EXHIBIT "A"
OREGON ADMINISTRATIVE RULES (TEMPORARY)
CHAPTER 436, DIVISION 010

EFFECTIVE DECEMBER 4, 1995

436-010-0003 Applicability Of Rules

(1) These rules are effective [February 1,1995] **immediately** to carry out the provisions of ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268(7), 656.325, 656.327, 656.794 and Sections (2) & (3), Chapter 771, Oregon Laws 1991, and govern all providers of medical services licensed or authorized to provide a product or service**. The provisions of OAR 436-010-0008 supercede any contrary provisions found elsewhere in OAR 436-010. Any rule provision which is contrary to Chapter 332, Oregon Laws 1995 is no longer applicable.**

(2) The provisions of OAR 436-010-0090 **as revised in these rules**, and other such rules specifying charges and fees, shall be applicable to all services rendered subsequent to the effective date of these rules.

(3) These rules apply to all compensable claims existing or arising on or after July 1, 1990.

(4) The provisions of OAR 436-010-0041, and 0046 shall apply to all disputes and requests for palliative care review received by the director on or after the effective date of these rules.

Stat. Auth: ORS 656.726(3), 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.325, 656327, 656.794(3)
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Amended 1/5/90 as Admin. Order 1-1990, eff. 2/1/90 (formerly OAR 436-010-004)
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Amended 12/4/95 as Admin. Order 95-071, eff. 12/4/95 (Temp)

436-010-0008 Administrative Review And Contested Cases

(1) [Dispute Resolution] **Administrative Review** Before the Director.

(a) [Pursuant to ORS 656, t]**T**he director has **exclusive** jurisdiction to resolve **all** disputes concerning medical [treatment and] services, including, but not limited to[,]**: treatment issues; related services:** palliative care[,]**; medical rules violations; advances in curative care; experimental or unscientific treatment**; fees and non-payment of compensable medical bills, requests for change of attending physician, and requests for independent medical examinations in excess of those allowed by statute. 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) [The processes to request these dispute resolutions are described in OAR 436-010-041 for palliative care; OAR 436-010-046 for medical treatment; OAR 436-010-110 for medical fee disputes; OAR 436-010-100 for independent medical examinations; and OAR 436-010-060(5) for change of -attending physician.] **The provisions of temporary rule OAR 436-010-0008 supersede any contrary rule provisions found elsewhere in Division 436-010.** For purposes of these rules, "dispute resolution before the director" means any problem solving process authorized by statute, rule, or order[, that is specifically] designed to resolve a dispute [that arises out of a formal decision] concerning the delivery [and] **or** 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 [offer] **provide** voluntary mediation prior to or concurrent with the administrative review or contested case. When a dispute is resolved by agreement of the parties, the director may issue a Stipulated Letter of Agreement, an Order of Dismissal if the party requesting review withdraws that request as a result of the agreement, or take other appropriate action.

(d) If the dispute does not resolve through mediation, a director's order may be issued.

(2) For both MCO and non-MCO cases the process(es) for obtaining administrative review by the director are described in OAR 436-010-0060 for change of attending physician; OAR 436-010-0100 for independent medical examinations; and OAR 436-010-0110 for fee disputes, including non-payment of medical services Non-medical MCO disputes are resolved as described in OAR 436-015 Therefore the administrative review provisions in sections (3) through (14) of this rule do not apply to such administrative reviews. Appeals of the director's administrative review orders on change of attending physician, fee disputes and non-medical MCO disputes are pursuant to section (14) of this rule. Appeals of director's administrative review orders on independent medical examination matters are provided for in OAR 436-010-0100(2)(b). All remaining medical services disputes are processed as appropriate in accordance with sections (3) through (14) of this rule.

(3) For both MCO and non-MCO cases when there is a formal decision that denies the underlying condition for which treatment is sought; or, when the claim for medical services is not authorized or approved because the insurer or self-insured employer contends that the need for the specific treatment in dispute is not due to the accepted condition(s) the parties must first apply to the Hearings Division of the Workers'

Compensation Board to resolve the compensability and causation issues. When the Hearings Division or the Workers' Compensation Board set aside such decisions, even if the order is appealed, the director will deem the disputed conditions "accepted" pending appeal and consider the medical treatments directed to the accepted conditions for purposes of resolving concurrent medical services and rules violation disputes. Notwithstanding the provisions of this rule, when the compensability of the underlying claim or condition is at issue before another adjudicatory body, any party may request director's review within 30 days after the date the matter has been adjudicated and that decision becomes final by operation of law.

(4) All issues pertaining to disagreement about medical services within a 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 an administrative review of the matter by the director. Dispute resolution pertaining to the provision of medical services within an MCO will then be processed in accordance with subsections (6) through (14) of these rules.

(5) In non-MCO cases, all medical services, whether past, present, or future disapproved for reasons other than a formal denial of the underlying claim will be processed as medical treatment issues and/or rules violations under ORS 656 327. These matters include, but are not limited to: the appropriateness of treatment or service, the medical services exceptions after a worker is medically stationary, including palliative care as described in ORS 656.245(1)(c); and whether the treatment is unscientific, unproven, outmoded or experimental, as described in ORS 656 245(3). Non-MCO disputes under this provision will be processed in accordance with subsections (6) through (14) of these rules.

(6) Under sections (3) through (14) of this rule, "parties" include workers, insurers, and self-insured employers. Attending physicians also have standing as "parties" for all MCO disputes and for non-MCO palliative care disputes. The director may, on the director's own motion, initiate a medical services review at any time.

(7) The following time frames and conditions apply to requests for administrative review under this rule:

(a) For all MCO cases, the aggrieved party must submit the request for administrative review to the director within 60 days of the date the MCO issues its final decision following the MCO's internal dispute resolution process. If a party has been denied access to an MCO internal 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.

(b) For non-MCO cases, the aggrieved party must submit the request for administrative review to the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services.

(c) Medical provider bills for treatment or services which are subject to director's review shall not be deemed payable pending the outcome of the review.

(8) Parties shall submit requests for administrative review to the director in the form and format prescribed by the director. The requesting party shall simultaneously notify all other interested parties of the dispute as follows:

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

(b) Specify what issues are in dispute and specify with particularity the relief sought.

(c) When the treatment has been rendered over a period of time, specify the time period of the treatment in dispute.

(9) In addition to medical documentation relating to the medical services dispute, all parties have an opportunity to be heard through written factual information and legal argument submitted for incorporation into the record. Such information may include, but is not limited to, responses to the documentation and arguments of the opposing party, written statements and sworn affidavits from the parties and witnesses.

(10) The insurer shall provide a record packet without cost to the director and all other parties as follows:

(a) The packet shall include certification that there is no issue of causation or compensability of the underlying claim or condition; and, if there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet shall include a complete, indexed copy of the worker's medical record that is arguably related to the medical service in dispute and other information described in section (9), arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages and date of the document. The packet shall include the following notice in bold face type:

AS REQUIRED BY OAR 436-010-0008(10), WE HEREBY NOTIFY YOU THAT THE DIRECTOR IS REVIEWING THE MEDICAL CARE OF THIS WORKER, WHICH MAY BE INAPPROPRIATE OR IN VIOLATION OF THE MEDICAL SERVICE RULES. THE DIRECTOR MAY ISSUE AN ORDER WHICH COULD AFFECT YOUR RIGHT TO REIMBURSEMENT FOR THIS MEDICAL SERVICE.

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

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request that the record be provided by the insurer as described above, within ten (10) days of the director's request. The insurer may request an extension of this time frame.

(e) If the insurer fails to submit the record in the time and format specified above, the director may penalize or sanction the insurer under OAR 436-010-0130.

(11) If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0047, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed.

(b) When a panel of physicians is selected, at least one panel member shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed.

(c) When such an examination of the worker is necessary, the director shall notify the worker, the insurer, and the attending and reviewing physicians of the date, time, and location of the examination. The physician or panal shall not be contacted directly by either party accept as it relates to the examination date, time, location, and attendance. If the parties wish to have specific issues addressed by the physician or panal, these questions must be submitted to the director in accordance with sections (9) and (10) of this rule. The examination may include, but is not limited to:

(A) A review of all medical records and diagnostic tests submitted, and

(B) An examination of the worker.

(12) [(2) Review of no Bona Fide Dispute Medical Review Order - Pursuant to ORS 656.327(1),] **The director shall review the information submitted by all parties and the observations and opinions of review physicians.**

(a) If the director determines that no bona fide dispute exists in a non-MCO case, the director will issue an order pursuant to ORS 656.327(1). I[i]f any party disagrees with an order of the director that no bona fide medical services dispute exists, the party may appeal the order. The request for review must be made directly to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(b) When a bona fide dispute exists, the director will issue a proposed and final order and notice of record closure. The parties may submit any additional information and respond to evidence presented by others within ten (10) days of the issuance of the proposed order. If the parties submit new material evidence, the director may, on the director's own motion, reopen the record to reconsider the decision. The proposed order will become final 30 days after it is issued unless revised by the director or appealed for a contested case hearing.

(13) If the director issues an order declaring the medical service inappropriate or in violation of the medical services rules the worker is not obligated to pay for such medical service.

[(3) Contested Cases Before the Workers' Compensation Boards Hearings Division:

(a) An order of the director concerning a bona fide medical treatment dispute, pursuant to ORS 656.327(2), may be appealed to the Hearings Division of the Workers' Compensation Board as follows:

(A) The party must send a written request for hearing to the Hearings Division.

(B) Review of the order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures under OAR 438-15 established by the board, except the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(b) An order of the director approving or disapproving an insurer's request for an independent medical examination of the worker pursuant to ORS 656.325 and OAR 436-010-100(2) may be appealed to the Hearings Division of the Workers' Compensation Board. Review of the order shall be as provided in ORS 656.283.

(c) A party may request a hearing before the Hearings Division of the Worker's Compensation Board on any other action taken pursuant to these rules where a worker's right to compensation or the amount of compensation is directly an issue in accordance with the provisions of ORS Chapter 656, except where another procedure is provided pursuant to ORS 656.704, or for disputes involving Managed Care Organizations, pursuant to ORS 656.260.]

[(a)] **(14)** Contested Cases Before the [D]director: Pursuant to 183.310 through 183.550, as modified by ORS 183.315(1) and ORS 656.704(2), any party that disagrees with an action or order of the [D]**d**irector pursuant to these rules**, other than a decision that no bona fide dispute exists,** [that qualifies for review by hearing before the Director as a contested case,] may request [review] **a contested ease before the director**. [This may include orders involving medical treatment through a managed care organization, orders involving medical fees, orders involving a request for a change of attending physician, jurisdictional dismissals, and actions or orders of the director pursuant to ORS 656 which do not involve the payment of compensation, when the matter qualifies for review as a contested case. Orders and actions which qualify for review as contested cases before the director are those specified by statute, by rule or by specific notice of right to such appeal.] 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 [D]**d**irector 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 [D]**d**irector is contested.

(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**.** [and the hearings officer determines that substantial injustice may otherwise result.]

(c) [The Division will conduct the hearing in accordance with the rules governing contested case hearings in OAR 436-01-001 through 436-01-290.] **No new medical evidence or issues shall be admitted at the contested case hearing. The administrative order may be modified only if not supported by substantial evidence in the record or if it reflects an error of law. For purposes of this rule "medical evidence" includes but is not limited to: expert testimony; written statements, opinions and sworn affidavits of medical professionals; records, reports, documents, laboratory, x-ray and test results authored, produced, generated or verified by medical professionals; and medical research and reference material.**

[(d) Any order that results from a contested case is a preliminary order subject to revision by the Director.]

[(5)] **(15)** 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 pursuant to ORS 656.254[, 656.735,] or 656.745 [or 656.750] may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) A written request for a hearing must be sent 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 received by the [D]**d**ivision within 20 calendar days after service of the order or notice of assessment.

(c) The [D]**d**ivision shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) [A referee] **An administrative law judge** from the Hearings Division, acting on behalf of the director, shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

[(6) Director's Administrative Review of Palliative care: An attending physician or insurer that disagrees with a final order concerning palliative care 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 ninety (90) days of the mailing date of the order unless the director determines that, in his or 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) The director's review of a palliative care order is a final order and is not subject to further review. However, the order does not prevent the attending physician from submitting additional requests for palliative care to the insurer for subsequent periods of time and/or forms of treatment.]

[(7)] **(16)** 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 [(6)]**15** above, 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, requested by a party aggrieved by an action taken pursuant to these rules. Any 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 [(4)] **(14)** above.

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436-010-0090 Charges And Fees

(1)(a) Inpatient and outpatient hospital 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. For purposes of this rule, inpatient hospital service 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 shall be multiplied by a hospital's adjusted cost/charge ratio to determine the allowable payment. When the insurer is auditing bills for outpatient hospital services, including emergency room services, the insurer shall first separate out and pay charges which have CPT codes and are subject to the Oregon Relative Value Schedule, pursuant to OAR 436-010-0090(5) and (15). The amount billed for services that are subject to the Oregon Relative Value Schedule should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance.

(b) Notwithstanding subsection (1)(a), 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. For the purposes of this rule, the rural hospital exemption will be based on the Financial Flexibility Index as calculated by the Oregon Health Sciences University, Office of Rural Health. As such, fee schedule exemption will be granted to all hospitals which are more than three standard deviations below the Index's zero point.

(c) Each hospital's HCFA form 2552 and audited financial statement shall be the basis for determining its adjusted cost/charge ratio. 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 (d), by the total patient revenues from Worksheet G-2.

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

(A) Malpractice Premiums and/or Self-Insurance Fund Contributions, less the Administrative portion of malpractice premiums and/or Self-Insurance Fund Contributions;

(B) Provider-Based physician adjustment;

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

(D) Telephone service;

(E) Television and radio service; and

(F) Expenses identified as for physician recruitment.

(e) 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: Use the audited financial statement and 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)(c) to obtain the factor for bad debt and charity care.

(f) The basic cost/charge ratio shall be further modified to allow for an adequate return on assets. The Director will determine an 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.

(g) The figures resulting from (e) and (f) will be added to the ratio calculated in (c) to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(h) 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 form 2552 and audited financial statements each year within [90] **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 **[**December**]** **February** 20 of each year to be effective for the subsequent six-month period beginning **[**January**]** **March** 1, and on or before **[**June**]** **August** 20 of each year to be effective for the subsequent six-month period beginning [July] **September** 1.

(i) For those newly formed or established hospitals for which no HCFA form 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.

(j) 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.

(k) If audit of a hospital's HCFA form 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.

(l) 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.

(m) 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 OAR 436-015-0090.

(2) The insurer may not pay any more than the medical provider's usual fee to the general public and, under ORS 656.248, shall in no case pay more than the 75th percentile of the usual and customary fees as determined by the director, and as published in the Oregon Relative Value Schedule, or elsewhere in these rules. 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.

(3) The director shall review and update medical fees annually by bulletin using data from a statistically valid survey, the physician service component of the National Consumer Price Index, or from any state agency having access to usual and customary medical fee information.

(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 shall 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 Relative Value Schedule at the next revision. 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) All billings shall be fully itemized, including ICD-9-CM codes, and services shall be identified by code numbers and descriptions found in the Oregon Relative Value Schedule or as otherwise provided in these rules. The definitions of commonality in the guidelines found in the Current Procedural Terminology shall be used as guides governing the descriptions of services, except as otherwise provided in the Oregon Relative Value Schedule or in these rules.

(6) All medical providers shall submit bills for medical services on current form UB92 or form HCFA 1500, except for dental billings which shall be submitted on ADA dental claim forms. 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 chart notes documenting services which have been billed.

(7) When a provider of medical services, including a hospital, submits a bill to an insurer for medical services, the medical provider shall submit a copy of such bill to the worker to whom the services were provided. The copy to the worker shall be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the worker.

(8) 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 436-010-0050;

(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 436-010-0041, 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 436-010-0100(23); 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 436-010-0045.

(9) 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.

(10) 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.

(11) 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.

(12) 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.

(13) 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.

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

(15)(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 or Oregon specific codes and reimbursed at no more than the 75th percentile as shown in the Oregon Relative Value Schedule. 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 or outpatient surgical services shall be considered part of the hospital services subject to the hospital fee schedule.

(16) 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.

(17) 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.

(18) 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.

(19) 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 the Oregon Relative Value Schedule, 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 one surgeon performs a discectomy and arthrodesis the procedure shall be billed under CPT codes 22550 through 22585 as specified in the Oregon Relative Value Schedule.

(c) 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 25 percent of the maximum allowable fee.

(d) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in the Oregon Relative Value Schedule and the subsequent procedures paid at 10 percent of the value listed.

(e) 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.

(f) Hospital charges for inpatient myelograms are not subject to the Oregon Relative Value Schedule. Physician's services for inpatient myelograms are subject to the Oregon Relative Value Schedule.

(20) (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 27) 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 technical component is to be reimbursed at 60 percent of the

maximum allowable fee and the professional component is to be reimbursed at 40 percent of the maximum allowable fee.

(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 60 percent for the technical component and 40 percent for the professional component.

(21) Outpatient hospital services shall be reimbursed as follows:

(a) The maximum allowable fees for X-ray and physical therapy, as determined by the Oregon Relative Value Schedule, 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 the Oregon Relative Value Schedule. 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 the Oregon Relative Value Schedule.

(22) A physical medicine modality or manipulation, when applied to two or more areas at one visit, shall be reimbursed at 100 percent of the maximum allowable fee for the first area treated, 50 percent for the second area treated, and 25 percent for all subsequent areas treated. This rule does not apply when a physical therapist uses CPT codes 97200 and 97201 from the Oregon Relative Value Schedule for physical therapy.

(23) When ultrasound, diathermy, microwave, infrared and hot packs are used in combinations of two or more during one treatment session, only one shall be reimbursed, unless two separate effects are demonstrated.

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

(25) (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 CARE 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.

(c) Billings for medical services provided within a CARF or JCAHO accredited multidisciplinary program which do not have established CPT codes shall be billed based upon

the Oregon specific codes identified in the Oregon Relative Value Schedule for multidisciplinary programs. 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.

(d) When an attending physician approves a multidisciplinary treatment program for an injured worker, the attending physician must provide the insurer with a copy of the approved treatment program within 7 days of the beginning of the treatment program.

(e) Notwithstanding section (5) of this rule, 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.

(26) Dimethylsulfoxide (DMSO) is not reimbursable except for treatment of compensable interstitial cystitis. Additionally, surface EMG tests, rolfing, prolotherapy, and thermography are not reimburseable. These nonreimburseable services may be administered; however, medical providers shall not receive additional reimbursement for providing such services.

(27) 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 of the Oregon Relative Value Schedule.

(28) 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 results from the machine, an interpretation of the results, and a report.

(29) 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.

(30) Fees and codes for records and reports requested by an insurer, worker, employer, or their representative:

(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 436-010-0090(6).

(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 Oregon specific code R0001.

(c) Brief Narrative - Summary of treatment to date and current status; answer to 3-5 specific questions shall be reimbursed, using the conversion factor for Medicine," at a relative value of 6.66 units and identified on billings by Oregon specific code N0001.

(d) Complete Narrative - Past history, history of present illness, treatment to date, current status, impairment, prognosis, medically stationary information shall be reimbursed, using the conversion factor for Medicine," at a relative value of 13.32 units and identified on billings by Oregon specific code N0002.

(e) When a medical service provider is asked to review records or reports prepared by another medical provider, the medical service provider should bill for their review of the records utilizing CPT Code 99080. The billing should include the actual time spent reviewing the records or reports and should list the medical service provider's normal hourly rate for such review. This would include, but not be limited to, insurer medical examination reports.

(31) Fee and codes for a deposition (includes preparation time):

(a) First hour of deposition: Relative value of 39.95 units; (including preparation using the conversion factor for time) "Medicine (Oregon specific code D0001)

(b) Each subsequent hour or Relative value of 13.32 units; portion thereof using the conversion factor for "Medicine" (Oregon specific code D0002)

[ED. NOTE: This Section has been moved to, and included in, Section (26) of this Rule.]

(32) The CPT codes included in Appendix "A" attached hereto are included in and made a part of the Oregon Relative Value Schedule, adopted effective July 1, 1992.

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