DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
OREGON MEDICAL FEE AND RELATIVE VALUE SCHEDULE

Revision-marked copy
[Bracketed 8 point text is deleted]; **bold/underlined text is added**

EFFECTIVE JULY 1, 1998

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Only adopted, amended, and repealed rules are included in this document. CPT® codes are not published with this electronic document due to copyright protection.

RULE **PAGE**

436-009-0003 Applicability of Rules

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

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

Stat. Auth.: ORS 656.726(3)
Stats. Implemented: ORS 656.248
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98

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 rule.

(2) Abbreviations used in these rules are defined as follows:

(a) ADA means American Dental Association

(b) ASA means American Society of Anesthesiologists

(c) BR means by report

(d) CARF means Commission on Accreditation of Rehabilitation Facilities

(e) CPT means Physicians Current Procedural Terminology

(f) DME means Durable Medical Equipment

(g) DMSO means Dimethylsulfozide

(h) DRG means diagnosis related group

(i) EDI means Electronic Data Interchange

(j) EMG means electromylography

(k) HCFA means Health Care Financing Administration

(l) HCPCS means HCFA (Health Care Financing Administration) Common Procedure Coding System

(m) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3

(n) JCAHO means Joint Commission on Accreditation of Healthcare Organizations

(o) MCO means Managed Care Organization

(p) MRI means magnetic resonance imaging

(q) NCPDP means National Council for Prescription Drug Programs

[(2)]**(r)** ["]OSC["] means Oregon specific code[.]

(s) PCE means physical capacity evaluation

[(3)]**(t)** ["]RVU["] means relative value unit[.]

(u) TC means technical component

(v) UB means Universal Billing

(w) WCE means work capacity evaluation

Stat. Auth.: ORS 656.726(3)(a)
Stats. Implemented: ORS 656.726(3)(a)
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98

436-009-0008 Administrative Review, Fee Disputes and Contested cases

Administrative review before the director:

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical fees and non-payment of compensable medical bills. A party need not be represented to participate in the administrative review before the director except as provided in ORS Chapter 183 and Division 001 of the Chapter 436 rules.

(b) **Any party may request the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the**

dispute does not resolve through mediation, a director's order may be issued. [For purposes of these rules, "dispute resolution before the director" means any problem solving process authorized by statute, rule, or order, designed to resolve a dispute concerning the payment of medical services covered by these rules.]

(c) [The objective of the dispute resolution before the director is to resolve the dispute fairly and expeditiously, in a manner that encourages a nonadversarial environment. Toward this end, any party may request that the director provide voluntary mediation prior to or concurrent with the administrative review or contested case. When a dispute is resolved by agreement of the parties to the satisfaction of the director, the director may issue a Stipulated Letter of Agreement, or an Order of Dismissal if the party requesting review withdraws that request as a result of the agreement, or take other appropriate action.]

(d)] All issues pertaining to disagreement about medical fees or non-payment of bills within a**n** [Managed Care Organization (]MCO[)] are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting administrative review of the matter by the director under section (2) of this rule. 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 in accordance with section (2) of this rule.

(2) The medical provider, the injured worker or the 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 [compensable] medical services **on a compensable injury**. The request for review must be mailed to the division within 90 days of the dispute. For purposes of this rule, the [day] **date** of the dispute**, for any party other than the insurer,** shall be the date the party knew or should have known there was a dispute over either the amount of a fee or the non-payment of a bill. **The date of the dispute for the insurer shall be the date payment action for the disputed bill is due, pursuant to OAR 436-009-0030**. If the request for review is submitted by either the insurer or the medical provider, it shall be in the form and format as prescribed by the director and must:

(a) State specific code(s) and dates of service(s) in dispute;

(b) State the grounds for questioning the disputed amount;

(c) State the request for correction and relief; and

(d) Include sufficient documentation to support the review request, including but not limited to copies of original HCFA bills, chart notes, bill analysis, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute;

(e) Certify that the involved parties have been provided a copy of the request for review and attached supporting documentation;

(f) Certify, if known, that there is no issue of causation or compensability of the underlying claim or condition.

(3) The division shall investigate the matter upon which review was requested. The investigation may include, but shall 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.

(4) If additional information is necessary, the director shall so advise the parties. Upon receipt of a written request for additional information, the parties shall have 14 days to respond.

If the parties do not provide the information requested by the director and/or when the investigation is complete, the director will issue an order resolving or dismissing the dispute based on available information. Pursuant to section (6) of this rule, within 30 days of the administrative order, any party may appeal to a contested case before the director.

(5) Notwithstanding any other provision of this rule, when the director becomes aware that a dispute exists regarding either the amount of a fee or the non-payment of bills for compensable medical services, the director may resolve the dispute pursuant to ORS 656.248(13).

(6) Contested Cases Before the Director: Pursuant to 183.310 through 183.550, as modified by OAR 436-001 and ORS 656.704(2), any party that disagrees with an action or order of the director pursuant to these rules, may request a contested case before the director. For purposes of these rules, "contested case" has the meaning prescribed in ORS 183.310(2) and OAR 436-001. A party may appeal to the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested and must attach a copy of the order being appealed.

(b) The appeal must be made within 30 days of the mailing date of the order or notice of action being appealed, unless the director determines that, in his or her discretion, there was good cause for delay.

(7) Contested Case Hearings of Sanction and Civil Penalties: The director may sanction a party or assess civil penalties due to a violation(s) of these rules. Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board. The process for requesting a hearing is 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, pursuant to these rules, may request administrative review by the director. For purposes of these rules, "administrative review" means any decision making process by the director, except as provided by ORS 183.310(2) and OAR 436-001. The aggrieved party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within [ninety (]90[)] days of the disputed action and must specify the grounds upon which the action is contested, unless the director determines that, in his or her discretion, there was good cause for delay or that substantial injustice may otherwise result.

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

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (5) of this rule.

Stat. Auth.: ORS 656.704, 656.726(3)

Stats. Implemented:
Hist: Renumbered from OAR 436-010-0110(1), (2), (3), (4), and (5) to OAR 436-009-0008(2), (3), (4), and (5); from OAR 436-010-0110(6) to OAR 436-009-0008(1)(b); and, filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98

436-009-0010 General Requirements for Medical Billings

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

([1]**2**) All billings shall be fully itemized[, including] **and include** ICD-9-CM codes**.**[, and s] **S**ervices shall be identified by **the** code numbers and descriptions provided in these rules. The definitions**, descriptions and** [of commonality in the] guidelines found in [the Current Procedural Terminology (]CPT[)] shall be used as guides governing the descriptions of services, except as otherwise provided in these rules.

([2]**3)** All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on current form UB92 or form HCFA 1500, except for:

(a) dental billings which shall be submitted on ADA dental claim forms**;**

(b) pharmacy billings, which shall be submitted on the most current NCPDP form;

(c) EDI transmissions of medical bills pursuant to OAR 436-009-0030(2)(a).

Computer-generated reproductions of these forms may also be used. Billings shall include the worker's full name, date of injury, the employer's name and, if available, the insurer's claim number. All original medical provider billings shall be accompanied by legible chart notes documenting services which have been billed, and identifying the person performing the service and license number of person providing the service. Medical doctors [(MD)] are not required to provide their medical license number if they are already providing other identification such as tax identification and social security numbers.

([3]**4**) The preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service. No additional fee shall be paid except a reasonable amount for copies or summaries of the records of treatment as provided in accordance with OAR 436-009-0020([29]**24) (b**).

([4]**5**) In order to be reimbursable, x-ray films must be of diagnostic quality. 14" x 36" lateral views are not reimbursable. Billings for X-rays are not reimbursable without a report of the findings.

([5]**6**) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0020([29]**24) (b**). If the evaluation of the records must be conducted on-site, the provider shall furnish a reasonable work-site for the records to be reviewed at no cost. These records shall be provided or made available for review within 14 days of a request. Failure to provide the records in a timely manner may result in a sanction or penalty as provided in OAR 436-009-0100.

Stat. Auth.: ORS 656.245, 656.252, 656.254

Stats. Implemented: ORS 656.245, 656.252, 656.254
Hist: Renumbered from OAR 436-010-0010(5) and (6) to OAR 436-009-0010(1) and (2);
from 436-010-0040(3)(d) and (e) to 436-009-0010(3) and (4);
from 436-010-0040(7) and (9) to 436-009-0010(4) and (5);
from 436-010-0040(11) to 436-009-0010(11); and
filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4/3/98 as Admin. Order 98-052, eff. 7/1/98

436-009-0020 Charges and Fees

(1) [Inpatient and outpatient h] **H**ospital **inpatient** charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes [and, additionally, inpatient hospital charges shall include the diagnostic related group (DRG) number.] Unless otherwise provided for by a governing MCO contract, insurers shall reimburse hospitals for inpatient [hospital] services using the current adjusted cost/charge ratio **(see Bulletin 290)**. For purposes of this rule, [inpatient] hospital **inpatient** service**s** [bills] include, but may not be limited to, those bills coded "111" through "118" in space #4 on the UB92 billing form. [Insurers shall audit each bill for inpatient services for mathematical accuracy and compensability.] The [resulting sum] **audited bill** shall be multiplied by [a] **the** hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes, CPT codes, HCPCS codes and NDC codes, where applicable. Unless otherwise provided for by a governing MCO contract, insurers shall reimburse hospitals for outpatient services according to the following: [When the insurer is auditing bills for outpatient hospital services, including emergency room services,] the insurer shall first separate out and pay charges **for services** [which have CPT codes subject to these rules and found in] **covered by** the Oregon Medical Fee and Relative Value Schedule [following these rules]. [The amount billed for services that are subject to these rules] **These charges** should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance.

[(a)]**(3)** Each hospital's HCFA Form 2552 and financial statement shall be the basis for determining its adjusted cost/charge ratio.

(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) Provider-Based physician adjustment - general services cost center;

(C) Telephone service;

(D) Television and radio service; and

(E) 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 ([1]**3**)(a) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow for 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 HCFA 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 ([1]**3**)(c) and ([1]**3**)(d) of this rule will be added to the ratio calculated in subsection ([1]**3**)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(f) The adjusted cost/charge ratio for each hospital shall be revised annually, at a time based on their fiscal year, as prescribed by bulletin. Each hospital shall submit a copy of their HCFA 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 shall be published by bulletin twice yearly, on or before March 20 of each year to be effective for the subsequent six-month period beginning April 1, and on or before September 20 of each year to be effective for the subsequent six-month period beginning October 1.

(g) For those newly formed or established hospitals for which no HCFA 2552 has been filed, or for those hospitals that do not file Worksheet G-2 with the submission of their HCFA form 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 and/or geographic location.

(h) If the financial circumstances of a hospital unexpectedly and/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 HCFA 2552 by the Health Care Financing Administration 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 cost/charge ratio shall be 1.000 for out-of-state hospitals, unless a lower rate is negotiated between the insurer and the hospital.

(k)[Hospitals which provide inpatient hospital and outpatient surgical services to injured workers who are governed by a MCO may be granted exemption or partial exemption from the cost/charge ratio in accordance with ORS 656.248(12).

(2)] Notwithstanding section (1) **and (2) of** this rule, the director may exclude rural hospitals defined in ORS 442.470 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 as reflected by its financial flexibility index, as developed by Dr. William Cleverley of the Center for Healthcare Industry Performance Studies (CHIPS), Ohio State University. All rural hospitals having a financial flexibility index at or below the median for hospitals nationwide with a bond rating of BBB+, BBB, or BBB- will qualify for the rural exemption.

([3]**4**) The insurer shall notify the medical provider in writing at the time of payment of the reasons for any reduction in payment of the medical provider's billings. The medical provider shall not attempt to collect from the injured worker any amounts reduced by the insurer pursuant to this rule.

[(4) When there is a dispute about a fee for a medical service for which no CPT code or relative value has been established, the director may determine and promulgate a reasonable fee for the services, which shall be the same for all medical providers. The director shall periodically issue a bulletin to all parties establishing the fee that shall apply to all similar disputes which arise. The director shall incorporate the fee into the Oregon Medical Fee and Relative Value Schedule. When determining such a fee the director shall consider:

(a) the relative difficulty of the service;

(b) the fee for like or similar services; and

(c) the skill, time, risk and investment of the medical provider and other medical providers in delivering the service.]

(5) Workers may make a written request to a medical provider to receive copies of medical billings. Providers receiving a request may issue the worker a copy during the next billing cycle, but not later than 30 days following receipt of the request. Thereafter, worker copies are to be issued during the regular billing cycle.

(6) In all cases of accepted compensable injury or illness under jurisdiction of the Workers' Compensation Law, the injured worker shall not be liable for payment for any services for the treatment of that injury or illness and a medical provider shall not attempt to collect from an injured worker for services, with the following exceptions:

(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 worker's attending physician. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period as set forth in 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 pursuant to 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 436-010-0270; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental pursuant to OAR 436-010-0300.

(7) The medical provider shall bill the medical provider's 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) The medical provider shall not bill for services not provided to the worker, nor shall the medical provider bill multiple charges for the same service. Rebillings shall indicate that the charges have been previously billed.

(9) Medical providers shall not submit false or fraudulent billings. As used in this section, "false or fraudulent" shall mean an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person.

(10) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided. Any service not identifiable with a code number shall be adequately described by report.

(11) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings will be subject to discounts, not to exceed 10 percent for each 30 day period or fraction thereof, beyond 60 days.

(12) Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

(13)(a) When services are provided in hospital emergency or outpatient departments and are similar to or identical with services provided in physician or physical therapist offices, such services shall be identified by CPT codes and reimbursed as shown in these rules. Such services include, but are not limited to, outpatient physical therapy, outpatient X-rays, and physician's services.

(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.

(14) Physician assistant or nurse practitioner fees will be paid at the rate of 80 percent of a physician's fee for a comparable service except that assisting in surgery shall be paid at the rate of 10 percent of the surgeon's reimbursable fee. The bills for services by these providers shall be marked with modifier 81. Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

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

(16) [Reimbursement to physicians shall not exceed 20 percent above the physician's costs for braces, supports and other medical devices. Invoices for devices with a unit price greater than $25 shall be provided on request of insurer. Invoices for devices with a unit price under $25 shall be provided upon request of the director.

([17])] When more than one surgeon performs surgery, the process for billing shall be as follows:

(a) When two surgeons operate and one performs a discectomy and one performs an arthrodesis, each procedure is to be billed separately. The maximum allowable fee for each procedure, as listed in these rules, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation each may bill an additional fee of 20 percent of the other surgeon's 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' fees.

(b) When multiple surgical procedures are performed, the principal procedure is reimbursed at 100 percent of the maximum allowable fee, the secondary procedure is reimbursed at 50 percent of the maximum allowable fee and all subsequent procedures are reimbursed at 50 percent of the maximum allowable fee.

(c) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures paid at 10 percent of the value listed.

(d) Surgery following severe trauma, for which several procedures are required and which take considerable time, and for which the surgeon feels his or her fees should not be reduced, can receive special consideration by the insurer. Such a request must be accompanied by written documentation and justification.

(e) Hospital charges for inpatient myelography are not subject to these rules. Physician's services for inpatient myelography are subject to these rules.

[([18])(a) When two bills are submitted for an X-ray, one by the person taking the X-ray (technical component to be designated by modifier TC) and one by the radiologist who interprets the X-ray (professional component to be designated by modifier 26), the maximum allowable fee is to be divided between them. The reimbursement shall be based on the Oregon Medical Fee and Relative Value Schedule.

(b) Physicians, other than the radiologist, who inject air, contrast materials or isotopes as part of a radiologic study, shall bill for this service using CPT codes from the surgery section. For example, CPT code 62284 shall be used for the injection for myelography. This fee for the injection will be reimbursed in addition to the value of the complete procedure. The complete procedure fee shall be reimbursed based on the Oregon Medical Fee and Relative Value Schedule.

([19])]**(17)** Outpatient [hospital] services shall be reimbursed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by these rules, are to be applied to hospital bills only for outpatient services.

(b) CAT scans, when performed as an outpatient service, are subject to the limitations of these rules. When multiple areas are examined by CAT scan, the first area examined shall be reimbursed at 100 percent, the second area at 50 percent and the third and all subsequent areas at 25 percent of these rules.

([20]**18**) When multiple treatments are provided simultaneously by a [table,] machine**,** [or] device **or table** there shall be a notation on the bill that treatments were provided simultaneously by a [table,] machine**,** [or] device **or table** and there shall be one charge.

([21]**19**)(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program is not reimbursable 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 reimbursement 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 multi[-]disciplinary 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.

(c) Billings for medical services provided within a CARF or JCAHO accredited multi[-]disciplinary program which do not have established CPT codes shall be billed based upon the Oregon specific codes identified in these rules for multi[-]disciplinary programs. Billings using the multi[-]disciplinary 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.

(d) When an attending physician approves a multi[-]disciplinary treatment program for an injured worker, the attending physician must provide the insurer with a copy of the approved treatment program within [seven] **14** days of the beginning of the treatment program .

(e) Notwithstanding [section (5) of this rule] **OAR 436-009-0010(2)**, program fees for services within a multi[-]disciplinary 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.

([22]**20**) [Dimethylsulfoxide (]DMSO[)] is not reimbursable except for treatment of compensable interstitial cystitis. Additionally, surface EMG tests, rolfing, prolotherapy, and thermography are not reimbursable. These non-reimbursable services may be administered; however, medical providers shall not receive additional reimbursement for providing such services. Side effects resulting from administration of these services are also not reimbursable.

([23]**21**) When multiple areas are examined using [Magnetic Resonance Imaging (]MRI[)], the first area examined shall be reimbursed at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent.

([24]**22**) Mechanical muscle testing shall be reimbursable a maximum of three times during a treatment program when prescribed and approved by the attending physician: once near the beginning, once near the middle and once near the end of the treatment program. Additional mechanical muscle testing is reimbursable 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.

([25]**23**) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness, the costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer. Modifiers from the CPT shall be used to indicate reduced billing.

([26]**24**) Fees and codes for records and reports requested by an insurer, worker, employer, or their representative shall be as follows:

(a) 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([2]**4**) of this rule.

(b) Copies of medical records when requested shall be reimbursed at $3.50 for the first page and 25 cents for each page thereafter and identified on billings by OSC-R0001.

(c) Brief Narrative by the Attending Physician - Summary of treatment to date and current status; if requested, brief answers to **1**[3]-5 specific questions which are related to the **attending physician's** current or proposed treatment shall be reimbursed, using the conversion factor for "Multidisciplinary and other Oregon-specific codes," at a RVU of [6.66] **10.50** and identified on billings by OSC-N0001.

(d) [Complete] **Complex** Narrative **by the Attending Physician - May include**[P] **p**ast history, history of present illness, **attending physician's** treatment to date, current status, impairment, prognosis, medically stationary information shall be reimbursed, using the conversion factor for "Multidisciplinary and other Oregon-specific codes," at a RVU of [13.32] **21.00** and identified on billings by OSC-N0002.

(e) When a medical provider is asked to **prepare a report, or** review records or reports prepared by another medical provider, insurance carrier or their representative, the medical provider should bill for their **report or** review of the records utilizing CPT Codes **such as** 99080 [, 99358, 99359, 99375 and 99376]. **Refer to specific code definitions in the CPT for other applicable codes.** These CPT codes shall be used for prolonged physician service without direct patient (face-to-face) contact that will require the physician to review complex, detailed medical records transferred from previous physicians and/or to complete a comprehensive treatment plan. They may also be used to review subsequent reports on patient status, to include communication with other health care professionals involved in the patient's care. The billing should include the actual time spent reviewing the records or reports.

([27]**25**) Fees for a [physical capacity evaluation(]PCE[)] and a [work capacity evaluation(]WCE[)] shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable reimbursement shall be as follows:

(a) FIRST LEVEL PCE: This is a limited evaluation to measure the functional performance testing of a specific body part. This level requires not less than 45 minutes of actual claimant contact. Using the conversion factor for "Multidisciplinary and other Oregon-specific codes," the RVU for this PCE is 16.79, which includes the evaluation and report. A first level PCE should be billed using OSC-99196. [An a]**A**dditional 15**-minute** increment**s** [of time] may be added for each additional body part [and if necessary] to establish endurance (e.g. cardiovascular)**,** or to project tolerances (e.g. repetitive motion). To report additional 15 minutes, use OSC-99193 and apply the conversion factor for "Multidisciplinary and other Oregon-specific codes." The RVU established for this additional 15 minutes, which includes evaluation and report, is 4.28.

(b) SECOND LEVEL PCE: This is a PCE requested by the insurer, or attending physician, to measure general residual functional capacity to perform work or provide other

general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level requires not less than two hours of actual claimant contact. Using the conversion factor for "Multidisciplinary and other Oregon-specific codes," the RVU for the second level PCE is 29.96, which includes the evaluation and report. A second level PCE should be billed using OSC-99197. Additional 15-minute increments (per additional body part) may be necessary to establish endurance (e.g., cardiovascular[, repetitive motion, etc.]) or to project tolerances **(e.g., repetitive motion)**. To report additional 15 minutes, use OSC-99193, and apply the conversion factors for "Multidisciplinary and other Oregon-specific codes". The RVU established for the additional 15 minutes, which includes evaluation and report, is 4.28.

(c) WORK CAPACITY EVALUATION: This is a residual functional capacity evaluation with special emphasis on the ability to perform essential physical function of the job based on specific job analysis. This level requires not less than 6 hours of actual claimant contact. The primary purpose of this evaluation is to establish if a worker can return to work at a specific job(s). Using the conversion factor for "Multidisciplinary and other Oregon-specific codes," the RVU for this WCE is 63.25, which includes the evaluation and report. A WCE should be billed using OSC-99198.

(d) In addition, if requested, a musculoskeletal evaluation (e.g., ROM, strength, sensory, etc.) with up to 30 minutes of actual claimant contact for the first body part may be added to a first level PCE**, second level PCE** or WCE. An additional 15 minutes may be requested for each additional body part tested. Musculoskeletal evaluation is billed using the conversion factor for "Multidisciplinary and other Oregon-specific codes," the RVU for this additional testing is 4.28 for each 15 minutes reported, which includes evaluation and report. Musculoskeletal evaluation and additional 15 minutes should be billed using OSC-99193.

([28]**26**) No fee shall be paid for the completion of a work release form or completion of a physical capacity evaluation form where no tests are performed.

(27) No fee is payable for a missed appointment unless the appointment was arranged by the insurer or the department.

(28) When an attorney requires a consultation with a medical provider, the medical provider shall be reimbursed under OSC-D0001 at the provider's usual and customary hourly rate.

(29**) The fee for a deposition shall be billed under OSC-D0002 at the medical provider's usual and customary hourly rate. This code should include time for preparation, travel and deposition.** [Fee and codes for a deposition (includes preparation time):

(a) First hour of deposition (including preparation time)	RVU of 39.95; using the conversion factor for "Multidisciplinary and other Oregon-specific codes" (OSC-D0001)
(b) Each subsequent hour or portion thereof	RVU of 13.32; using the conversion factor for "Multidisciplinary and other Oregon-specific codes" (OSC-D0002)]

(30) The most recent publication by the department of CPT codes and relative values is included in [Appendix "A"] **and** attached hereto [and are made a] **as** part of these rules.

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

(a) Level 1 OSC-A0001 Exam 21.72 (RVU)

Level 2 OSC-A0002 Exam 32.58 (RVU)

Level 3 OSC-A0003 Exam 43.44 (RVU)

As determined by the director, a level 1 exam generally has 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.

(b) Level 1 OSC-A0011 Report 5.43 (RVU)

Level 2 OSC-A0012 Report 8.15 (RVU)

Level 3 OSC-A0013 Report 10.86 (RVU)

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

(c) Level 1 OSC-A0021 File Review 5.43 (RVU)

Level 2 OSC-A0022 File Review 13.58 (RVU)

Level 3 OSC-A0023 File Review 32.58 (RVU)

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 an extensive record.

(d) Use the OSC unit value for Multidisciplinary found in Bulletin 288. The director shall notify the physician and the insurer of the approved code for each component to establish the total fee for the medical arbiter review. The physician shall use the approved code when billing the insurer.

(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-A0031 3.15 (RVU)

Complex OSC-A0032 7.35 (RVU)

(f) Prior to completion of the reconsideration process, the medical arbiter physician 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.

(32) A single physician selected pursuant to OAR 436-010-0310, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under OSC-P0001 for the examination and OSC-P0003 for the report. Using the conversion factor for Multidisciplinary and other Oregon-specific codes, the RVU for services billed under OSC-P0001 is 19.97. Using the same conversion factor, the relative value for the report billed under OSC-P0003 is 13.32.

(b) Physicians selected pursuant to OAR 436-010-0008, to serve on a panel of physicians shall each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. The panel member who prepares and submits the panel report shall receive an additional payment. Billings by each physician selected to a panel shall be billed under OSC-P0002. Billings for the panel report shall be billed under OSC-P0003. Using the conversion factor for Multidisciplinary and other Oregon-specific codes, the RVU for services billed under OSC-P0002 is 19.97. Using the same conversion factor, the relative value for the report billed under OSC-P0003 is 13.32.

(c) The director may in a complex case requiring extensive review by a physician pre-authorize an additional fee based on a RVU up to 26.63 above the units specified in this rule. Billings for such additional units shall be billed under OSC-P0004 using the conversion factor for Multidisciplinary and other Oregon-specific codes.

(33) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each selected physician shall bill under OSC-A0005. Using the conversion factor for Multidisciplinary and other Oregon-specific codes, the RVU for this service is 13.32.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.248, Sect. 2, Chpt. 771, OR Laws 1991, 656.252, 656.256
Hist: Renumbered from OAR 436-010-0090(1) thru (4), (7) thru (32) to OAR 436-009-0020(1) thru (29), (32) and (33);
from OAR 436-010-0040(4)(b)(A) and (c) to OAR 436-009-0020(30) and (31);
from OAR 436-010-0047(6) and (7) to OAR 436-009-0020(34) thru (37), and;
filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4-21-97 as Admin. Order 97-053, eff. 7-1-97
Amended 7-9-97 as WCD Admin. Order 97-056, eff. 7-9-97 (Temp)
Amended 12-15-97 as WCD Admin. Order 97-056, eff. 12-15-97
Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98

436-009-0030 Insurer's Duties and Responsibilities

(1) The insurer shall pay for [compensable] medical services relating to a compensable injury claim, except as provided by OAR 436-060-0055. [Compensable medical services include but are not limited to medical, surgical, hospital, nursing, ambulance and other related services, drugs, medicine, crutches, prosthetic appliances, braces, supports, and where necessary physical rehabilitation.]

(2) Insurers shall date stamp medical bills and reports upon receipt and shall pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010([1]**2**) and ([2]**3**) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form may be returned to the medical provider for correction and resubmission [.If an insurer returns such billings, it must be documented and done]within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing to the provider and the date the insurer receives the corrected billing, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer shall retain a copy of each medical provider's bill received by the insurer or shall be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2) and insurer action, for any fee reduction other than a fee schedule reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

[(a)]**(b)** The insurer, or their representative, shall guarantee when receiving an [electronic data interchange (]EDI[)] bill that the mailing date is to be defined as the date the record is sent to the queue for transmission; i.e., the actual date the transmission of the data should have occurred. This is equivalent to a mailing date, since any delay after the transmission is due to technical problems on the receiver's end (e.g., computer down, paper tray empty in facsimile, etc.) should not be counted toward the sender's timeliness requirements. Generally, the transmission date will automatically be included with the data and be sent as part of the medical bill transmission.

(3) Payment of medical bills [in the following situations] is required within 14 days of [the] **any** action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.[:

(a) When an order designating a paying agent pursuant to ORS 656.307 and OAR 436-60-180 has been issued;

(b) When an insurer voluntarily rescinds a claim denial;

(c) When there is a Stipulated Agreement which rescinds a claim denial;

(d) When there is an Opinion and Order or Order on Review that has become final which overturns a claim denial;

(e) When medical benefits become due upon claim acceptance following a claim denial; and

(f) When medical benefits become due upon claim acceptance following a claim deferral period.]

(4) Failure to pay for medical services timely may:

(a) result in civil penalties pursuant to OAR 436-009-0100;

(b) result in the assessment of penalties and fees in accordance with OAR 436-**0**60-**0**155; and

(c) shall render 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.

(5) When there is a dispute over the amount of a bill or the [necessity] **appropriateness** of

services rendered, the insurer shall, 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 shall be made in accordance with OAR 436-009-0008**, 436-010-0008** and [OAR] 436-015.

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

(7) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-0010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(8) Insurers and self-insurers that have at least 100 accepted disabling claims in a calendar year, as determined by the [Department of Consumer and Business Services] **director**, are required to transmit detailed medical service and billing data to the Information Management Division of the Department of Consumer and Business Services. Once an insurer has been determined to have the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. In such circumstances, the insurer may apply for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will publish a bulletin identifying the affected insurers and advising the insurers of the data and format requirements for data transmission;

(b) The data shall include all payments made during each calendar quarter for medical services which are covered by the department's fee schedules. These fee schedules include anesthesiology, surgery, radiology, laboratory and pathology, medicine, physical medicine, evaluation and management services, multidisciplinary and other Oregon-specific codes, [and] all hospital services**, pharmacy, and durable medical equipment**;

(c) The affected insurers shall submit the medical data within 45 days of the end of each calendar quarter. However, a grace period of two calendar quarters may be granted for revised requirements and also for insurers which are newly affected by these requirements. The quality of data submitted shall be provided under the following quality requirements:

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

(e) Audit Quality: The [Department of Consumer and Business Services] **director** may also conduct field audits of actual payments reported for individual claims. When an audit occurs, in order to be in compliance with [Oregon Administrative Rules 436-009-0030(8)] **this rule** and **OAR** 436-010-0270 [as described in these rules], audited data must have no more than 15 percent inaccurate data in any field.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Filed 2/23/82 as Admin. Order 5-1982, eff. 3/1/82
Amended 1/16/84 as Admin. Order 1-1984, eff. 1/16/84
Renumbered from OAR 436-69-801, 5/1/85
Amended 12/10/85 as Admin. Order 6-1985, eff. 1/1/86
Amended 1/20/88 as Admin. Order 1-1988, eff. 2/1/88
Amended 9/6/88 as Admin. Order 6-1988, eff. 9/15/88
Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90
Amended 6/20/90 as Admin. Order 6-1990, eff. 7/1/90 (Temp)
Amended 12/10/90 as Admin. Order 32-1990, eff. 12/26/90
Amended 6/11/92 as Admin. Order 13-1992, eff. 7/1/92
Amended 12/20/94 as Admin. Order 94-064, eff. 2/1/95
Renumbered from OAR 436-010-0100(8) thru (15), (27) and (28) to OAR 436-009-0030 and filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4-21-97 as Admin. Order 97-053, eff. 7-1-97
Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98

436-009-0100 Sanctions and Civil Penalties

(1) If the director finds any medical provider[,] **or** insurer[, self-insurer or designated agent] in violation of the medical reporting requirements established pursuant to [Bulletin 220, issued September 9, 1996,] **any bulletin published by the director** and [as found] **the requirements** in ORS 656.252, OAR 436-009-0010, 436-009-0020, and 436-009-0030 of these rules, the director may impose sanctions in accordance with OAR 436-010-0340 and 436-010-0350.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Filed 5/3/96 as Admin. Order 96-059, eff. 6/1/96
Amended 10-2-96 as Admin. Order 96-069, eff. 1-1-97
Amended 4/3/98 as WCD Admin. Order 98-052, eff. 7/1/98