chart notes with each bill.

(2) Services that were not performed.

(3) Treatment that falls outside the scope and field of the ASC's license to operate.

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

436-009-0225 What Services Are Included In the ASC Facility Fee?

(1) The following services are included in the ASC facility fee and the ASC may not be paid separately for them:

(a) Nursing, technical, and related services;

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

(c) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;

(d) Radiology services designated as packaged in Appendix D;

(e) Administrative, record-keeping, and housekeeping items and services;

(f) Materials for anesthesia; and

(g) Supervision of the services of an anesthetist by the operating surgeon.

(2) Packaged services identified in Appendix C or D.

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

436-009-0230 What Services Are Not Included in the ASC Facility Fee?

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

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

436-009-0235 When Must the ASC Submit a Bill?

(1) Unless the ASC establishes good cause, the ASC must submit a bill within:

(a) 60 days of the date of service;

(b) 60 days of the date the ASC learns which insurer is responsible for the worker's compensable claim; or

(c) 60 days after any litigation affecting the compensability of the services is final, if the ASC receives written notice of the final litigation from the insurer.

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

(3) A bill is considered submitted on the date the envelope is postmarked, the date the document is faxed, or the date the document is transmitted electronically.

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

436-009-0240 Are There Specific Billing Requirements for Certain Services That the ASC Needs to Know?

(1) If the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the ASC should include the charges for the packaged services in the surgical charges.

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

(3)(a) When the ASC's cost for an implant is more than $100, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.

(b) For the purpose of these rules, an implant is an object or material inserted or grafted into the body.

(4) When a surgical procedure is performed bilaterally, the ASC must add the modifier "50" on the bill for the second side.

(5) When a service is provided by a physician assistant or nurse practitioner, the ASC must add the modifier "81" to the appropriate code. The chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.

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

(a) NU for purchased, new equipment;

(b) UE for purchased, used equipment; and

(c) RR for rented equipment

(7) When the ASC receives a request for medical records, the ASC should use the Oregon specific code R0001 to bill for the copies.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12
Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12

Ambulatory Surgery Centers – Payment Calculations

436-009-0245 Who is Responsible for Payment?

The insurer is responsible for paying an ASC for compensable medical services.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.248; 656.252
Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12
Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12

436-009-0255 What Does the Insurer Not Have to Pay for?

(1) The insurer is not required to pay for services that have been excluded from compensability under OAR 436-009-0015, or for treatment of any of the side effects caused by the excluded services. The following are excluded services:

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

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface EMG (electromyography) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography;

(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:

(A) The single level artificial disc replacement is between L3 and S1;

(B) The injured worker is 16 to 60 years old;

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

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

~~(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:~~

~~(A) The single level artificial disc replacement is between C3 and C7;~~

~~(B) The injured worker is 16 to 60 years old;~~

~~(C) The injured worker underwent unsuccessful conservative treatment;~~

~~(D) There is intraoperative visualization of the surgical implant level; and~~

~~(E) The procedure is not found inappropriate under OAR 436-010-0230(15) or (16).~~

~~(2) The insurer is not required to pay an ASC when:~~

~~(a) The patient misses an appointment;~~

~~(b) The ASC bills later than:~~

~~(A) 12 months after the date of service;~~

~~(B) 12 months after the ASC's knowledge of the workers' compensation insurer; or~~

~~(C) 12 months after any litigation affecting the compensability of the services is final, if the ASC receives written notice of the final litigation from the insurer.~~

~~(c) X-ray films are not of diagnostic quality, do not include a report of findings, or the films are 14" x 36" lateral views; or~~

~~(d) The ASC provides services to a worker who is enrolled in a managed care organization (MCO) and:~~

~~(A) The ASC is not a contracted facility for the MCO;~~

~~(B) The MCO has not pre-certified the service provided; or~~

~~(C) The surgeon is not a panel provider.~~

~~Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.248; 656.252~~
~~Hist: Adopted 3/1/11 as Admin. Order 11-050, eff. 4/1/12~~
~~Amended 2/16/12 as Admin. Order 12-050, eff. 4/1/12~~

~~436-009-0260~~ What are the Payment Amounts for Services Provided by an ~~ASC?~~

~~Unless otherwise provided by contract, insurers must pay ASCs for services, equipment, and supplies according to this rule,~~

~~(1) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services at the lesser amount of:~~

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

~~(b) The ASC's usual fee for surgical procedures and ancillary services.~~

~~(2) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation, is considered a secondary procedure and paid accordingly. The multiple surgery discount described in this subsection does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.~~

~~(3) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead.~~

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

~~(4) Notwithstanding section (5), insurers must pay implants at 110 percent of the ASC's actual cost documented on a receipt of sale when the implant's cost to the ASC is more than $100. For the purposes of this rule, Appendix D does not apply when the ASC's cost for the implant is more than $100.~~

~~(5) Except as provided in sections (6) through (8), insurers must pay for durable medical equipment, prosthetics, orthotics, and supplies (DEMPOS) according to the following table:~~

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

(6) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (5) to determine the rental rates for these codes):

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

(7) For items rented:

(a) When an item is rented on a daily basis, the maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (5) and (6) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13-month rental period, with a credit of 75 percent of the rental paid going towards the purchase.

(8) For items purchased:

(a) The ASC 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 (the insurer must pay for labor at the provider's usual rate); or

(b) The ASC may offer a service agreement at an additional cost.

(9) When the insurer requests copies of medical records from the ASC, the insurer must pay $10.00 for the first page and $0.50 for each page thereafter.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248; 656.252
Hist: Amended 9/20/12 as Admin. Order 12-055, eff. 10/20/12
Amended 3/11/13 as Admin. Order 13-051, eff. 4/1/13

436-009-0265 What If the Insurer Doesn't Receive All the Information Needed to Process Payment?

When the insurer receives a bill that cannot be processed because it is not submitted in the proper form or the form is not complete, the insurer must return the bill to the ASC within 20

~~days of receipt of the bill with a written explanation describing why the bill was returned. The insurer must provide specific information about what is needed in order to process the bill.~~

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

~~436-009-0270 What If the Insurer Disagrees With the Billing?~~

~~If the insurer disagrees with 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.~~

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

~~436-009-0275 What Discounts May the Insurer Apply Under This Fee Schedule?~~

~~(1) The insurer may apply a discount to the ASC's fee if a written contract exists.~~

~~(2) If the insurer and the ASC have multiple contracts, only one discount may be applied.~~

~~(3) If the insurer has multiple contracts and one of the contracts is through a certified managed care organization for services provided to an enrolled worker, the insurer may only apply the discount under the managed care organization's contract.~~

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

~~436-009-0285 When Must the Insurer Pay the ASC?~~

~~The insurer must pay the ASC by whichever date is later:~~

~~(1) 45 days after the date the insurer receives the bill; or~~

~~(2) 14 days after any action causes the service to be payable.~~

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

~~436-009-0290 What Must the Insurer Include on an Explanation of Benefits?~~

~~(1) The insurer must provide a written explanation for services being paid or denied, and must send the explanation to the ASC that billed for the services. All information on the explanation must be in 10 point size font or larger.~~

~~(2) The explanation must include:~~

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

~~(b) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;~~

~~(c) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an ASC's payment questions within 48 hours, excluding weekends and legal holidays;~~

~~(d) The following notice, web link, and phone number:~~

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

~~(e) Space for a signature and date; and~~

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

~~(3) The insurer or its representative must respond to an ASC's inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the ASC's inquiry. The insurer or its representative may not refer the ASC to another entity to obtain an answer.~~

~~(4) The insurer or its representative and an ASC may agree to send and receive payment information by e-mail. Electronic records sent by e-mail are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.~~

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

~~Sanctions and Civil Penalties~~

~~436-009-0998~~ Sanctions and Civil Penalties

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

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

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

~~(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the~~

~~insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS chapter 656.~~

~~(5) If a prescribing provider fails to submit Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, to the insurer, in accordance with OAR 436-009-0090(4)(b) and (c), the insurer may file a complaint with the director.~~

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