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CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

FILING CAPTION: Workers' compensation medical fees and payments, medical services, MCOs, and visual field loss impairment rating.

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RULES:
436-009-0004, 436-009-0005, 436-009-0010, 436-009-0012, 436-009-0023, 436-009-0030, 436-009-0040, 436-009-0060, 436-009-0080, 436-009-0110, 436-010-0270, 436-015-0037, 436-035-0260

AMEND: 436-009-0004

RULE TITLE: Adoption of Standards

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0004:
-Adopts, by reference, new medical billing codes and related references; and
-Adopts, in rule or by reference, CPT® codes and descriptors published by the American Medical Association.

RULE TEXT:
(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2026 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2026, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumberg, IL 60173, 847-825-5586, or www.asahq.org.
(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2026), Fourth Edition Revised, 2025, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 2026 govern the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.
(3) The director adopts, by reference, the AMA's CPT® Assistant, Issue 04, 1990 through Issue 12, 2025. If there is a conflict between CPT® 2026 and the CPT® Assistant, CPT® 2026 is the controlling resource.
(4) To get a copy of the CPT® 2026, or the CPT® Assistant, contact the American Medical Association, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885, 312-464-4782, or www.ama-assn.org.
(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.
(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
(6) The director adopts, by reference, CDT 2026: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, 312-440-2500, or www.ada.org.
(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 13.0 7/25 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, or www.nucc.org.
(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2025 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606, 312-422-3000, or www.nubc.org.
(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 –5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or www.ncpdp.org.
(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2026, CPT® 2026, CPT® Assistant, HCPCS 2026, CDT 2026. 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.
(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem, OR 97301.

STATUTORY/OTHER AUTHORITY: ORS 656.248, ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248

AMEND: 436-009-0005

RULE TITLE: Definitions

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0005 adds a definition of “regular Oregon business hours.”

RULE TEXT:

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

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

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

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

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

(d) EDI means electronic data interchange.

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

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

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

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

(i) NPI means national provider identifier.

(j) OSC means Oregon specific code.

(k) PCE means physical capacity evaluation.

(l) WCE means work capacity evaluation.

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

(4) “Ambulatory surgery center” or “ASC” means:

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

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

(5) “Attending physician” has the same meaning as described in ORS 656.005(12)(b). See Appendix A, “Matrix for Health Care Provider Types.” [Attached.]

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

(7) “Board” means the Workers’ Compensation Board and includes its Hearings Division.

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

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

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

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

(12) “Date stamp” means to stamp or display the initial receipt date and the recipient’s name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(13) “Days” means calendar days.

(14) “Director” means the director of the Department of Consumer and Business Services or the director’s designee.

(15) “Division” means the Workers’ Compensation Division of the Department of Consumer and Business Services.
(16) “Enrolled” means an eligible worker has received notification from the insurer that the worker is being required to receive treatment under the provisions of a managed care organization (MCO). However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker’s primary residence is more than 100 miles outside the MCO’s certified geographical service area.
(17) “Fee discount agreement” means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.
(18) “Good Cause” means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.
(19) “Hospital” means an institution licensed by the State of Oregon as a hospital.
(a) “Inpatient” means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.
(b) “Outpatient” means a patient not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments that do not result in admission are also considered outpatient services.
(20) “Initial claim” means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the “initial claim” means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.
(21) “Insurer” means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 and meets the qualifications of a self-insured employer under ORS 656.407.
(22) “Interim medical benefits” means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002, that are not denied within 14 days of the employer’s notice of the claim.
(23) “Interpreter” means a person who:
(a) Provides oral or sign language translation; and
(b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider’s employee, or a family member or friend of the worker.
(24) “Interpreter services” means the act of orally translating between a medical provider and a worker who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the worker as well as reasonable time spent on necessary paperwork for the provider’s office.
(25) “Legal holidays” means holidays listed in ORS 187.010 and 187.020.
(26) “Mailed or mailing date” means the date a document is postmarked. Requests submitted by facsimile or “fax” are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped by the division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.
(27) “Managed care organization” or “MCO” means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.
(28) “Medical provider” means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.
(29) “Medical service” means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.
(30) “Medical service provider” means a person duly licensed to practice one or more of the healing arts.
(31) “Medical treatment” means the management and care of a patient for the purpose of combating disease, injury, or

disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.
(32) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.
(33) "Patient" means the same as worker as defined in ORS 656.005(28).
(34) "Physical capacity evaluation" means an objective, directly observed, measurement of a patient's ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.
(35) "Provider network" means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.
(36) "Regular Oregon business hours" means from 8:00 am to 5:00 pm Pacific Time.
(37) "Report" means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.
(38) "Residual functional capacity" means a patient's remaining ability to perform work-related activities. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the patient can perform each activity.
(39) "Specialist physician" means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.
(40) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A). See Appendix A, "Matrix for Health Care Provider Types." [Attached.]
(41) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B). See Appendix A, "Matrix for Health Care Provider Types." [Attached.]
(42) "Usual fee" means the medical provider's fee charged to the general public for a given service.
(43) "Work capacity evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening has the same meaning as Work Capacity Evaluation.
(44) "Work hardening" means an individualized, medically prescribed and monitored, work-oriented treatment process. The process involves the patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.726(4), ORS 656.000 et seq., ORS 656.005

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

	Attending physician status (primarily responsible for treatment of a patient)	Provides compensable medical services for initial injury or illness	Authorizes payment of temporary disability and releases the patient to work	Establishes impairment findings (permanent disability)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathic medicine Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician	Yes, for a total of 60 consecutive days or 18 visits, from the date of the first visit on the initial claim with any type B attending physician.	Yes, unless the total of 60 consecutive days or 18 visits from the date of the first visit on the initial claim with any type B attending physician has passed. Or, if authorized by an attending physician and under a treatment plan.	Yes, 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18 visit period.	No, unless the type B attending physician is a chiropractic physician.	No, unless authorized by a type A attending physician and under a written treatment plan.
Type C attending physician Physician Assistant	Yes, for a total of 180 consecutive days from the date of the first visit on the initial claim with any physician assistant.	Yes, for 180 consecutive days from the date of the first visit to any physician assistant on the initial claim. Or, if authorized by an attending physician.	Yes, for 180 days from the date of the first visit with any physician assistant on the initial claim.	No	No, unless authorized by a type A attending physician.
Authorized nurse practitioner	No	Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or, if authorized by an attending physician.	Yes, for 180 days from the date of the first visit with any authorized nurse practitioner on the initial claim.	No	No, unless authorized by a type A attending physician.
Emergency room physician	No, if the physician refers the patient to a primary care physician.	Yes	An ER physician who is not authorized to serve as attending physician under ORS 656.005(12)(c) may authorize temporary disability for up to 14 days, including retroactive authorization.	No, if patient referred to a primary care physician.	Yes
"Other Health Care Providers" e.g. acupuncturists	No	Yes, for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any "Other Health Care Providers." Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No, unless referred by a type A attending physician and under a written treatment plan.

* This matrix does not apply to managed care organizations

AMEND: 436-009-0010

RULE TITLE: Medical Billing and Payment

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0010 updates references to CPT® 2026.

RULE TEXT:

(1) General.

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim. Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner. Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

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

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

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

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

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

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

(a) Medical providers must bill within:

(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

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

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

(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause.

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

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

(3) Billing Forms.

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).
(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or CMS 1500 except for:
(A) Dental billings, which must be submitted on American Dental Association dental claim forms;
(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or
(C) Electronic billing transmissions of medical bills (see OAR 436-008).
(c) Notwithstanding subsection (3)(b) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.
(d) Medical providers may use computer-generated reproductions of the appropriate forms.
(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual. [See attached table.]
(4) Billing Codes.
(a) When billing for medical services, a medical provider must use codes listed in CPT® 2026, or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service. If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service. If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2026, or the appropriate unlisted HCPCS code, and provide a description of the service provided. A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.
(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.
(5) Modifiers.
(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2026, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.
(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:
(A) Unusually lengthy procedure;
(B) Excessive blood loss during the procedure;
(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);
(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;
(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or
(F) The services rendered are significantly more complex than described for the submitted CPT®.
(6) Physician Associates and Nurse Practitioners. Physician associates and nurse practitioners must document in the chart notes that they provided the medical service. If physician associates or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."
(7) Chart Notes.
(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.
(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.
(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes.

The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.
(8) Challenging the Provider's Bill. For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.
(9) Billing the Patient and Patient Liability.
(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:
(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;
(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;
(C) If the insurer notifies the patient that they are medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;
(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or
(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.
(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.
(c) A provider may bill a patient for a missed appointment under section (13) of this rule.
(10) Disputed Claim Settlement (DCS). The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.
(11) Payment Limitations.
(a) Insurers do not have to pay providers for the following:
(A) Completing form 827;
(B) Providing chart notes with the original bill;
(C) Preparing a written treatment plan;
(D) Supplying progress notes that document the services billed;
(E) Completing a work release form or completion of a PCE form, when no tests are performed;
(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or
(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.
(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.
(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.
(12) Excluded Treatment. The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:
(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;
(b) Intradiscal electrothermal therapy (IDET);
(c) Surface electromyography (EMG) tests;
(d) Rolfing;
(e) Prolotherapy;
(f) Thermography;
(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:
(A) The single level artificial disc replacement is between L3 and S1;
(B) The patient is 16 to 60 years old;
(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and
(D) The procedure is not found inappropriate under OAR 436-010-0230;
(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and
(i) Platelet rich plasma (PRP) injections, unless they are for non-operative:
(A) Knee: Osteoarthritis pain, chondral surface injury and partial thickness meniscal tears after failure of three months of conservative care, which may include a standard course of physical therapy;
(B) Elbow: Lateral and medial epicondylitis after failure of three months of conservative care, which may include a standard course of physical therapy; or
(C) Shoulder: Tendon, bursa, and muscle injuries, including partial tears and small tears, and adhesive capsulitis after failure of three months of conservative care, which may include a standard course of physical therapy.
(13) Missed Appointment (No Show).
(a) In general, the insurer does not have to pay for “no show” appointments. However, insurers must pay for “no show” appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.
(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:
(A) The provider has a written missed-appointment policy that applies not only to workers’ compensation patients, but to all patients;
(B) The provider routinely notifies all patients of the missed-appointment policy;
(C) The provider’s written missed-appointment policy shows the cost to the patient; and
(D) The patient has signed the missed-appointment policy.
(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider’s policy.

STATUTORY/OTHER AUTHORITY: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-009-0010 Medical Billing and Payment****

(3) Billing Forms. ****

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

Box Reference Number	Instruction
10d	May be left blank
11a, 11b, and 11c	May be left blank
17a	May be left blank if box 17b contains the referring provider's NPI
21	For dates of service prior to Oct. 1, 2015, use ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, use ICD-10-CM codes.
22	May be left blank
23	May be left blank
24D	The provider must use the following codes to accurately describe the services rendered: • CPT® codes listed in CPT® ~~2025~~ 2026; • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® ~~2025~~ 2026 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician associates must use modifier "81" when billing as the surgical assistant during surgery.
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	If the bill includes the rendering provider's NPI in the nonshaded area of box 24J, the shaded area of box 24I and 24J may be left blank. If the rendering provider does not have an NPI, then include the rendering provider's state license number and use the qualifier "0B" in box 24I.

32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

AMEND: 436-009-0012

RULE TITLE: Telehealth

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0012 updates references to CPT® 2026.

RULE TEXT:

(1) Definitions.

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

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

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

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

(2) Scope of services.

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

(b) Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2025 or CPT® 2026.

(3) Distant site provider billing.

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

(A) Use the place of service (POS) code “02” (Telehealth Provided Other than in Patient’s Home) or “10” (Telehealth Provided in Patient’s Home); and

(B) Except for services billed with CPT® codes 98000 – 98007, use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.

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

(A) Must use the POS code “02” (Telehealth Provided Other than in Patient’s Home) or “10” (Telehealth Provided in Patient’s Home); and

(B) May not use modifier 95.

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

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

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

(5) Payment.

(a) Insurers must pay distant site providers at the non-facility rate or at the provider's usual fee, whichever is less.

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

(c) The payment amount for code Q3014 is $35.70 per unit or the provider’s usual fee, whichever is lower. In calculating the units of time, 15 minutes, or any portion of 15 minutes, equals one unit.

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

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

STATUTORY/OTHER AUTHORITY: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254, ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.254

Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

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

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers. [Effective January 1, 2026]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective January 1, 2026]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective January 1, 2026]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective January 1, 2026]

Note: If the above links do not connect you to the division's website, click:
https://wcd.oregon.gov/medical/Pages/disclaimer.aspx
If you have questions, call the Workers' Compensation Division, 503-947-7606.

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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

Or, contact the division for a paper copy, 971-286-0316

AMEND: 436-009-0023

RULE TITLE: Ambulatory Surgery Center (ASC)

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0023's ambulatory surgery center fee schedules, Appendices C and D, include new billing codes for 2026. While some maximum payment amounts are higher or lower, the overall reimbursement is not projected to change.

RULE TEXT:

(1) Billing Form.

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

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

(2) ASC Facility Fee.

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

(A) Nursing, technical, and related services;

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

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

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

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

(F) Materials for anesthesia;

(G) Supervision of the services of an anesthetist by the operating surgeon; and

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

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

(3) ASC Billing.

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

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

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

(4) ASC Payment.

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

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

(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or

(B) The ASC's usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly. The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.

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

(e) When the ASC's cost of an implant is $100 or more, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.
(f) When the ASC's cost of an implant is less than $100, insurers are not required to pay separately for the implant. An implant may consist of several separately billable components, some of which may cost less than $100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.
(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:
(A) The ASC is not a contracted facility for the MCO;
(B) The MCO has not pre-certified the service provided; or
(C) The surgeon is not an MCO panel provider.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-009-0023 Ambulatory Surgery Center (ASC) ****

(4) ASC Payment. ****

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

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

*****

Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

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Or, contact the division for a paper copy, 971-286-0316

AMEND: 436-009-0030

RULE TITLE: Insurer's Duties and Responsibilities

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0030 clarifies that insurers must respond to medical providers' payment questions during regular Oregon business hours.

RULE TEXT:

(1) General.

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

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

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

(2) Bill Processing.

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b), (3), and (7) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill. The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.

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

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

(3) Payment Requirements.

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

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

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

(A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must

clearly separate and identify payments for each patient;
(B) The specific reason for nonpayment, reduced payment, or discounted payment for each service billed;
(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within two days during regular Oregon business hours, excluding Saturdays, Sundays, and legal holidays;
(D) The following notice, Web link, and phone number:

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

(E) Space for the provider's signature and date; and
(F) A notice of the right to administrative review in bold text and formatted as follows:

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:
- Submit your request within 90 days of the mailing date of this explanation
- Sign and date this explanation in the space provided
- Explain why you think the payment is incorrect
- Attach required supporting documentation of your expense
- Send the documents to:
DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405
Or
Fax your request to the Medical Resolution Team at 503-947-7629
- Send a copy of your request to the insurer
Keep a copy of this document for your records.

(d) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.
(e) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily applies such a service charge to the general public.
(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment or reduction of each medical service code.
(g) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid within 45 days of receipt by the insurer even if the claim is denied.
(h) If an insurer determines that it has made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.
(4) Electronic Payment.
(a) An insurer may pay a provider through a direct deposit system, automated teller machine card or debit card, or other means of electronic transfer if the provider voluntarily consents.

(A) The provider's consent must be obtained before initiating electronic payments.
(B) The consent may be written or verbal. The insurer must send the provider a written confirmation when consent is obtained verbally.
(C) The provider may discontinue receiving electronic payments by notifying the insurer in writing.
(b) Cardholder agreement for ATM or debit cards. The provider must receive a copy of the cardholder agreement outlining the terms and conditions under which an automated teller machine card or debit card has been issued before or at the time the initial electronic payment is made.
(c) Instrument of payment. The instrument of payment must be negotiable and payable to the provider for the full amount of the benefit paid, without cost to the provider.
(5) Communication with Providers.
(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within two days, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.
(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Information Protection Act under ORS 646A.600 to 646A.628 and federal law.
(6) EDI Reporting. For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248, ORS 656.252, ORS 656.260, ORS 656.264, ORS 656.325

AMEND: 436-009-0040

RULE TITLE: Fee Schedule

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0040:
-Makes changes to associated Appendix B, physician fee schedule, to include new billing codes for 2026;
-Assign a maximum payment amount for platelet rich plasma injection; and
-Some maximum payment amounts may be higher or lower, but the overall reimbursement is not projected to change.

RULE TEXT:
(1) Fee Schedule Table.
(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table: [See attached table.]
(b) The global period is listed in the column 'Global Days' of Appendix B.
(2) Anesthesia.
(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.
(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.
(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier 'NT' (no time) must be on the bill.
(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.
(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.
(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $60.93. Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:
(A) The maximum allowable payment amount for anesthesia codes; or
(B) The provider's usual fee.
(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.
(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.
(3) Surgery. Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:
(a) One surgeon [See attached table.]
(b) Two or more surgeons [See attached table.]
(c) Assistant surgeons [See attached table.]
(d) Nurse practitioners or physician associates [See attached table.]
(e) Self-employed surgical assistants who work under the direct control and supervision of a physician [See attached table.]
(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.
(g) If the surgery is nonelective, the physician is entitled to payment for the initial evaluation of the patient in addition to

the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.
(4) Radiology Services.
(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.
(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component. The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.
(5) Pathology and Laboratory Services.
(a) The payment amounts in Appendix B apply only when there is direct physician involvement.
(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.
(6) Physical Medicine and Rehabilitation Services.
(a) Time-based CPT® codes must be billed and paid per code according to this table: [See attached table.]
(b) Except for CPT® codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code. When a provider bills for more than three separate CPT®-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.
(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.
(d) CPT® codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.
(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.
(7) Reports.
(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT® codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.
(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.
(8) Nurse Practitioners and Physician Associates. Services provided by authorized nurse practitioners, physician associates, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-009-0040 Fee Schedule ***

(1) Fee Schedule Table. ****

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

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

****

(3) Surgery.

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

(a) One surgeon

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

(b) Two or more surgeons

Procedures	**Appendix B lists:**	**The payment amount for each surgeon is:**	
Each surgeon performs a principal procedure (and any additional procedures) Any additional procedures including: • diagnostic arthroscopy performed prior to open surgery • the second side of a bilateral procedure	A dollar amount	The lesser of:	75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or
			The billed amount
	80% of billed amount	60% of the billed amount (and 30% of the billed amount for any additional procedures*) (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)	
*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global			

period indicator of ZZZ.

(c) Assistant surgeons

Procedures	**Appendix B lists:**	**The payment amount is:**	
One or more surgical procedures	A dollar amount	The lesser of:	20% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	20% of the surgeon(s) fee calculated in subsections (a) or (b)	

(d) Nurse practitioners or physician assistants

Procedures	**Appendix B lists:**	**The payment amount is:**	
One or more surgical procedures as the primary surgical provider, billed without modifier "81."	A dollar amount	The lesser of:	85% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	85% of the surgeon(s) fee calculated in subsections (a) or (b)	
One or more surgical procedures as the surgical assistant*	A dollar amount	The lesser of:	15% of the surgeon(s) fee calculated in subsections (a) or (b); or
			The billed amount
	80% of billed amount	15% of the surgeon(s) fee calculated in subsections (a) or (b)	
*Physician assistants and nurse practitioners must mark their bills with a modifier "81." Chart notes must document when medical services have been provided by a physician assistant or nurse practitioner.			

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

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

****

(6) Physical Medicine and Rehabilitation Services.

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

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

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Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

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Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective January 1, 2026]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective January 1, 2026]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective January 1, 2026]

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Or, contact the division for a paper copy, 971-286-0316

AMEND: 436-009-0060

RULE TITLE: Oregon Specific Codes

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0060 provides that OSC W0001 may also be used to bill for an addendum to a WRME report when authored in response to an IME addendum report.

RULE TEXT:
(1) Multidisciplinary Services.
(a) Services provided by multidisciplinary programs not otherwise described by CPT® codes must be billed under Oregon specific codes.
(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:
(A) The type of service rendered,
(B) The medical provider who provided the service,
(C) Whether treatment was individualized or provided in a group session, and
(D) The amount of time treatment was rendered for each service billed.
(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.) [See attached table.]
(3) CARF / JCAHO Accredited Programs.
(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.
(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.
(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-009-0060 Oregon Specific Codes ****

(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.)

Service	OSC
Addictionologist consultant services: Services requested by a managed care organization consisting of an extensive records review, a physical exam, reports, responses to letters, and urine drug screening.	D0091
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A complex exam that may have several complicating factors.	AR003
Arbiter exam - level 4: A very complex exam that may have several complicating factors or multiple body systems.	AR004
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR005
Arbiter exam – psychiatric and neuropsychological exam: First hour of the examination.	AR006
Arbiter exam – psychiatric and neuropsychological exam: Each additional 30 minutes of the examination. If an arbiter bills for a portion of 30 minutes, the insurer must round the time up to the next 30 minutes and pay one unit for the portion of time.	AR007
Arbiter file review - level 1: A file review of a limited record.	AR021

Service	OSC
Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - level 4: A report that answers complex questions and addresses several complicating factors or multiple body systems.	AR014
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001

Service	OSC
Copies of medical records electronically: Electronic copies of medical records provided on a disc or USB drive, uploaded to an insurer's secure website, or using secure email or e-fax, requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002
Director required medical exam: Services by a physician selected under ORS 656.327 to perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate for exam (P0001) and record review (P0002) up to six hours combined.	P0001
Director required file review time: Time spent by a physician selected under ORS 656.327 to review the record. Services must be paid at an hourly rate for record review (P0002) and exam (P0001) up to six hours combined.	P0002
Director required medical report: Preparation and submission of the report.	P0003
Director required review - complex case fee: One time, flat fee pre-authorized by the director for an extensive review in a complex case.	P0004
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003
IME – review and response: Insurer-requested review and response by treating physician; document time spent.	D0019
Interdisciplinary rehabilitation conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655

Service	OSC
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – provided by a noncertified interpreter, excluding American Sign Language	D0004
Interpreter services – American Sign Language	D0005
Interpreter services - provided by a health care interpreter certified by the Oregon Health Authority, excluding American Sign Language	D0006
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002

Service	OSC
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644

Service	OSC
Physical conditioning – individual - each additional 30 minutes	97645
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Records review: Review of medical records on an MCO-enrolled claim by a nontreating physician requested by an insurer or a managed care organization.	RECRW
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Video Review: Review of video requested by an insurer or a managed care organization.	VIDEO
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662
Vocational evaluation - each additional 15 minutes	97663

Service	OSC
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam, report, ~~or~~ time spent reviewing the records associated with the scheduled exam, or addendum to a report when authored in response to an IME addendum report.	W0001

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Appendices B through E

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AMEND: 436-009-0080

RULE TITLE: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0080:
-The durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule, Appendix E, includes new billing codes for2026; and
-Increases overall maximum payments by 1.5 percent for the DMEPOS fee schedule, Appendix E.

RULE TEXT:
(1) Durable medical equipment (DME), such as Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc., is equipment that:
(a) Is primarily and customarily used to serve a medical purpose,
(b) Can withstand repeated use,
(c) Could normally be rented and used by successive patients,
(d) Is appropriate for use in the home, and
(e) Is not generally useful to a person in the absence of an illness or injury.
(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prescribed prosthetic appliance, the worker may do so but must pay the difference in price.
(3) An orthotic is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.
(4) Supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.
(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:
(a) NU for purchased, new equipment;
(b) UE for purchased, used equipment; and
(c) RR for rented equipment
(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table: [See attached table.]
(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes): [See attached table.]
(8) For items rented, unless otherwise provided by contract:
(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.
(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.
(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.
(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:
(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or

(b) The provider may offer a service agreement at an additional cost.
(10) Hearing aids: Notwithstanding OAR 436-009-0010(1)(a), a licensed audiologist may prescribe programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel hearing aids without the approval of an attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. Any hearing aids other than BTEs, ITEs, or CICs needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner. Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $7000 for a pair of hearing aids, or $3500 for a single hearing aid. If the worker chooses to upgrade the prescribed hearing aid, the worker may do so but must pay the difference in price.
(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for vision services billed with HCPCS codes V0000 through V2999.
(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.
(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.
(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.248

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

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

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

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

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

Code	Monthly Rate		Code	Monthly Rate
E0163	$26.33		E0849	$98.40
E0165	$30.24		E0900	$93.68
E0168	$27.28		E0935	$996.97
			E0940	$52.20
E0261	$259.66			
E0277	$1135.64		E0990	$25.52
			E1800	$262.29

E0441	$86.85		E1815	$276.15
E0650	$1423.50		E2402	$2487.86

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AMEND: 436-009-0110

RULE TITLE: Interpreters

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0110:
-Clarifies that when an insurer denies a claim, an interpreter may only bill a worker if the interpreter is chosen by the worker; and
-Clarifies that insurers must respond to interpreters' payment questions during regular Oregon business hours.

RULE TEXT:
(1) Choosing an Interpreter.
(a) A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or an interpreter. However, for signed language interpretation services, the worker may only choose an interpreter who is a medical sign language interpreter licensed under ORS 676.765. A representative of the worker's employer may not provide interpreter services. The medical provider may disapprove of the worker's choice at any time the medical provider feels the interpreter services are not improving communication with the worker, or feels the interpretation is not complete or accurate.
(b) When a worker asks an insurer to arrange for interpreter services, the insurer must:
(A) For interpretation services, other than signed language interpretation services, use a certified or qualified health care interpreter listed on the Oregon Health Care Interpreter Registry of the Oregon Health Authority available at: http://www.oregon.gov/OHA/OEI/Pages/HCI-Program.aspx. The interpreter's certification or qualification must be in effect on the date the interpreter services are provided. If no certified or qualified health care interpreter is available, the insurer may schedule an interpreter of its choice subject to the limits in subsection (a) of this section.
(B) For signed language interpretation services, use a sign language interpreter licensed under ORS 676.750 to 676.789.
(c) Prior to offering interpreter services by a health care interpreter employed by the medical provider, the medical provider must inform the worker of the worker's right to choose an interpreter.
(2) Billing.
(a) Interpreters must charge the usual fee they charge to the general public for the same service.
(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the interpreter is chosen by the worker and the insurer denies the claim, the interpreter may bill the worker.
(c) Interpreters may bill for interpreter services and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule, "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location and back to the interpreter's starting point.
(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:
(A) The worker fails to attend the appointment; or
(B) The provider has to cancel or reschedule the appointment.
(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the division at 503-947-7814. They may also access insurance policy information at http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm.
(3) Billing and Payment Limitations.
(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if the provider cancels or reschedules the appointment.
(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, an interpreter may bill a workers' compensation client if the client fails to attend the appointment and if:

(A) The interpreter has a written missed-appointment policy that applies not only to workers' compensation clients, but to all clients;
(B) The interpreter routinely notifies all clients of the missed-appointment policy;
(C) The interpreter's written missed-appointment policy shows the cost to the client; and
(D) The client has signed the missed-appointment policy.
(c) The implementation and enforcement of subsection (b) of this section is a matter between the interpreter and the client. The division is not responsible for the implementation or enforcement of the interpreter's policy.
(d) The insurer is not required to pay for interpreter services or mileage when the services are provided by:
(A) A family member or friend of the worker; or
(B) A medical provider's employee, unless the employee is a health care interpreter certified or qualified by the Oregon Health Authority and is employed by the provider solely to provide in-person (face-to-face) interpreter services.
(e) A health care interpreter certified or qualified by the Oregon Health Authority who is employed by a medical provider solely to provide in-person (face-to-face) interpreter services is not entitled to mileage reimbursement.
(4) Billing Timelines.
(a) Interpreters must bill within:
(A) 60 days of the date of service;
(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or
(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.
(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the interpreter may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.
(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause.
(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.
(5) Billing Form.
(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:
(A) D0004 for interpreter services, excluding American Sign Language interpreter services, provided by noncertified interpreters;
(B) D0005 for American Sign Language interpreter services;
(C) D0006 for interpreter services, excluding American Sign Language interpreter services, provided by a health care interpreter certified by the Oregon Health Authority;
(D) D0007 for interpreter services provided by a health care interpreter certified or qualified by the Oregon Health Authority and employed by the provider solely to provide in-person (face-to-face) interpreter services; and
(E) D0041 for mileage.
(b) An interpreter's invoice must include:
(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;
(B) The worker's name;
(C) The worker's workers' compensation claim number, if known;
(D) The correct Oregon specific codes for the billed services (D0004, D0005, D0006, D0007, or D0041);
(E) The workers' compensation insurer's name and address;
(F) The date interpreter services were provided;
(G) The name and address of the medical provider that conducted the exam or provided treatment;
(H) The total amount of time interpreter services were provided; and
(I) The mileage, if the round trip was 15 or more miles.
(6) Payment Calculations.
(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.

(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters: [See attached table.]
(7) Payment Requirements.
(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.
(b) When the worker fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay the no-show fee and mileage if the round-trip mileage is 15 or more miles.
(c) The insurer must retain the invoice and pay the interpreter within:
(A) 14 days of the date of claim acceptance or any action causing the service to be payable, which includes receiving a bill for or chart note of the corresponding medical appointment, or 45 days of receiving the invoice, whichever is later; or
(B) 45 days of receiving the invoice for an exam required by the insurer or director.
(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.
(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.
(f) If the insurer does not receive all the information to process the invoice, other than a bill for or chart note of the corresponding medical appointment, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.
(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for nonpayment or reduction of each service billed.
(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.
(i) Electronic and written explanations must include:
(A) The payment amount for each service billed. When the payment covers multiple workers, the explanation must clearly separate and identify payments for each worker;
(B) The specific reason for nonpayment, reduced payment, or discounted payment for each service billed;
(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within two days, excluding Saturdays, Sundays, and legal holidays;
(D) The following notice, Web link, and phone number:

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

(E) Space for a signature and date; and
(F) A notice of the right to administrative review in bold text and formatted as follows:

If you disagree with this decision about payment, contact {the insurer or its representative} first. If you still disagree about payment, you may request administrative review by the Department of Consumer and Business Services (DCBS). To request review, you must do all of the following:
- Submit your request within 90 days of the mailing date of this explanation
- Sign and date this explanation in the space provided
- Explain why you think the payment is incorrect

- Attach required supporting documentation of your expense
- Send the documents to:
DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405
Or
Fax your request to the Medical Resolution Team at 503-947-7629
- Send a copy of your request to the insurer
Keep a copy of this document for your records.

(j) The insurer or its representative must respond to an interpreter's inquiry about payment within two days during regular Oregon business hours, excluding Saturdays, Sundays, and legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.
(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Information Protection Act under ORS 646A.600 to 646A.628 and federal law.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.245, ORS 656.248

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-009-0110 Interpreters ****

(6) Payment Calculations. ****

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

For:	The maximum payment is:
Interpreter services provided by a noncertified or nonqualified interpreter of an hour or less	$75.00
In-person (face to face) interpreter services of two hours or less provided by health care interpreters certified or qualified by the Oregon Health Authority[1] who are not employed by a health care provider	$174.00
Interpreter services via video or audio of one hour or less provided by health care interpreters certified or qualified by the Oregon Health Authority[1]	$87.00
In-person (face to face) American sign language interpreter services of two hours or less	$174.00
American sign language interpreter services via video or audio of one hour or less	$87.00
Interpreter services provided by a noncertified or nonqualified interpreter of more than one hour	$18.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
In-person interpreter service of more than two hours or, if provided via video or audio, of more than one hour provided by health care interpreters certified or qualified by the Oregon Health Authority[1]	$21.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
In-person American sign language	$21.75 per 15-minute increment; a 15-

interpreter services of more than two hours or, if provided by video or audio, of more than one hour	minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
In-person (face to face) interpreter services of 15 minutes or more provided by health care interpreters certified or qualified by the Oregon Health Authority[1] employed by a medical provider solely to provide interpreter services	$21.75 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Mileage of less than 15 miles round trip	No payment allowed
Mileage of 15 or more miles round trip	The private vehicle mileage rate published in Bulletin 112
An examination required by the director or insurer that the worker fails to attend or when the provider cancels or reschedules	$75.00 no-show fee plus payment for mileage if 15 or more miles round trip
An interpreter who is the only person in Oregon able to interpret a specific language	The amount billed for interpreter services and mileage
[1] A list of certified health care interpreters can be found online under the Health Care Interpreter Registry at http://www.oregon.gov/oha/oei/Pages/HCI-Program.aspx .	

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AMEND: 436-010-0270

RULE TITLE: Insurer's Rights and Duties

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0270:
-Provides that, within seven days of notice or knowledge that the worker is medically stationary, the insurer must notify the worker and all actively treating ancillary care providers in writing which medical services remain compensable;
-Clarifies that, for the purpose of this rule, "actively treating ancillary care providers" means ancillary care providers who have submitted a current treatment plan to the insurer as required by OAR 436-010-0230; and
-Defines "regular Oregon business hours" and clarifies that insurers must respond to medical providers' inquiries about claim status, accepted conditions, or MCO enrollment during regular Oregon business hours.

RULE TEXT:
(1) Notifications.
(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.
(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.
(c) In disabling and nondisabling claims, within seven days notice or knowledge that the worker is medically stationary, the insurer must notify the worker, the attending physician, and all actively treating ancillary care providers in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c). For the purpose of this rule, actively treating ancillary care providers means ancillary care providers who have submitted a current treatment plan to the insurer as required by OAR 436-010-0230.
(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.
(2) Medical Records Requests.
(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.
(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.
(3) Pre-authorization. Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.
(4) Communication with Providers.
(a) The insurer or its representative must respond to a medical provider's inquiry about claim status, accepted conditions, or MCO enrollment within two days during regular Oregon business hours, excluding Saturdays, Sundays, and legal holidays listed in ORS 187.010 and 187.020. For the purpose of this rule, "regular Oregon business hours" means from 8:00 am to 5:00 pm Pacific Time. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.
(b) An insurer or its representative and a medical provider may agree to communicate about claim status, accepted conditions, or MCO enrollment by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Information Protection Act under ORS 646A.600 to 646A.628 and federal law.
(5) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:
(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);
(B) How workers can receive compensable medical services within the MCO;
(C) How workers can receive compensable medical services by non-panel providers; and
(D) The geographical service area governed by the MCO.
(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.
(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the worker's attorney's name, mailing address, phone number, and, if known, fax number and email address to the MCO.
(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:
(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:
(i) Provide a telephone number the worker may call to ask for a written list; and
(ii) Tell the worker that they have seven days from the mailing date of the notice to request the list;
(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;
(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:
(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or
(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;
(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;
(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the workers with health care benefits even if a workers' compensation claim is denied; and
(F) Notify the worker of the worker's right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.
(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.
(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.
(g) The insurer may delegate to the MCO responsibility for issuing the enrollment notice required by ORS 656.245(4)(a) and these rules by express provision in the contract between those parties; however, the insurer remains liable for any deficiencies in the notice issued by the MCO.
(h) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0037(3).
(i) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute

resolution process and a copy has not been sent to the MCO, the insurer must:
(A) Send a copy of the dispute to the MCO; or
(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.
(j) The insurer must notify the MCO within seven days of receiving notification of the following:
(A) When the worker obtains representation by an attorney, the attorney's name, mailing address, phone number, and, if known, fax number and email address;
(B) Any changes to the worker's or worker's attorney's name, address, or telephone number;
(C) Any requests for medical services from the worker or the worker's medical provider; or
(D) Any request by the worker to continue treating with a "come-along" provider.
(k) When an MCO pre-certifies a surgical service as medically appropriate, the insurer must, within 45 days from the mailing date of the MCO decision, notify the worker, the worker's representative, the provider, and the MCO whether the insurer approves the surgery.
(A) If the insurer disapproves the surgery for reasons other than appropriateness or whether the surgery is excessive or ineffectual, the disapproval must include the following notice in bold text and be formatted as follows:

Notice to worker, worker's attorney, and medical provider:
If you want to appeal this decision, you must do so within 90 days from the mailing date of this notice. To appeal you must:
- Notify the Department of Consumer and Business Services (DCBS) in writing.
- Send your written request for review of the insurer's disapproval to:
DCBS Workers' Compensation Division
Medical Resolution Team
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405
If you do not notify DCBS in writing within 90 days, you will lose all rights to appeal the insurer's decision.
For help, call the Workers' Compensation Division's toll-free hotline at 800-452-0288 and ask to speak with a benefit consultant.

(B) If the insurer disagrees with the appropriateness decision of the MCO, the insurer must appeal the decision to the MCO under OAR 436-015-0110(4).
(l) Insurers under contract with MCOs must maintain records including, but not limited to:
(A) A listing of all employers covered by MCO contracts;
(B) The employers' WCD employer numbers;
(C) The estimated number of employees governed by each MCO contract;
(D) A list of all workers enrolled in the MCO; and
(E) The effective dates of such enrollments.
(m) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.
(n) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

STATUTORY/OTHER AUTHORITY: ORS 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.252, ORS 656.325, ORS 656.245, ORS 656.248, ORS 656.260, ORS 656.264

AMEND: 436-015-0037

RULE TITLE: MCO-Insurer Contracts

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0037 provides that upon enrollment, workers may continue to treat with the current medical service providers for at least 30 days after the mailing date of the notice of enrollment.

RULE TEXT:
(1) An MCO must provide comprehensive medical services to all enrolled workers covered by the MCO-insurer contract according to the MCO's certification.
(2) An MCO may not contract exclusively with a single insurer. However, an MCO has up to one year from the effective date of its first contract to obtain contracts with more than one insurer. If the MCO has not obtained additional contracts within this time period, the MCO must provide the director with a report documenting the MCO's efforts to obtain additional contracts.
(3) An MCO may contract only with insurers. The contract must include the following terms and conditions:
(a) Who is governed by the contract;
(b) The covered place of employment must be within the authorized geographic service area;
(c) Insurers may contract with multiple MCOs to provide coverage for employers. All workers at any specific employer's location must be governed by the same MCO(s). When insurers contract with multiple MCOs each worker must have initial choice at the time of injury to select which MCO will manage their care except when the employer provides a coordinated health care program;
(d) Workers enrolled in an MCO must receive medical services as prescribed by the terms and conditions of the contract; and
(e) A continuity of care provision specifying how workers will receive medical services on open claims, including the following:
(A) Upon enrollment, allowing workers to continue to treat with the current medical service providers for at least 30 days after the mailing date of the notice of enrollment; and
(B) Upon termination or expiration of the MCO-insurer contract, allowing workers to continue treatment under ORS 656.245(4)(a).
(4) Notwithstanding the requirements of this rule, failure of the MCO to provide medical services does not relieve the insurers of their responsibility to ensure benefits are provided to workers under ORS chapter 656.

STATUTORY/OTHER AUTHORITY: ORS 656.260, 656.726(4)

STATUTES/OTHER IMPLEMENTED: ORS 656.260, 656.245

AMEND: 436-035-0260

RULE TITLE: Visual Loss

NOTICE FILED DATE: 01/29/2026

RULE SUMMARY: Amended rule 0260:
-Removes reference to the “Goldmann perimeter” as the required device for taking visual field loss measurements; and
-Clarifies that measurements can be taken on any device that can produce the findings required to complete the reporting requirements outlined in OAR 436-035-0260(3)(a) or (b), using kinetic perimetry and a III/4e stimulus.

RULE TEXT:
(1) Visual loss due to a work-related illness or injury is rated for central visual acuity, integrity of the peripheral visual fields, and ocular motility. For ocular disturbances that cause visual impairment that is not reflected in visual acuity, visual fields or ocular motility refer to section (5) of this rule. Visual loss is measured with best correction, using the lenses recommended by the worker’s physician. For lacrimal system disturbances refer to OAR 436-035-0440.
(2) Ratings for loss in central visual acuity are calculated for each eye as follows:
(a) Reports for central visual acuity must be for distance and near acuity.
(b) The ratings for loss of distance acuity are as follows, reported in standard increments of Snellen notation for English and Metric 6: [Ratings not included. See ED. NOTE.]
(c) The ratings for loss of near acuity are as follows: reported in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation: [Ratings not included. See ED. NOTE.]
(d) Once the ratings for near and distance acuity are found, add them and divide by two. The value which results is the rating for lost central visual acuity.
(e) If a lens has been removed and a prosthetic lens implanted, an additional 25%, is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).
(f) If a lens has been removed and there is no prosthetic lens implanted, an additional 50% is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).
(g) The table below may be substituted for combining central visual acuity and the loss of a lens for a total central visual acuity. The table displays the percent loss of central vision for the range of near and distance acuity combined with lens removal for a total central visual acuity. The upper figure is to be used when the lens is present (as found in (d)), the middle figure is to be used when the lens is absent and a prosthetic lens has been implanted (as found in (e)), and the lower figure is to be used when the lens is absent with no implant (as found in (f)). If near acuity is reported in Revised Jaeger Standard or American Point-type, convert these findings to Near Snellen for rating purposes under (2)(c) of this rule when using this table.
(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using kinetic perimetry and a III/4e stimulus. The examiner must use a device that can produce the findings required to complete one of the following reporting methods:
(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or
(b) Using a perimetric chart which indicates the extent of retained vision for each of the eight standard 45° meridians out to 90°. The directions and normal extent of each meridian are as follows: [Ratings not included. See ED. NOTE.]
(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.
(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.
(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

(4) Ratings for ocular motility impairment resulting in binocular diplopia are determined as follows:
(a) Determine the single highest value of loss for diplopia noted on each of the standard 45° meridians as listed in the following table.
(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more is rated as 100% of the eye. As an example: Diplopia on looking horizontally off center from 30 degrees in a left direction is valued at 10%. Diplopia in the same eye when looking horizontally off center from 21 to 30 degrees in a right direction is valued at 20%. The impairments for diplopia in both ranges are added, so the impairment rating would be 10% plus 20% resulting in a total loss of ocular motility of 30%.
(5) To the extent that stereopsis (depth perception), glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields or ocular motility will be combined with an additional 5% when in the opinion of the physician the impairment is moderate, 10% if the impairment is severe.
(6) The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and loss of ocular motility and loss for other conditions specified in section (5) of this rule.
(7) The total rating for binocular loss is figured as follows:
(a) Find the percent of monocular loss for each eye.
(b) Multiply the percent of loss in the better eye by three.
(c) Add to that result the percent of loss in the other eye.
(d) Divide this sum by four. The result is the total percentage of binocular loss.
(e) This method is expressed by the formula 3(A) + B 4. “A” is the percent of loss in the better eye; “B” is the percent of loss in the other eye.
(8) Use the method (monocular or binocular) which results in the greater impairment rating.
(9) Enucleation of an eye is rated at 100% of an eye.
[ED. NOTE: Formula and Ratings referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 656.726

STATUTES/OTHER IMPLEMENTED: ORS 656.005, 656.214, 656.268, 656.726

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

NOTE: Revisions are marked: new text | ~~deleted text~~.

436-035-0260 Visual Loss

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(2) Ratings for loss in central visual acuity are calculated for each eye as follows:

(a) Reports for central visual acuity must be for distance and near acuity.

(b) The ratings for loss of distance acuity are as follows, reported in standard increments of Snellen notation for English and Metric 6:

English	Metric 6	% Loss
20/15	6/5	0
20/20	6/6	0
20/25	6/7.5	5
20/30	6/10	10
20/40	6/12	15
20/50	6/15	25
20/60	6/20	35
20/70	6/22	40
20/80	6/24	45
20/100	6/30	50
20/125	6/38	60
20/150	6/50	70
20/200	6/60	80
20/300	6/90	85
20/400	6/120	90
Able to count fingers at 4 feet		95
Not able to count fingers at 4 feet		100

(c) The ratings for loss of near acuity are as follows: reported in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation:

Near Snellen inches	Revised Jaeger Standard	American Point-type	% Loss
14 /14	1	3	0
14 /18	2	4	0

14 /21 .....3 .....5 5
14 /24 .....4 .....6 7
14 /28 .....5 .....7 10
14 /35 .....6 .....8 50
14 /40 .....7 .....9 55
14 /45 .....8 .....10 60
14 /60 .....9 .....11 80
14 /70 .....10 .....12 85
14 /80 .....11 .....13 87
14 /88 .....12 .....14 90
14 /112 .....13 .....21 95
14 /140 .....14 .....23 98

(d) Once the ratings for near and distance acuity are found, add them and divide by two. The value which results is the rating for lost central visual acuity.

(e) If a lens has been removed and a prosthetic lens implanted, an additional 25%, is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(f) If a lens has been removed and there is no prosthetic lens implanted, an additional 50% is to be combined (not added) with the percent loss for central visual acuity to determine total central visual acuity, as shown in table (g).

(g) The table below may be substituted for combining central visual acuity and the loss of a lens for a total central visual acuity. The table displays the percent loss of central vision for the range of near and distance acuity combined with lens removal for a total central visual acuity. The upper figure is to be used when the lens is present (as found in (d)), the middle figure is to be used when the lens is absent and a prosthetic lens has been implanted (as found in (e)), and the lower figure is to be used when the lens is absent with no implant (as found in (f)). If near acuity is reported in Revised Jaeger Standard or American Point-type, convert these findings to Near Snellen for rating purposes under (2)(c) of this rule when using this table.

Rating for distance in feet	**Near Snellen rating inches (**under **(c))**													
	14/14	14/18	14/21	14/24	14/28	14/35	14/40	14/45	14/60	14/70	14/80	14/88	14/112	14/140
20/15 **(d)**	0	0	3	4	5	25	28	30	40	43	44	45	48	49
(e)	25	25	27	28	29	44	46	48	55	57	58	59	61	62
(f)	50	50	52	52	53	63	64	65	70	72	72	73	74	75
20/20 **(d)**	0	0	3	4	5	25	28	30	40	43	44	45	48	49
(e)	25	25	27	28	29	44	46	48	55	57	58	59	61	62
(f)	50	50	52	52	53	63	64	65	70	72	72	73	74	75
20/25 **(d)**	3	3	5	6	8	28	30	33	43	45	46	48	50	52
(e)	27	27	29	30	31	46	48	50	57	59	60	61	63	64
(f)	52	52	53	53	54	64	65	67	72	73	73	74	75	76
20/30 **(d)**	5	5	8	9	10	30	33	35	45	48	49	50	53	54
(e)	29	29	31	32	33	48	50	51	59	61	62	63	65	66
(f)	53	53	54	55	55	65	67	68	73	74	75	75	77	77
20/40 **(d)**	8	8	10	11	13	33	35	38	48	50	51	53	55	57
(e)	31	31	33	33	35	50	51	54	61	63	63	65	66	68
(f)	54	54	55	56	57	67	68	69	74	75	76	77	78	79
20/50 **(d)**	13	13	15	16	18	38	40	43	53	55	56	58	60	62
(e)	35	35	36	37	39	54	55	57	65	66	67	68	70	72
(f)	57	57	58	58	59	69	70	72	77	78	78	79	80	81
20/60 **(d)**	18	18	20	21	23	43	45	48	58	60	61	63	65	67
(e)	39	39	40	41	42	57	59	61	69	70	71	72	74	75
(f)	59	59	60	61	62	72	73	74	79	80	81	82	83	84
20/70 **(d)**	20	20	23	24	25	45	48	50	60	63	64	65	68	69
(e)	40	40	42	43	44	59	61	63	70	72	73	74	76	77
(f)	60	60	62	62	63	73	74	75	80	82	82	83	84	85

Rating for distance in feet	Near Snellen rating inches (under (c))													
	14/14	14/18	14/21	14/24	14/28	14/35	14/40	14/45	14/60	14/70	14/80	14/88	14/112	14/140
20/80 (d)	23	23	25	26	28	48	50	53	63	65	66	68	70	72
(e)	42	42	44	45	46	61	63	65	72	74	75	76	78	79
(f)	62	62	63	63	64	74	75	77	81	83	83	84	85	86
20/100 (d)	25	25	28	29	30	50	53	55	65	68	69	70	73	74
(e)	44	44	46	47	48	63	65	66	74	76	77	78	80	81
(f)	63	63	64	65	65	75	77	78	83	84	85	85	87	87
20/125 (d)	30	30	33	34	35	55	58	60	70	73	74	75	78	79
(e)	48	48	50	51	51	66	68	70	78	80	81	81	84	84
(f)	65	65	67	67	68	78	79	80	85	87	87	88	89	90
20/150 (d)	35	35	38	39	40	60	63	65	75	78	79	80	83	84
(e)	51	51	54	54	55	70	72	74	81	84	84	85	87	88
(f)	68	68	69	70	70	80	82	83	88	89	89	90	92	92
20/200 (d)	40	40	43	44	45	65	68	70	80	83	84	85	88	89
(e)	55	55	57	58	59	74	76	78	85	87	88	89	91	92
(f)	70	70	72	72	73	83	84	85	90	92	92	93	94	95
20/300 (d)	43	43	45	46	48	68	70	73	83	85	86	88	90	92
(e)	57	57	59	60	61	76	78	80	87	89	90	91	93	94
(f)	72	72	73	73	74	84	85	87	92	93	93	94	95	96
20/400 (d)	45	45	48	49	50	70	73	75	85	88	89	90	93	94
(e)	59	59	61	62	63	78	80	81	89	91	91	93	94	96
(f)	73	73	74	75	75	85	87	88	93	94	94	95	97	97
20/800 (d)	48	48	50	51	53	73	75	78	88	90	91	93	95	97
(e)	61	61	63	63	65	79	81	84	91	93	93	94	96	98
(f)	74	74	75	76	77	87	88	89	94	95	96	97	98	99

(3) Ratings for loss of visual field are based upon the results of field measurements of each eye separately using kinetic perimetry and ~~the Goldmann perimeter with~~ a III/4e stimulus. The examiner must use a device that can produce the findings required to complete one of the following reporting methods: ~~The results may be scored in either one of the two following methods:~~

(a) Using the monocular Esterman Grid, count all the printed dots outside or falling on the line marking the extent of the visual field. The number of dots counted is the percentage of visual field loss; or

(b) Using a ~~A~~ perimetric chart ~~may be used~~ which indicate~~s~~ the extent of retained vision for each of the eight standard 45° meridians out to 90°. The directions and normal extent of each meridian are as follows:

Minimal normal extent of peripheral visual field

Direction	**Degrees**
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
TOTAL	500

(A) Record the extent of retained peripheral visual field along each of the eight meridians. Add (do not combine) these eight figures. Find the corresponding percentage for the total retained degrees by use of the table below.

(B) For loss of a quarter or half field, first find half the sum of the normal extent of the two boundary meridians. Then add to this figure the extent of each meridian included within the retained field. This results in a figure which may be applied in the chart below.

(C) Visual field loss due to scotoma in areas other than the central visual field is rated by adding the degrees lost within the scotoma along affected meridians and subtracting that amount from the retained peripheral field. That figure is then applied to the chart below.

Total degrees retained	% of loss	Total degrees retained	% of loss	Total degrees retained	% of loss	Total degrees retained	% of loss	Total degrees retained	% of loss
0	100	105	79	210	58	315	37	420	16
5	99	110	78	215	57	320	36	425	15
10	98	115	77	220	56	325	35	430	14
15	97	120	76	225	55	330	34	435	13
20	96	125	75	230	54	335	33	440	12
25	95	130	74	235	53	340	32	445	11
30	94	135	73	240	52	345	31	450	10
35	93	140	72	245	51	350	30	455	9
40	92	145	71	250	50	355	29	460	8
45	91	150	70	255	49	360	28	465	7
50	90	155	69	260	48	365	27	470	6
55	89	160	68	265	47	370	26	475	5
60	88	165	67	270	46	375	25	480	4
65	87	170	66	275	45	380	24	485	3
70	86	175	65	280	44	385	23	490	2
75	85	180	64	285	43	390	22	495	1
80	84	185	63	290	42	395	21	500	0
85	83	190	62	295	41	400	20		
90	82	195	61	300	40	405	19		
95	81	200	60	305	39	410	18		
100	80	205	59	310	38	415	17		

(4) Ratings for ocular motility impairment resulting in binocular diplopia are determined as follows:

(a) Determine the single highest value of loss for diplopia noted on each of the standard 45° meridians as listed in the following table.

(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more is rated as 100% of the eye. As an example: Diplopia on looking horizontally off center from 30 degrees in a left direction is valued at 10%. Diplopia in the same eye when looking horizontally off center from 21 to 30 degrees in a right direction is valued at 20%. The impairments for diplopia in both ranges are added, so the impairment rating would be 10% plus 20% resulting in a total loss of ocular motility of 30%.

Direction of gaze	Distance from point of fixation	% of loss
central	central vision to 20 degrees	100
Down	21 degrees to 30 degrees	50
Down	beyond 30 degrees	30
Right	21 degrees to 30 degrees	20
Right	beyond 30 degrees	10
down right	21 degrees to 30 degrees	20
down right	beyond 30 degrees	10
Left	21 degrees to 30 degrees	20
Left	beyond 30 degrees	10
down left	21 degrees to 30 degrees	20
down left	beyond 30 degrees	10
Up	beyond 20 degrees	10
up right	beyond 20 degrees	10
up left	beyond 20 degrees	10

(5) To the extent that stereopsis (depth perception), glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields or ocular motility will be combined with an additional 5% when in the opinion of the physician the impairment is moderate, 10% if the impairment is severe.

(6) The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and loss of ocular motility and loss for other conditions specified in section **(5)** of this rule.

(7) The total rating for binocular loss is figured as follows:

(a) Find the percent of monocular loss for each eye.

(b) Multiply the percent of loss in the better eye by three.

(c) Add to that result the percent of loss in the other eye.

(d) Divide this sum by four. The result is the total percentage of binocular loss.

(e) This method is expressed by the formula $\frac{3(A) + B}{4}$

"A" is the percent of loss in the better eye;

"B" is the percent of loss in the other eye.

(8) Use the method (monocular or binocular) which results in the greater impairment rating.

(9) Enucleation of an eye is rated at 100% of an eye.