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

FILING CAPTION: Permanent Changes: OAR 436-009, -010, -015 (HB 3412 and HB 2696)

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RULES:
436-009-0005, 436-009-0110, 436-010-0005, 436-010-0210, 436-010-0220, 436-010-0225, 436-010-0230, 436-010-0280, 436-015-0005, 436-015-0030, 436-015-0040, 436-015-0070

AMEND: 436-009-0005

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0005: Clarifies “patients” as “workers” within the definitions of “Interpreter” and “Interpreter services.”
• Amended matrix for health care providers, Appendix A:
Removes “physician assistants” from existing “type B” attending physician category;
Includes “physician assistants” in new category of “type C” attending physician;
States that a physician assistant may serve as the attending physician for up to 180 days rather than the current 60 days or 18 visits; and
Clarifies that medical services for aggravation of injury or illness provided by a chiropractic physician, naturopathic physician, physician assistant, authorized nurse practitioner, or any other health care provider must be authorized by a type A attending physician.

CHANGES TO RULE:

436-009-0005
Definitions ¶

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.¶
(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:¶
(a) 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 ~~patient~~worker.¶
(24) "Interpreter services" means the act of orally translating between a medical provider and a ~~patient~~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 ~~patient~~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(~~30~~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) "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.¶
(37) "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.¶
(38) "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.¶
(39) "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.]¶
(40) "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.]¶
(41) "Usual fee" means the medical provider's fee charged to the general public for a given service.¶
(42) "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.¶
(43) "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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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)	Provides 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

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)	Provides compensable medical services for aggravation of injury or illness
"Other Health Care Providers" e.g. acupuncturist	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: 436-009-0110

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0110:

Specifies that any sign language interpreter chosen to assist a worker, whether chosen by the worker or by the insurer, must be a sign language interpreter licensed by the Health Licensing Office under Oregon Laws 2023, chapter 414;

Clarifies “patients” as “workers” for purposes of seeking sign language interpreter services under this chapter.

CHANGES TO RULE:

436-009-0110
Interpreters ¶

(1) Choosing an Interpreter.¶
(a) A ~~patient~~worker may choose a person to communicate with a medical provider when the ~~patient~~worker and the medical provider speak different languages, including sign language. The ~~patient~~worker may choose a family member, a friend, an employee of the medical provider, or an interpreter. However, ~~a~~for signed language interpretation services, the worker may only choose an interpreter who is a medical sign language interpreter licensed under Oregon Laws 2023, chapter 414, section 6. A representative of the worker's employer may not provide interpreter services. The medical provider may disapprove of the ~~patient~~worker's choice at any time the medical provider feels the interpreter services are not improving communication with the ~~patient~~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 Oregon Laws 2023, chapter 414.¶
(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 insurer denies the claim, interpreters may bill the ~~patient~~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 ~~patient~~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 ~~patient~~worker; or¶
(B) A medical provider's employee.¶
(4) Billing Timelines.¶
(a) Interpreters must bill within:¶
(A) 60 days of the date of service;¶
(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or¶
(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.¶
(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the 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; and¶
(D) D0041 for mileage.¶
(b) An interpreter's invoice must include:¶
(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;¶
(B) The ~~patient~~worker's name;¶
(C) The ~~patient~~worker's workers' compensation claim number, if known;¶
(D) The correct Oregon specific codes for the billed services (D0004, D0005, D0006, 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 ~~patient~~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 ~~patient~~worker<u>s</u>, the explanation must clearly separate and identify payments for each ~~patient~~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 as follows:¶
"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."¶
(j) The insurer or its representative must respond to an interpreter's inquiry about payment within two days, 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 Identity Theft 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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

436-009-0110 Interpreters

(6) Payment Calculations.

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(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 interpreter of an hour or less	$65.00
Interpreter service of an hour or less provided by health care interpreters certified by the Oregon Health Authority[1]	$76.00
American sign language interpreter services of an hour or less	$76.00
Interpreter services provided by a noncertified interpreter of more than one hour	$16.25 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
Interpreter service of more than one hour provided by health care interpreters certified by the Oregon Health Authority[1]	$19.00 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
American sign language interpreter services of more than one hour	$19.00 per 15-minute increment; a 15-minute increment is considered a time period of at least eight minutes and no more than 22 minutes.
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	$65.00 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 .	

AMEND: 436-010-0005

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0005 modifies the definition of “come-along provider” to include “physician assistant.”

CHANGES TO RULE:

436-010-0005
Definitions ¶

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.¶
(2) "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.¶
(3) "Attending physician" has the same meaning as described in ORS 656.005(12)(b). See Appendix A "Matrix for Health Care Provider Types."¶
(4) "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.¶
(5) "Board" means the Workers' Compensation Board and includes its Hearings Division.¶
(6) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records information such as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return-to-work goals and status.¶
(7) "Come-along provider" means a primary care physician, chiropractic physician, physician assistant or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continues to treat the worker when the worker becomes enrolled in an MCO. (See OAR 436-015-0070.)¶
(8) "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.¶
(9) "Days" means calendar days.¶
(10) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.¶
(11) "Direct medical sequela" means a condition that is clearly established medically and originates or stems from an accepted condition. For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a "direct medical sequela."¶
(12) "Director" means the director of the Department of Consumer and Business Services or the director's designee.¶
(13) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(14) "Eligible worker" means a worker who has filed a claim or who has an accepted claim and whose employer is located in an MCO's authorized geographical service area, covered by an insurer that has a contract with that MCO.¶
(15) "Enrolled" means an eligible worker has received notification from the insurer that the worker is being required to treat 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 managed care organization's certified geographical service area.¶
(16) "Health care practitioner or health care provider" has the same meaning as a "medical service provider."¶
(17) "Home health care" means necessary medical and medically related services provided in the patient's home environment. These services may include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.¶
(18) "Hospital" means an institution licensed by the State of Oregon as a hospital.¶
(19) "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.¶
(20) "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 that meets the qualifications of a self-insured employer under ORS 656.407.¶
(21) "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.¶
(22) "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.¶
(23) "Managed care organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.¶
(24) "Medical evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, X-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material used, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.¶
(25) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.¶
(26) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, or other related services; drugs, medicine, crutches, prosthetic appliances, braces, and supports; and where necessary, physical restorative services.¶
(27) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.¶
(28) "Medical treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.¶
(29) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.¶
(30) "Patient" means the same as worker as defined in ORS 656.005(~~30~~28).¶
(31) "Physical capacity evaluation" means an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.¶
(32) "Physical restorative services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia or a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the patient's highest functional ability consistent with the patient's condition.¶
(33) "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.¶
(34) "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.¶
(35) "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.¶
(36) "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.¶
[Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.000 et seq., ORS 656.005

AMEND: 436-010-0210

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0210:

Removes “physician assistants” from existing “type B” attending physician category;

Includes “physician assistants” in new category of “type C” attending physician;

Specifies that physician assistants must certify to the director that they have reviewed packet of material prior to providing compensable medical services;

Allows workers to keep a physician assistant as the attending physician for up to 180 days rather than the current 60 days or 18 visits;

Allows physician assistants to authorize the payment of temporary disability compensation for 180 days rather than the current 30 days; and

Specifies that physician assistants may not make findings regarding the worker’s impairment for the purpose of evaluating the worker’s disability.

CHANGES TO RULE:

436-010-0210
Attending Physician, Authorized Nurse Practitioner, and Temporary Disability Authorization ¶

(1) An attending physician or authorized nurse practitioner is primarily responsible for the patient's care, authorizes temporary disability, and prescribes and monitors ancillary care and specialized care.¶
(a) No later than five days after becoming a patient's attending physician or authorized nurse practitioner, the provider must notify the insurer using Form 827. Regardless of whether Form 827 is filed, the facts of the case and the actions of the provider determine if the provider is the attending physician or authorized nurse practitioner.¶
(b) Type A ~~and B~~, type B, and type C attending physicians and authorized nurse practitioners may authorize temporary disability and manage medical services subject to the limitations of ORS chapter 656 or a managed care organization contract. (See Appendix A "Matrix for Health Care Provider Types" [Attached])¶
(c) Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be approved by the worker's attending physician or authorized nurse practitioner.¶
(2) Chiropractic Physicians~~;~~ and Naturopathic Physicians~~, Physician Assistants~~ (Type B providers).¶
(a) Prior to providing any compensable medical service or authorizing temporary disability benefits under ORS 656.245, a type B provider must certify to the director that the provider has reviewed a packet of materials provided by the director.¶
(b) Type B providers may assume the role of attending physician for a cumulative total of 60 days or 18 visits, whichever occurs first, from the first visit on the initial claim with any type B provider.¶
(c) Type B providers may authorize payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim to any type B provider.¶
(d) Except for chiropractic physicians serving as the attending physician at the time of claim closure, type B providers may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.¶
(3) ~~Emergency Room Physicians. Emergency room physicians may~~Physician Assistants (Type C providers).¶
(a) Prior to providing any compensable medical service or authorize~~ing~~ temporary disability ~~for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in the physician's private practice apart from their duties as an emergency room physician, the physician may be the attending physician~~benefits under ORS 656.245, a physician assistant must certify to the director that the provider has reviewed a packet of materials provided by the director.¶
(b) Physician assistants may assume the role of attending physician for a cumulative total of 180 days from the date of the first visit on the initial claim with any physician assistant.¶
(c) Physician assistants may authorize payment of temporary disability compensation for a period not to exceed 180 days from the date of the first visit on the initial claim to any physician assistant.¶
(d) Physician assistants may not make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.¶
(4) Authorized Nurse Practitioners.¶
(a) In order to provide any compensable medical service, a nurse practitioner licensed in Oregon under ORS 678.375 to 678.390 must review a packet of materials provided by the division and complete the statement of

authorization. (See www.oregonwcdoc.info) Once the nurse practitioner has completed the statement of authorization, the division will assign an authorized nurse practitioner number.¶
(b) An authorized nurse practitioner may:¶
(A) Provide compensable medical services to an injured worker for a period of 180 days from the date of the first visit with a nurse practitioner on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without the attending physician's authorization; and¶
(B) Authorize temporary disability benefits for a period of up to 180 days from the date of the first nurse practitioner visit on the initial claim.¶
(5) Emergency Room Physicians. Emergency room physicians may authorize temporary disability for no more than 14 days when they refer the patient to a primary care physician. If an emergency room physician sees a patient in the physician's private practice apart from their duties as an emergency room physician, the physician may be the attending physician.¶
(6) Unlicensed to Provide Medical Services. Attending physicians may prescribe services to be carried out by persons not licensed to provide a medical service or treat independently. These services must be rendered under the physician's direct control and supervision. Home health care provided by a patient's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.¶
(~~6~~7) Out-of-State Attending Physicians. The worker may choose an attending physician outside the state of Oregon with the approval of the insurer. When the insurer receives the worker's request or becomes aware of the worker's request to treat with an out-of-state attending physician, the insurer must give the worker written notice of approval or disapproval of the worker's choice of attending physician within 14 days. If an approved out-of-state attending physician does not comply with OAR 436-009 or 436-010, the insurer may withdraw approval of the attending physician.¶
(a) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the physician in writing of the following:¶
(A) The Oregon medical fee and payment rules, OAR 436-009;¶
(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon workers; and¶
(C) That the insurer cannot pay bills for compensable services above the Oregon fee schedule.¶
(b) If the insurer disapproves the worker's out-of-state attending physician or withdraws a prior approval, the insurer must send the worker written notice that:¶
(A) Clearly states the reasons for the disapproval or withdrawal of the prior approval, for example, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010;¶
(B) Identifies at least two other physicians of the same healing art and specialty in the same area that the insurer would approve;¶
(C) Informs the worker that if the worker disagrees with the disapproval or withdrawal, the worker may request approval from the director under OAR 436-010-0220; and¶
(D) Informs the worker that the worker may be liable for payment of services provided after the date of notification if the worker receives further medical services from the disapproved or no longer approved out-of-state physician.¶
(c) If the insurer withdraws approval of the out-of-state attending physician, the insurer must notify the physician of the following in writing:¶
(A) The reasons for withdrawing the approval;¶
(B) That any future services provided by that physician will not be paid by the insurer; and¶
(C) That the worker may be liable for payment of services provided after the date of notification.¶
(d) The worker or worker's representative may request approval from the director under OAR 436-010-0220 if the worker disagrees with the insurer's decision to:¶
(A) Disapprove an out-of-state attending physician; or¶
(B) Withdraw the approval of the out-of-state attending physician.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.005(12), ORS 656.245, ORS 656.260, ORS 656.799

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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)	Provides 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

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)	Provides compensable medical services for aggravation of injury or illness
"Other Health Care Providers" e.g. acupuncturist	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: 436-010-0220

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0220 clarifies that, when a worker must change its attending physician, that change does not count toward the worker's two changes if that change is prompted by the period of treatment by a type C attending physician expiring, a physician assistant's requirement to refer the worker to an attending physician for a closing examination, or a possible worsening of the worker's condition following claim closure.

CHANGES TO RULE:

436-010-0220
Choosing and Changing Medical Providers ¶

(1) The worker may have only one attending physician or authorized nurse practitioner at a time. Concurrent treatment or services by other medical providers, including specialist physicians, must be sufficiently different that separate medical skills are needed for proper care, and must be based on a written referral by the attending physician or authorized nurse practitioner. The referral must specify any limitations and a copy must be sent to the insurer. A specialist physician is authorized to provide or order all compensable medical services and treatment the physician considers appropriate, unless the referral is for a consultation only. The attending physician or authorized nurse practitioner continues to be responsible for authorizing temporary disability even if the specialist physician is providing or authorizing medical services and treatment. Physicians who provide the following services are not considered attending physicians:¶
(a) Emergency services;¶
(b) Insurer or director requested examinations;¶
(c) A Worker Requested Medical Examination;¶
(d) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner; and¶
(e) Diagnostic studies provided by radiologists and pathologists upon referral.¶
(2) Changing Attending Physician or Authorized Nurse Practitioner. The worker may choose to change attending physician or authorized nurse practitioner only twice after the initial choice. When the worker requests a referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, the change will count as one of the worker's choices. The limitation of the worker's right to choose attending physicians or authorized nurse practitioners begins with the date of injury and extends through the life of the claim. The following are not considered changes of attending physician or authorized nurse practitioner initiated by the worker and do not count toward the worker's two changes:¶
(a) When the worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines;¶
(b) When the worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence; or¶
(c) When the worker is required to change attending physician or authorized nurse practitioner due to conditions beyond the worker's control. This could include, but is not limited to:¶
(A) When the attending physician or authorized nurse practitioner terminates practice or leaves the area;¶
(B) When the attending physician or authorized nurse practitioner is no longer willing to treat the worker;¶
(C) When the worker moves out of the area requiring more than a 50 mile commute to the attending physician or authorized nurse practitioner;¶
(D) When the period for treatment or services by a type B or type C attending physician or an authorized nurse practitioner has expired (See Appendix A "Matrix for Health Care Provider Types");¶
(E) When the physician assistant or authorized nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure;¶
(F) When the worker becomes subject to a managed care organization (MCO) contract and must change to an attending physician or authorized nurse practitioner on the MCO's panel;¶
(G) When the worker who, at the time of MCO enrollment was required to change attending physician or authorized nurse practitioner, is disenrolled from an MCO; or¶
(H) When the worker has to change because their attending physician or authorized nurse practitioner is no longer qualified as an attending physician or authorized to continue providing compensable medical services.¶
(3) Insurer Notice to the Worker. When the worker has changed attending physicians or authorized nurse practitioners twice by choice or has reached the maximum number of changes established by the MCO, the

insurer must notify the worker by certified mail that any additional changes by choice must be approved by the insurer or the director. If the insurer fails to provide such notice and the worker later chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable medical services rendered prior to notice to the worker. The insurer must notify the newly selected provider that the worker was not allowed to change attending physician or authorized nurse practitioner without approval of the insurer or director, and therefore any future services will not be paid. The insurer must pay for appropriate medical services rendered prior to this notification.¶
(4) Worker Requesting Additional Changes of Attending Physician or Authorized Nurse Practitioner.¶
(a) If a worker not enrolled in an MCO has changed attending physicians or authorized nurse practitioners by choice twice (or for MCO enrolled workers, the maximum allowed by the MCO) and wants to change again, the worker must request approval from the insurer. The worker must make the request in writing or by signing Form 827. The insurer must respond to the worker within 14 days of receiving the request whether the change is approved. If the insurer objects to the change, the insurer must:¶
(A) Send the worker a written explanation of the reasons;¶
(B) Send the worker Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner); and¶
(C) Inform the worker that the worker may request director approval by sending Form 2332 to the director.¶
(b) When the worker submits a request to the director for an additional change of attending physician or authorized nurse practitioner, the director may request, in writing, additional information. If the director requests additional information, the parties must respond in writing within 14 days of the director's request.¶
(c) The director will issue an order advising whether the request for change of attending physician or authorized nurse practitioner is approved. On a case-by-case basis the director will consider circumstances, such as:¶
(A) Whether there is medical justification for a change, e.g., whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.¶
(B) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.¶
(d) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order.¶
(5) Managed Care Organization (MCO) Enrolled Workers.¶
(a) An MCO enrolled worker must choose:¶
(A) A panel provider unless the MCO approves a non-panel provider, or¶
(B) A "come-along provider" who provides medical services subject to the terms and conditions of the governing MCO.¶
(b) Notwithstanding subsection (a) of this section, if a worker is unable to find three providers that are willing to treat the worker in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's geographic service area (GSA), the worker may contact the MCO for a list of three providers who are willing to treat the worker. If the MCO, within a reasonable period of time, is unable to provide a list of three providers who are willing to treat the worker, the worker may choose a non-panel provider in that category.¶
(c) Notwithstanding subsection (a) of this section, if the MCO has fewer than three providers in a category of providers listed in OAR 436-015-0030(6)(a) and (b) in the worker's GSA, the worker may choose a non-panel provider in that category.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, ORS 656.252, ORS 656.260

AMEND: 436-010-0225

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0225 specifies that any sign language interpreter chosen to assist a worker, whether chosen by the worker or by the insurer, must be a sign language interpreter licensed by the Health Licensing Office under Oregon Laws 2023, chapter 414, section 6.

CHANGES TO RULE:

436-010-0225
Choosing a Person to Provide Interpreter Services ¶

(1) A worker may choose a person to communicate with a medical provider when the worker and the medical provider speak different languages, including sign language. The worker may choose a family member, a friend, an employee of the medical provider, or someone who provides interpreter services as a profession. However, ~~a~~for signed language interpretation services, the worker may only choose an interpreter who is a medical sign language interpreter licensed under Oregon Laws 2023, chapter 414, section 6. 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.¶
(2) 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 section (1) of this rule.¶
(b) For signed language interpretation services, use a sign language interpreter licensed under Oregon Laws 2023, chapter 414.¶
(3) For the purpose of this rule, interpreter services means the act of orally translating between a medical provider and a ~~patient~~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 ~~patient~~worker as well as reasonable time spent on necessary paperwork for the provider's office.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245

AMEND: 436-010-0230

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0230 replaces “physician or authorized nurse practitioner” with “the prescribing provider.”

CHANGES TO RULE:

436-010-0230
Medical Services and Treatment Guidelines ¶

(1) Medical services provided to the worker must not be more than the nature of the compensable injury or the process of recovery requires. Services that are unnecessary or inappropriate according to accepted professional standards are not reimbursable.¶
(2) If the provider's chart notes do not provide evidence of frequency, extent, and efficacy of treatment and services, the insurer may request additional information from the provider.¶
(3) All medical service providers must notify the patient at the time of the first visit of how they can provide compensable medical services and authorize temporary disability. Providers must also notify patients that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the patient's medical record.¶
(4) Consent to Attend a Medical Appointment.¶
(a) An employer or insurer representative, such as a nurse case manager, may not attend a patient's medical appointment without written consent of the patient. The patient has the right to refuse such attendance.¶
(A) The consent form must be written in a way that allows the patient to understand it and to overcome language or cultural differences.¶
(B) The consent form must state that the patient's benefits cannot be suspended if the patient refuses to have an employer or insurer representative present.¶
(C) The insurer must keep a copy of the signed consent form in the claim file.¶
(b) The patient or the medical provider may refuse to allow an employer or insurer representative to attend an appointment at any time, even if the patient previously signed a consent form. The medical provider may refuse to meet with the employer or insurer representative.¶
(5) Request for Records at a Medical Appointment. The medical provider may refuse to provide copies of the patient's medical records to the insurer representative without proof that the person is representing the insurer. The provider may charge for any copies that are provided.¶
(6) Requesting a Medical Provider Consultation. The attending physician, authorized nurse practitioner, or the MCO may request a consultation with a medical provider regarding conditions related to an accepted claim. MCO-requested consultations that are initiated by the insurer, which include an exam of the worker, must be considered independent medical exams under OAR 436-010-0265.¶
(7) Ancillary Services - Treatment Plan.¶
(a) Ancillary medical service providers include but are not limited to physical or occupational therapists, chiropractic or naturopathic physicians, and acupuncturists. When an attending or specialist physician or an authorized nurse practitioner prescribes ancillary services, unless an MCO contract specifies other requirements, the ancillary provider must prepare a treatment plan before beginning treatment.¶
(b) The ancillary medical service provider must send the treatment plan to the prescribing provider and the insurer within seven days of beginning treatment. If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided before the treatment plan is sent.¶
(c) The treatment plan must include objectives, modalities, frequency of treatment, and duration. The treatment plan may be in any legible format, e.g., chart notes. If the ancillary treatment needs to continue beyond the duration stated in the treatment plan, the ancillary care provider must obtain a new prescription from the attending or specialist physician or authorized nurse practitioner to continue treatment. The ancillary care provider also must send a new treatment plan to the insurer ~~and physician or authorized nurse practition~~the prescribing provider within seven days.¶
(d) Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A). (See Appendix A "Other Health Care Providers.")¶
(e) Within 30 days of the beginning of ancillary services, the prescribing provider must sign a copy of the treatment plan and send it to the insurer. If the prescribing provider does not sign and send the treatment plan, the provider may be subject to sanctions under OAR 436-010-0340. However, this will not affect payment to the ancillary provider.¶
(f) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants directed by the

attending physician do not have to provide a written treatment plan as prescribed in this section.¶
(8) Massage Therapy. Unless otherwise provided by an MCO, when an attending physician, authorized nurse practitioner, or specialist physician prescribes ancillary services provided by a massage therapist licensed by the Oregon State Board of Massage Therapists under ORS 687.011 to 687.250, the massage therapist must prepare a treatment plan before beginning treatment. Massage therapists not licensed in Oregon must provide their services under the direct control and supervision of the attending physician. Treatment plans provided by massage therapists must follow the same requirements as those for ancillary providers in section (7) of this rule.¶
(9) Therapy Guidelines and Requirements.¶
(a) Unless otherwise provided by an MCO's utilization and treatment standards, the usual range for therapy visits is up to 20 visits in the first 60 days, and four visits a month thereafter. This is only a guideline and insurers should not arbitrarily limit payment based on this guideline nor should the therapist arbitrarily use this guideline to exceed medically necessary treatment. The medical record must provide clinical justification when therapy services exceed these guidelines. When an insurer believes the treatment is inappropriate or excessive, the insurer may request director review as outlined in OAR 436-010-0008.¶
(b) Unless otherwise provided by an MCO, a physical therapist must submit a progress report to the attending physician (or authorized nurse practitioner) and the insurer every 30 days or, if the patient is seen less frequently, after every visit. The progress report may be part of the physical therapist's chart notes and must include:¶
(A) Subjective status of the patient;¶
(B) Objective data from tests and measurements conducted;¶
(C) Functional status of the patient;¶
(D) Interpretation of above data; and¶
(E) Any change in the treatment plan.¶
(10) Physical Capacity Evaluation. The attending physician or authorized nurse practitioner must complete a physical capacity or work capacity evaluation within 20 days after the insurer or director requests the evaluation. If the attending physician or authorized nurse practitioner does not wish to perform the evaluation, they must refer the patient to a different provider within seven days of the request. The attending physician or authorized nurse practitioner must notify the insurer and the patient in writing if the patient is incapable of participating in the evaluation.¶
(11) Prescription Medication.¶
(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the worker is medically stationary. For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.¶
(b) Providers should review and are encouraged to adhere to the division's opioid guidelines. See https://wcd.oregon.gov/medical/provider-training/Pages/opioid-guidelines.aspx.¶
(12) Diagnostics. Unless otherwise provided by an MCO, a medical provider may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays. The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies. Pre-authorization is not a guarantee of payment. The insurer must respond to the provider's request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.¶
(13) Articles. Articles, including but not limited to, beds, hot tubs, chairs, and gravity traction devices are not compensable unless a report by the attending physician or authorized nurse practitioner clearly justifies the need. The report must:¶
(a) Establish that the nature of the injury or the process of recovery requires the item be furnished, and¶
(b) Specifically explain why the worker requires the item when the great majority of workers with similar impairments do not.¶
(14) Physical Restorative Services.¶
(a) Physical restorative services include, but are not limited to, a regular exercise program, personal exercise training, or swim therapy. They are not services to replace medical services usually prescribed during the course of recovery. Physical restorative services are not compensable unless:¶
(A) The nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social or functional activity, and¶

(B) A report by the attending physician or authorized nurse practitioner clearly justifies why the worker requires services not usually considered necessary for the majority of workers.¶
(b) Trips to spas, resorts, or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.¶
(15) Lumbar Artificial Disc Replacement Guidelines.¶
(a) Lumbar artificial disc replacement is always inappropriate for patients with the following conditions (absolute contraindications):¶
(A) Metabolic bone disease - for example, osteoporosis;¶
(B) Known spondyloarthropathy (seropositive and seronegative);¶
(C) Posttraumatic vertebral body deformity at the level of the proposed surgery;¶
(D) Malignancy of the spine;¶
(E) Implant allergy to the materials involved in the artificial disc;¶
(F) Pregnancy - currently;¶
(G) Active infection, local or systemic;¶
(H) Lumbar spondylolisthesis or lumbar spondylolysis;¶
(I) Prior fusion, laminectomy that involves any part of the facet joint, or facetectomy at the same level as proposed surgery; or¶
(J) Spinal stenosis - lumbar - moderate to severe lateral recess and central stenosis.¶
(b) Lumbar artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(g) may be inappropriate for patients with the following conditions, depending on severity, location, etc. (relative contraindications):¶
(A) A comorbid medical condition compromising general health, for example, hepatitis, poorly controlled diabetes, cardiovascular disease, renal disease, autoimmune disorders, AIDS, lupus, etc.;¶
(B) Arachnoiditis;¶
(C) Corticosteroid use (chronic ongoing treatment with adrenal immunosuppression);¶
(D) Facet arthropathy - lumbar - moderate to severe, as shown radiographically;¶
(E) Morbid obesity - BMI greater than 40;¶
(F) Multilevel degenerative disc disease - lumbar - moderate to severe, as shown radiographically;¶
(G) Osteopenia - based on bone density test;¶
(H) Prior lumbar fusion at a different level than the proposed artificial disc replacement; or¶
(I) Psychosocial disorders - diagnosed as significant to severe.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.245, 656.248, 656.252

AMEND: 436-010-0280

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0280 adds “physician assistants” to the list of medical service providers unable to perform a worker’s closing exam and clarifies they must refer the worker to a type A attending physician to do the closing exam.

CHANGES TO RULE:

436-010-0280
Determination of Impairment/Closing Exams ¶

(1) When a worker becomes medically stationary and there is a reasonable expectation of permanent disability, the attending physician must complete a closing exam or refer the worker to a consulting physician for all or part of the closing exam. If the worker is under the care of an authorized nurse practitioner ~~or a type B attending physician, other than a chiropract~~, physician assistant, or a naturopathic physician, the provider must refer the worker to a type A attending physician to do a closing exam. ¶
(2) The closing exam must be completed under OAR 436-030 and 436-035 and Bulletin 239. (See Appendix A "Matrix for Health Care Provider Types".) ¶
(3) When the attending physician completes the closing exam, the attending physician has 14 days from the medically stationary date to send the closing report to the insurer. When the attending physician does not complete the closing exam, the attending physician must arrange, or ask the insurer to arrange, a closing exam with a consulting physician within seven days of the medically stationary date.¶
(4) When an attending physician or authorized nurse practitioner requests a consulting physician to do the closing exam, the consulting physician has seven days from the date of the exam to send the report to the attending physician for concurrence or objections. Within seven days of receiving the closing exam report, the attending physician must state in writing whether the physician concurs with or objects to all or part of the findings of the exam, and send the concurrence or objections with the report to the insurer. ¶
(5) The attending physician must specify the worker's residual functional capacity if:¶
(a) The attending physician has not released the worker to the job held at the time of injury because of a permanent work restriction caused by the compensable injury, and ¶
(b) The worker has not returned to the job held at the time of injury, because of a permanent work restriction caused by the compensable injury.¶
(6) Instead of specifying the worker's residual functional capacity under section (5) of this rule, the attending physician may refer the worker for: ¶
(a) A second-level physical capacities evaluation (see OAR 436-009-0060) when the worker has not been released to return to the job held at the time of injury, has not returned to the job held at the time of injury, has returned to modified work, or has refused an offer of modified work; or ¶
(b) A work capacities evaluation (see OAR 436-009-0060) when there is a question of the worker's ability to return to suitable and gainful employment. The provider may also be required to specify the worker's ability to perform specific job tasks.¶
(7) When the insurer issues a major contributing cause denial on an accepted claim and the worker is not medically stationary: ¶
(a) The attending physician must do a closing exam or refer the worker to a consulting physician for all or part of the closing exam; or ¶
(b) An authorized nurse practitioner ~~or a type B attending physician, other than a chiropract~~, physician assistant, or naturopathic physician, must refer the worker to a type A attending physician for a closing exam.¶
(8) The closing report must include all of the following:¶
(a) Findings of permanent impairment.¶
(A) In an initial injury claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.¶
(B) In a new or omitted condition claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.¶
(C) In an aggravation claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.¶
(D) In an occupational disease claim, the closing report must include objective findings of any permanent impairment that is caused in any part by an accepted occupational disease or a direct medical sequela of an

accepted occupational disease.¶
(b) Findings documenting permanent work restrictions.¶
(A) If the worker has no permanent work restriction, the closing report must include a statement indicating that:¶
(i) The worker has no permanent work restriction; or¶
(ii) The worker is released, without restriction, to the job held at the time of injury.¶
(B) In an initial injury claim, the closing report must include objective findings documenting any permanent work restriction that:¶
(i) Prevents the worker from returning to the job held at the time of injury; and¶
(ii) Is caused in any part by an accepted condition or a direct medical sequela of an accepted condition.¶
(C) In a new or omitted condition claim, the closing report must include objective findings documenting any permanent work restriction that:¶
(i) Prevents the worker from returning to the job held at the time of injury; and¶
(ii) Is caused in any part by an accepted new or omitted condition or a direct medical sequela of an accepted new or omitted condition.¶
(D) In an aggravation claim, the closing report must include objective findings documenting any permanent work restriction that:¶
(i) Prevents the worker from returning to the job held at the time of injury; and¶
(ii) Is caused in any part by an accepted worsened condition or a direct medical sequela of an accepted worsened condition.¶
(E) In an occupational disease claim, the closing report must include objective findings documenting any permanent work restriction that:¶
(i) Prevents the worker from returning to the job held at the time of injury; and¶
(ii) Is caused in any part by an accepted occupational disease or a direct medical sequel of an accepted occupational disease.¶
(c) A statement regarding the validity of an impairment finding is required in the following circumstances:¶
(A) If the examining physician determines that a finding of impairment is invalid, the closing report must include a statement that identifies the basis for the determination that the finding is invalid.¶
(B) If the examining physician determines that a finding of impairment is valid but the finding is not addressed by any applicable validity criteria under Bulletin 239, the closing report must include a statement that identifies the basis for the determination that the finding is valid.¶
(C) If the examining physician chooses to disregard applicable validity criteria under Bulletin 239 because the criteria are medically inappropriate for the worker, the closing report must include a statement that describes why the criteria would be inappropriate.
Statutory/Other Authority: ORS 656.726(4), 656.245(2)(b)
Statutes/Other Implemented: ORS 656.245, 656.252

AMEND: 436-015-0005

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0005 modifies the definition of “come-along provider” to include physician assistants.

CHANGES TO RULE:

436-015-0005
Definitions ¶

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made a part of these rules.¶
(1) "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.¶
(2) "Come-along provider" means a primary care physician, a chiropractic physician, physician assistant, or an authorized nurse practitioner who is not a managed care organization (MCO) panel provider and who is authorized to continue to treat the worker when the worker becomes enrolled in an MCO.¶
(3) "Coordinated health care program" means an employer program providing for the 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 workers with health care benefits even if a workers' compensation claim is denied.¶
(4) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.¶
(5) "Geographic service area (GSA)" means an area of the state in which a managed care organization may be authorized by the director of the Department of Consumer and Business Services to provide managed care services. There are 15 geographic service areas in Oregon.¶
(6) "Good cause" means circumstances that are outside the control of a party or circumstances that are considered to be extenuating by the division.¶
(7) "Group of medical service providers" means individuals duly licensed to practice one or more of the healing arts who join together to provide medical services through a managed care organization, whether or not such providers have an ownership interest in the managed care organization.¶
(8) "Health care provider" means an entity or group of entities, organized to provide health care services or to provide administrative support services to entities providing health care services. An entity solely organized to become an MCO under these rules is not, in and of itself, a health care provider.¶
(9) "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.¶
(10) "Managed care organization" ("MCO") means an organization formed to provide medical services and certified under these rules.¶
(11) "Medical provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.¶
(12) "Medical service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and, where necessary, physical restorative services.¶
(13) "Medical service provider" means a person duly licensed to practice one or more of the healing arts.¶
(14) "Non-qualifying employer" means either:¶
(a) An insurer as defined in this rule, with respect to managed care services to be provided to any subject worker; or¶
(b) An employer as defined under ORS 656.005(13), other than a health care provider, with respect to managed care services to such employer's employees.¶
(15) "Primary care physician" means a physician qualified to be an attending physician according to ORS 656.005(12)(b)(A) and who is a general practitioner, family practitioner, or internal medicine practitioner.¶
(16) "Show-cause hearing" means an informal meeting with the director or the director's designee where the MCO is provided an opportunity to explain and present evidence regarding any proposed orders by the director to suspend or revoke the MCO's certification.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0030

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0030 includes a requirement that MCOs have a process that allows workers to select a physician assistant.

CHANGES TO RULE:

436-015-0030
Applying for Certification ¶

(1) General. The MCO must establish one place of business in Oregon where it administers the plan and keeps membership and other records as required by OAR 436-015-0050.¶
(2) An applicant for MCO certification must submit the following to the director:¶
(a) One copy of the application;¶
(b) A non-refundable fee of $1,500, payable to the Department of Consumer and Business Services, which will be deposited in the Consumer and Business Services Fund;¶
(c) Affidavits of each person identified in section (3) of this rule, certifying that the individuals have no interest in a non-qualifying employer under OAR 436-015-0009;¶
(d) An affidavit of an authorized officer or agent of the MCO, certifying that the MCO is financially sound and able to meet all requirements necessary to ensure delivery of services under the plan, and in full satisfaction of the MCO's obligations under ORS 656.260 and OAR 436-015; and¶
(e) A complete organizational chart.¶
(3) MCO Application. The application must include:¶
(a) The name of the MCO;¶
(b) The name of each person who will be a director of the MCO;¶
(c) The name of the person who will be the president of the MCO;¶
(d) The title and name of the person who will be the day-to-day administrator of the MCO;¶
(e) The title and name of the person who will be the administrator of the financial affairs of the MCO; and¶
(f) A proposed plan for the MCO, in which the applicant identifies how the MCO will meet the requirements of ORS 656.260 and these rules.¶
(4) MCO Plan - General. The plan must:¶
(a) Identify the initial GSAs in which the MCO intends to operate (For details regarding GSAs, see http://wcd.oregon.gov/Bulletins/bul_248.pdf);¶
(b) Describe the reimbursement procedures for all services provided;¶
(c) Include a process for developing financial incentives directed toward reducing service costs and utilization, without sacrificing quality of service;¶
(d) Describe how the MCO will provide insurers with information that will inform workers of all choices of medical service providers and how workers can access those providers;¶
(e) Provide a procedure to identify those providers in the panel provider listings that only accept existing patients as workers' compensation patients. This procedure is not subject to the timeframe established in subsection (f) of this section;¶
(f) Provide a procedure for regular, periodic updating of all MCO panel provider listings, with published updates being available electronically no less frequently than every 30 days; and¶
(g) Include a procedure for timely and accurate reporting to the director of necessary information regarding medical and health care service costs and utilization under OAR 436-015-0040 and OAR 436-009.¶
(5) MCO Plan - Worker Rights. The plan must provide a description of the times, places, and manner of providing services adequate to ensure that workers governed by the MCO will be able to:¶
(a) Access an MCO panel with a minimum of one attending physician within the MCO for every 1,000 workers covered by the plan;¶
(b) Receive initial treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within 24 hours of the MCO's knowledge of the need or a request for treatment;¶
(c) Receive treatment by an MCO attending physician or authorized nurse practitioner of the worker's choice within five working days after the worker received treatment outside the MCO;¶
(d) Receive information on a 24-hour basis regarding medical services available within the MCO which must include:¶
(A) The worker's right to receive emergency or urgent care, and¶
(B) The MCO's regular hours of operation if the worker needs assistance selecting an attending physician or has other questions.¶

(e) Access medical providers, including attending physicians, within a reasonable distance from the worker's place of employment, considering the normal patterns of travel. For purposes of this rule, 30 miles (one way) in urban areas and 60 miles (one way) in rural areas will be considered a reasonable distance;¶
(f) Receive treatment by a non-MCO medical service provider when the enrolled worker resides outside the MCO's geographic service area. Such a worker may only select non-MCO providers if they practice closer to the worker's residence than an MCO provider of the same category, and if the provider agrees to the MCO's terms and conditions;¶
(g) Receive services that meet quality, continuity, and other treatment standards which will provide all medical and health care services in a manner that is timely, effective, and convenient for the worker;¶
(h) Receive specialized medical services the MCO is not able to provide;¶
(i) Receive treatment that is consistent with MCO treatment standards and protocols; and¶
(j) Remain eligible to receive authorized temporary disability benefits up to 14 days after the mailing date of a notice enrolling the worker's claim in an MCO under OAR 436-010-0270(4)(d).¶
(6) MCO Plan - Choice of Provider. The plan must provide all of the following:¶
(a) An adequate number, but not less than three, of medical service providers from each provider category. For purposes of these rules, the categories include acupuncturist, chiropractic physician, dentist, naturopathic physician, optometric physician, osteopathic physician, medical physician, and podiatric physician. The worker also must be able to choose from at least three physical therapists and three psychologists. The plan must meet this section's requirements unless the MCO establishes that there is not an adequate number of providers in a given category able or willing to become members of the MCO. For categories where the MCO has fewer than three providers within a GSA or the MCO is unable to provide a list of three providers willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a provider in each of those categories, consistent with the MCO's treatment and utilization standards. Such providers cannot be required to comply with the terms and conditions regarding services performed by the MCO. These providers are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(b) A process that allows workers to select an authorized nurse practitioner. If the MCO has fewer than three authorized nurse practitioners within a GSA or the MCO is unable to provide a list of three authorized nurse practitioners willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from an authorized nurse practitioner, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such authorized nurse practitioners cannot be required to comply with the terms and conditions regarding services performed by the MCO. These authorized nurse practitioners are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(c) A process that allows workers to select a physician assistant. If the MCO has fewer than three physician assistants within a GSA or the MCO is unable to provide a list of three physician assistants willing to treat a worker within a reasonable period of time, the MCO must allow the worker to seek treatment outside the MCO from a physician assistant, consistent with the MCO's treatment and utilization standards and ORS 656.245(2)(b)(D). Such physician assistants cannot be required to comply with the terms and conditions regarding services performed by the MCO. These physician assistants are not bound by the MCO's treatment and utilization standards, however, workers are subject to those standards.¶
(d) A procedure that allows workers to receive compensable medical treatment from a come-along provider authorized under OAR 436-015-0070.¶
(7) MCO Plan - Provider Agreement. The plan must include:¶
(a) A copy of the standard provider agreement used by the MCO when a provider is credentialed as a panel provider. Variations from the standard provider agreement must be identified when the plan is submitted for director approval; and¶
(b) An initial list of the names, addresses, and specialties of the individuals who will provide services within the MCO. This list must indicate which medical service providers will act as attending physicians in each GSA.¶
(8) MCO Plan - Monitoring and Reviewing. The plan must provide adequate methods for monitoring and reviewing contract matters between providers and the MCO to ensure appropriate treatment and to prevent inappropriate or excessive treatment including:¶
(a) A program of peer review and utilization review including the following:¶
(A) Pre-admission review of elective admissions to the hospital and elective surgeries;¶
(B) Individual case management programs, which identify ways to provide appropriate care at a lower cost for cases that are likely to prove very costly;¶
(C) Physician profile analysis which may include such information as each physician's total charges, number and costs of related services provided, workers' temporary disability, and total number of visits in relation to care provided by other physicians to patients with the same diagnosis. A physician's profile must not be released to

anyone outside the MCO without the physician's specific written consent, except that the physician's profile must be released to the director without the necessity of obtaining such consent;¶
(D) Concurrent review programs that periodically review the care after treatment has begun, to determine if continued care is medically necessary;¶
(E) Retrospective review programs that examine care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and¶
(F) Second surgical opinion programs that allow workers to obtain the opinion of a second physician when elective surgery is recommended.¶
(b) A quality assurance program that includes:¶
(A) A system for monitoring and resolving problems or complaints, including those identified by workers or medical service providers;¶
(B) Physician peer review, which must be conducted by a group designated by the MCO or the director. The group must include members of the same healing art as the peer-reviewed physician; and¶
(C) A standardized medical record system.¶
(c) A program that specifies the criteria for selection and termination of panel providers and the process for peer review. The processes for terminating a panel provider and peer review must provide adequate notice and hearing rights.¶
(d) A program that meets the requirements of ORS 656.260(4) for monitoring and reviewing other contract matters not covered under peer review, service utilization review, dispute resolution, or quality assurance.¶
(9) MCO Plan - Dispute Resolution. The plan must include:¶
(a) A procedure for internal dispute resolution to resolve complaints by enrolled workers, medical providers, and insurers under OAR 436-015-0110. The internal dispute resolution procedure must include a provision allowing waiver of the 30-day period to appeal a decision to the MCO upon a showing of good cause; and¶
(b) A description of how the MCO will ensure workers continue to receive appropriate care in a timely, effective, and convenient manner throughout the dispute resolution process.¶
(10) MCO Plan - Treatment Standards, Protocols, and Guidelines. The plan must include a summary of the process the MCO uses to develop and review treatment standards, protocols, and guidelines. This summary must describe:¶
(a) The medical expertise or specialties of the clinicians involved;¶
(b) The basis for protocols and guidelines;¶
(c) The criteria the MCO uses in selecting the conditions for which the MCO implements treatment protocols and guidelines;¶
(d) The criteria the MCO uses to determine when it needs to review or revise its treatment standards, protocols, and guidelines;¶
(e) How the MCO makes the standards, protocols, and guidelines available to its panel providers and how it notifies them of any changes; and¶
(f) A process that provides sufficient flexibility to allow treatment outside the standards, protocols, and guidelines if such treatment is supported by persuasive professional medical judgment and reasoning.¶
(11) MCO Plan - Return to Work and Workplace Safety. The plan must provide other programs that meet the requirements of ORS 656.260(4), including:¶
(a) A program involving cooperative efforts by the workers, the employer, the insurer, and the MCO to promote early return to work for enrolled workers; and¶
(b) A program involving cooperative efforts by the workers, the employer, and the MCO to promote workplace safety and health consultative and other services. The program must:¶
(A) Identify how the MCO will promote such services;¶
(B) Describe the method by which the MCO will report to the insurer within 30 days of knowledge of occupational injuries and illnesses involving serious physical harm as defined by OAR 437-001, occupational injury and illness trends as observed by the MCO, and any observations that indicate an injury or illness was caused by a lack of diligence of the employer;¶
(C) Describe the method by which the MCO's knowledge of needed loss control services will be communicated to the insurer for determining the need for services as detailed in OAR 437-001;¶
(D) Include a provision that all notifications to the insurer from the MCO will be considered as a request to the insurer for services as detailed in OAR 437-001; and¶
(E) Include a provision that the MCO will maintain complete files of all notifications for a period of three years following the date that notification was given by the MCO.¶
(12) Within 45 days of receipt of all information required for certification, the director will notify the applicant if the certification is approved, the effective date of the certification, and the initial GSA(s) of the MCO. If the certification is denied, the director will provide the applicant with the reason for the denial.¶
(13) The director will not certify an MCO if the plan does not meet the requirements of these rules.¶

(14) Communication Liaison. The MCO must designate an in-state communication liaison(s) to the director and the insurers at the MCO's established in-state location.
Statutory/Other Authority: ORS 656.~~7~~26~~(4), ORS~~0, 656.7260~~(4)~~
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0040

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0040 adds “physician assistants” to the list of come-along providers for which an MCO has to report to the director denials and terminations of come-along status.

CHANGES TO RULE:

436-015-0040
Reporting Requirements for an MCO ¶

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO must provide the director with a copy of the entire text of any MCO-insurer contract, signed by the insurer and the MCO, within 30 days of execution of such contracts. The MCO must submit any amendments, addenda, or cancellations to the director within 30 days of execution.¶
(2) When an MCO-insurer contract contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination. If the MCO does not provide the director with a copy of the signed contract extension, workers will no longer be subject to the contract after it expires or terminates.¶
(3) The MCO must submit any amendments to the certified plan to the director for approval. The MCO must not take any action based on a proposed amendment until the director approves the amendment.¶
(4) Within 45 days of the end of each calendar quarter, each MCO must provide the following information to the director, current on the last day of the quarter, as described in Bulletin 247:¶
(a) The quarter being reported;¶
(b) MCO certification number; and¶
(c) Membership listings by category of medical service provider (in coded form), including:¶
(A) Provider names;¶
(B) Specialty (in coded form);¶
(C) Tax ID number;¶
(D) National Provider Identifier (NPI) number; and¶
(E) Business address and phone number. When a medical service provider has multiple offices, only one office location in each geographic service area needs to be reported.¶
(5) By April 30 of each year, each MCO must provide the director with the following information for the previous calendar year:¶
(a) A summary of any sanctions or punitive actions taken by the MCO against its members; and¶
(b) A summary of actions taken by the MCO's peer review committee.¶
(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of come-along providers. The MCO's report must include the following:¶
(a) Provider type (primary care physician, chiropractic physician, physician assistant, or authorized nurse practitioner) reported by geographic service area (GSA).¶
(b) The number of workers affected, reported by provider type.¶
(c) Date of denial or termination.¶
(d) One or more of the following reasons for each denial or termination:¶
(A) Provider failed to meet the MCO's credentialing standards within the last two years;¶
(B) Provider has been previously terminated from serving as an attending physician within the last two years;¶
(C) Treatment is not according to the MCO's service utilization process;¶
(D) Provider failed to comply with the MCO's terms and conditions after being granted come-along privileges; or¶
(E) Other reasons authorized by statute or rule.¶
(7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.¶
(8) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260

AMEND: 436-015-0070

NOTICE FILED DATE: 09/01/2023

RULE SUMMARY: • Amended rule 0070 allows an MCO enrolled worker to continue to treat with a physician assistant who is not a member of the MCO, if the physician assistant maintains the worker's medical records and with whom the worker has a documented history of treatment.

CHANGES TO RULE:

436-015-0070
Come-along Providers ¶

(1) The MCO must authorize a physician, physician assistant, or nurse practitioner who is not an MCO panel provider to provide medical services to an enrolled worker if:¶
(a) The nurse practitioner is an authorized nurse practitioner under ORS 656.245, the chiropractic physician or physician assistant has certified to the director that the chiropractic physician or physician assistant has reviewed required materials under ORS 656.799, or the physician is a primary care physician under ORS 656.260(4)(g);¶
(b) The physician, physician assistant, or authorized nurse practitioner agrees to comply with MCO treatment standards, protocols, utilization review, peer review, dispute resolution, billing and reporting procedures, and fees for services under OAR 436-015-0090; and¶
(c) The physician, physician assistant, or authorized nurse practitioner agrees to refer the worker to the MCO for specialized care that the worker may require, including physical therapy.¶
(2) The physician, physician assistant, or authorized nurse practitioner who is not an MCO panel provider will be deemed to have maintained the worker's medical records and established a documented history of treatment, if the physician's, physician assistant's, or nurse practitioner's medical records show treatment has been provided to the worker prior to the date of injury. Additionally, if a worker has selected a physician, physician assistant, or authorized nurse practitioner through a private health plan, prior to the date of injury, that selected provider will be deemed to have maintained the worker's medical records and established a documented history of treatment prior to the date of injury.¶
(3) The MCO may not limit the length of treatment authority of a come-along provider unless such limits are stated in ORS chapter 656.¶
(4) Notwithstanding section (1), for those workers receiving their medical services from a facility that maintains a single medical record on the worker, but provides treatment by multiple primary care or chiropractic physicians, physician assistants, or authorized nurse practitioners who are not MCO panel providers, the requirements of sections (1) and (2) will be deemed to be met. In this situation, the worker must select one primary care or chiropractic physician, physician assistant, or authorized nurse practitioner to treat the compensable injury.¶
(5) Any questions or disputes relating to the worker's selection of a physician, physician assistant, or authorized nurse practitioner who is not an MCO panel provider must be resolved under OAR 436-015-0110.¶
(6) Any disputes relating to a come-along provider's or other non-MCO provider's compliance with MCO standards and protocols must be resolved under OAR 436-015-0110.
Statutory/Other Authority: ORS 656.726(4), ORS 656.260
Statutes/Other Implemented: ORS 656.260

OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

WCD 6-2023
CHAPTER 436
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

FILED
12/26/2023 3:31 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: **Corrected** Adoption of temporary changes, new medical billing codes for 2024

EFFECTIVE DATE: 01/01/2024 THROUGH 03/31/2024

AGENCY APPROVED DATE: 12/26/2023

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Filed By:
Marie Loiseau
Rules Coordinator

NEED FOR THE RULE(S):

Temporary rules are needed to allow health care providers and workers' compensation insurers to use 2024 medical billing codes on and after Jan. 1, 2024.

JUSTIFICATION OF TEMPORARY FILING:

Failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned. Delay in adoption of up-to-date codes creates procedural friction in workers' compensation billing and payment. Adoption of 2024 codes will keep workers' compensation billing codes consistent with industry standards.

The agency finds that issuing temporary rules under ORS 183.335(5) is appropriate because it will avert administrative burdens to health care providers, workers' compensation insurers, and self-insured employers we would expect with delayed adoption of 2024 codes. Without these temporary rule changes: providers and payers would be required to use only 2023 codes until the agency can formally adopt new codes effective April 1, 2024 (projected); workers' compensation bills would have to be processed differently than bills for private health insurance, Medicare, etc.; providers using new codes would be subject to bill rejection; and insurers submitting data containing new codes to the agency would be subject to civil penalties. In addition, workers' access to quality health care is jeopardized if health care providers perceive workers' compensation care as too burdensome.

The agency finds that issuing permanent rules under ORS 183.335(2) and (3) is not appropriate because updated billing codes are not published by the Centers for Medicare and Medicaid Services and others in time for Oregon to adopt changes using standard (permanent) rulemaking procedures.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Rulemaking advisory committee records; this issue was discussed with the committee. These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Marie Loiseau, rules coordinator, 971-286-0316, WCD.Policy@dcbs.oregon.gov.

RULES:

436-009-0004, 436-009-0010, 436-009-0012, 436-009-0023, 436-009-0040, 436-009-0080

AMEND: 436-009-0004

SUSPEND: Temporary 436-009-0004 from WCD 5-2023

RULE SUMMARY: • Revised rule 0004 adopts, by reference, new medical billing codes for 2024 and related references:

The American Medical Association (AMA) Current Procedural Terminology (CPT®2024);

The AMA CPT® Assistant through Volume 32, Issue 12, 2023;

The Healthcare Common Procedure Coding System (HCPCS2024); and

The American Dental Association's CDT 2024 Dental Procedure Codes.

CHANGES TO RULE:

436-009-0004
Adoption of Standards.¶

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2023 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2023, 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® 2023 and CPT® 2024), Fourth Edition Revised, 2022 and 2023, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 2023 and CPT® 2024 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, Volume 0, Issue 04 1990 through Volume 3~~1~~2, Issue 12, 202~~2~~3. If there is a conflict between CPT® 2023 or CPT® 2024 and the CPT® Assistant, CPT® 2023 ~~is~~and CPT® 2024 are the controlling resource~~s~~.¶
(4) To get a copy of the CPT® 2023, CPT® 2024, 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 2023 and CDT 2024: 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 ~~9~~11.0 7/2~~1~~3 (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 202~~2~~3 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 2023, CPT® 2023, CPT® 2024, CPT® Assistant, HCPCS 2023, ~~CDT 2023,~~HCPCS 2024, CDT 2023, CDT 2024. 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: 436-009-0010

SUSPEND: Temporary 436-009-0010 from WCD 5-2023

RULE SUMMARY: • Revised rule 0010 specifies that billing codes and modifiers in Current Procedural Terminology (CPT®2024) may be used on billing forms.

CHANGES TO RULE:

436-009-0010
Medical Billing and Payment ¶

(1) General.¶
(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a 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® 2023, CPT® 2024, 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® 2023, CPT® 2024, 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® 2023, CPT® 2024, 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 Assistants and Nurse Practitioners. Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants 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 forms 827 and 4909;¶
(B) Providing chart notes with the original bill;¶
(C) Preparing a written treatment plan;¶
(D) Supplying progress notes that document the services billed;¶
(E) Completing a work release form or completion of a PCE form, when no tests are performed;¶
(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or¶
(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.¶
(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing 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.¶
(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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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® 2023 or CPT® 2024; • 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® 2023, CPT® 2024 (e.g., CPT® code 21299), or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. Nurse practitioners and physician assistants must use modifier "81" 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

SUSPEND: Temporary 436-009-0012 from WCD 5-2023

RULE SUMMARY: Revised rule 0012 is amended to include a reference to CPT® 2024.

CHANGES TO RULE:

436-009-0012
Telehealth
(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® 2023 or CPT® 2024.¶
(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) 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.¶
(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

AMEND: 436-009-0023

SUSPEND: Temporary 436-009-0023 from WCD 5-2023

RULE SUMMARY: Revised rule 0023 includes associated fee schedules in Appendices C and D that list codes and maximum allowable payments for ambulatory surgery center services. Appendices C and D have been amended to include new medical billing codes for2024. Maximum payment amounts for new codes have been set using 2023 multipliers if the Centers for Medicare & Medicaid Services has published Outpatient Prospective Payment System amounts. Otherwise, the maximum payment is set at 80% of the amount billed.

CHANGES TO RULE:

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

(1) Billing Form.¶
(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010 (3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.¶
(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.¶
(2) ASC Facility Fee.¶
(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:¶
(A) Nursing, technical, and related services;¶
(B) Use of the facility where the surgical procedure is performed;¶
(C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;¶
(D) Radiology services designated as packaged in Appendix D;¶
(E) Administrative, record-keeping, and housekeeping items and services;¶
(F) Materials for anesthesia;¶
(G) Supervision of the services of an anesthetist by the operating surgeon; and¶
(H) Packaged services identified in Appendix C or D.¶
(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.¶
(3) ASC Billing.¶
(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says "packaged" in Appendices C or D.¶
(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.¶
(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC's cost for an implant is $100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.¶
(4) ASC Payment.¶
(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.¶
(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:¶
(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or¶
(B) The ASC's usual fee for surgical procedures and ancillary services.¶
(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly. The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.¶
(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead. [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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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

* * * *

AMEND: 436-009-0040

SUSPEND: Temporary 436-009-0040 from WCD 5-2023

RULE SUMMARY: Revised rule 0040 includes an associated Appendix B, “Physician Fee Schedule,” that lists codes and maximum allowable payments for numerous medical services. Appendix B has been amended to include new medical billing codes for 2024. Maximum payment amounts for new codes have been set using 2023 conversion factors if the Centers for Medicare & Medicaid Services has published relative value units. Otherwise, the maximum payment is set at 80% of the amount billed.

CHANGES TO RULE:

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: [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 assistants [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 Assistants. Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

436-009-0040 Fee Schedule *(temporary rule)*

(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.			

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(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:

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount is:</th></tr>
<tr><td rowspan="3">Principal procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>The amount in Appendix B; or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">80% of billed amount</td></tr>
<tr><td rowspan="3">Any additional procedures* including:
• diagnostic arthroscopy performed prior to open surgery
• the second side of a bilateral procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>50% of the amount in Appendix B; or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">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)</td></tr>
<tr><td colspan="4">*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.</td></tr>
</table>

(b) Two or more surgeons

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount for each surgeon is:</th></tr>
<tr><td rowspan="3">Each surgeon performs a principal procedure (and any additional procedures)
Any additional procedures including:
• diagnostic arthroscopy performed prior to open surgery
• the second side of a bilateral procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">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)</td></tr>
<tr><td colspan="4">*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.</td></tr>
</table>

(c) Assistant surgeons

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

(d) Nurse practitioners or physician assistants

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount is:</th></tr>
<tr><td rowspan="3">One or more surgical procedures as the primary surgical provider, billed without modifier "81."</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>85% of the surgeon(s) fee calculated in subsections (a) or (b); or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">85% of the surgeon(s) fee calculated in subsections (a) or (b)</td></tr>
<tr><td rowspan="3">One or more surgical procedures as the surgical assistant*</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>15% of the surgeon(s) fee calculated in subsections (a) or (b); or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">15% of the surgeon(s) fee calculated in subsections (a) or (b)</td></tr>
<tr><td colspan="4">*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.</td></tr>
</table>

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

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount is:</th></tr>
<tr><td rowspan="3">One or more surgical procedures</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>10% of the surgeon(s) fee calculated in subsections (a) or (b); or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">10% of the surgeon(s) fee calculated in subsections (a) or (b)</td></tr>
</table>

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(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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AMEND: 436-009-0080

SUSPEND: Temporary 436-009-0080 from WCD 5-2023

RULE SUMMARY: Revised rule 0080 includes an associated Appendix E, that lists codes and maximum allowable payments for durable medical equipment, prosthetics, orthotics, and supplies. Appendix E has been amended to include new medical billing codes for 2024. Maximum payment amounts for new codes have been set using 2023 multipliers applied to payment amounts published by the Centers for Medicare & Medicaid Services.

CHANGES TO RULE:

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

(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 must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner. Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999.

However, without approval from the insurer or director, the payment for hearing aids may not exceed $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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

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

(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
E0194	$3643.05		E0940	$52.20
E0261	$259.66		E0971	$5.68
E0277	$1135.64		E0990	$25.52
E0434	$35.31		E1800	$262.29
E0441	$86.85		E1815	$276.15
E0650	$1423.50		E2402	$2487.86

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