

BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON

In the Matter of the Amendment of:

436-009, Oregon Medical Fee and Payment Rules)	SUMMARY OF
436-010, Medical Services)	TESTIMONY AND
436-015, Managed Care Organizations)	AGENCY RESPONSES

This document summarizes the significant data, views, and arguments contained in the hearing record. The purpose of this summary is to create a record of the agency’s conclusions about the major issues raised. Exact copies of the written testimony are attached to this summary.

The proposed amendment to the rules was announced in the Secretary of State’s *Oregon Bulletin* dated Feb. 1, 2019. On Feb. 19, 2019, a public rulemaking hearing was held as announced at 10 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record was held open for written comment through Feb. 25, 2019.

Rules subject to testimony at the rulemaking hearing were OAR 436-001, 009, 010, and 015. A separate summary of testimony has been prepared for division 001. One person testified at the public rulemaking hearing, and a transcript of the hearing is recorded below as exhibit 6. Six written documents were submitted as testimony.

Testimony list:

Exhibit	Testifying
<u>1</u>	John Richardson, DC, Corazón Chiropractic Clinic
<u>2</u>	Juerg Kunz, Workers’ Compensation Division
<u>3</u>	Kate Ropp, MD, President, Oregon Society of Anesthesiologists
<u>4</u>	Diana Godwin, Attorney at Law, Engrav Law Office
<u>5</u>	Colin Cave, MD
<u>6</u>	Transcript of rulemaking hearing: Lisa Johnson, Majoris Health Systems
<u>7</u>	Jaye Fraser, SAIF Corporation

Testimony: OAR 436-009-0010(9)

Exhibit 4

“We support the addition of language in subsections (9) and (13) to permit a provider to bill a workers’ compensation patient for a missed appointment if the provider complies with the new requirements set out in subsection (13)(b). Currently – and for too long – the Division 9 rules

have not allowed a medical provider to charge a “no show” fee to a workers’ compensation patient when the patient fails to show up for a scheduled appointment without any prior notice. And except for instances where a worker fails to show for an appointment for an arbiter exam, director required medical exam, IME, worker requested medical exam or a closing exam, the insurer has not provided any compensation to a provider when the worker fails to show for a scheduled medical treatment. When a worker “no shows” without any notice the provider has no opportunity to schedule another paying patient in that time slot, but the provider still incurs all the costs of maintaining and running a medical clinic, including staff costs and overhead. Moreover, if there is no financial downside, the worker may be more careless in attending medical appointments, and failing to show up for care can delay the worker’s return to work.”

Response: Thank you for your testimony.

Testimony: OAR 436-009-0040, Appendix B

Exhibit 1

“I * * * was shocked to see massage units reduced by nearly 10%. That, and nearly every other rehab-centered CPT code has been reduced. I run a successful rehab-based chiropractic, physiotherapy, and massage clinic in Hillsboro. Most of our patients' care is reimbursed through PIP coverage or work comp insurance.

“I bend over backwards to provide healthy, living wages, cover 100% of my staff's medical, vision, and dental premiums, and am in the process of instituting a 401K plan. A loss of 10% collections could literally be 100% of what I take home for the year. I guarantee the proposed fee changes will cost the jobs and/or benefits of, and shorten the hours of, hundreds or thousands of workers, across Oregon.

“Small businesses trying to create a better world for everyone should never be squeezed in exchange for extending the profits of SAIF and State Farm.”

Response: Thank you for your testimony. As you know, the division uses CMS’ resource-based relative value scale (RBRVS) with its relative value units (RVUs) published by CMS for each CPT® code as the basis for the Oregon workers’ compensation physician fee schedule. However, unlike CMS’ Medicare fee schedule, the division creates different conversion factors for each category (evaluation and management, major surgery, minor surgery, radiology, laboratory and pathology, medicine, physical medicine and rehabilitation.) Using CMS’ RVUs and the division’s own conversion factors allows us to adjust the payment amounts for a category as a whole. However, the difference of individual payment amounts for each code within a category are determined by CMS’ RVUs. The CPT® codes that you refer to are part of the physical medicine and rehabilitation (PM&R) category. The conversion factor for the PM&R category is \$59.13 for the April 1, 2019, physician fee schedule. The division projects that this conversion factor will neither increase nor decrease the payments for the PM&R category as a whole. However, as a result of using CMS’ RVUs, an individual provider may see either an increase or a decrease in payments depending on which codes the provider uses. Based on your testimony, it appears that, unfortunately, you are one of the providers who will see a decrease in payments for the PM&R services you provide most often.

Of note may be that when the division held the advisory committee meeting regarding the Oregon Medical Fee and Payment Rules the committee did not specifically discuss the payment

level of the PM&R category, but did discuss the fee schedule model in general. It was the consensus of the committee that the division should continue to use CMS' RVUs and update conversion factors for the seven categories listed above, i.e., the committee was against adjusting individual payment amounts for each code.

You may be interested in participating in next year's advisory committee, and Fred Bruyns, the division's rule coordinator will send you an invitation to that meeting.

Testimony: OAR 436-009-0040, Appendix B

Exhibit 2

“Proposed Appendix B erroneously lists CPT® codes 80300 and 80301 as valid CPT® codes. However, these two codes are no longer listed as valid codes in CPT® 2019.

“WCD intends to correct this error by removing CPT® codes 80300 and 80301 from Appendix B when filing notice of the permanent OAR 436-009 with the secretary of state.”

Response: The division has removed CPT® codes 80300 and 80301 from Appendix B.

Testimony: OAR 436-009-0040(2)(h)

Exhibit 5

“Regarding the proposed regulatory changes * * *, specifically stating:

B. Anesthesiologists may not perform other services while medically directing anesthesia procedures

“We are questioning whether this is specifically regards to billing (ie: cannot bill for two services provided at the same time) or limiting medical practice (ie: cannot do a preop in the preop area while being available for a CRNA in a case).

“Are you able to help clarify?”

Response: Thank you for your testimony. The intent of the proposed rule change is not to limit medical practice, but rather to clarify the correct payment amounts when providers bill with modifiers QK, QY and QX. As such, the division deleted most of the proposed rule language. The only change made to OAR 436-009-0040(2), effective April 1, 2019, is now the insertion of the following language:

(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.

Testimony: OAR 436-009-0040(2)(h)

Exhibit 3

“* * * Our comments are specific to the amendments to 436-009-0040 and the requirements for billing QK, QY and QX modifiers.

“There are existing restrictions as to what anesthesiologists can and cannot do while medically directing in the Medicare Claims Processing Manual in Chapter 12, Section 50:

A physician who is concurrently furnishing services that meet the requirements for payment at the medically directed rate cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, periodic (rather than continuous) monitoring of an obstetrical patient, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling

scheduling matters, do not substantially diminish the scope of control exercised by the physician and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met.

“Notably, the proposed rules are much more restrictive. For example, “services” is not defined. If this refers to billable services it does not account for services necessary for the performance of an anesthetic (arterial line, CVP, etc.), or routine or emergent care in the post-anesthesia care unit. Services like evaluating a patient or performing a procedure on a patient in a pain clinic while simultaneously medically directing is not considered to be an allowable activity. The OSA suggests aligning these rules with those in the Medicare Claims Processing Manual in Chapter 12, Section 50.

“Additionally, these proposed rules state that payment for modifiers QK, QY and QX are at 50% of the applicable fee schedule amounts, but this does not account for the rare cases where it is medically necessary for a CRNA and a physician anesthesiologist to be actively engaged and treating a patient through all or part of a procedure. For cases like this, CMS allows for full payment of each provider if the physician uses the AA modifier and the CRNA uses the QZ modifier and each submit the proper documentation (Section 140.4.2 in <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf>). The OSA suggest that a similar exception is made here.

“The OSA is unclear as to the intent for this rule. If the intent is to make sure that the CRNAs get paid separately for their contributions, then we recommend that it only apply to CRNAs who have a different tax ID than the medically directing physician. This would certainly simplify things for groups where the CRNAs and MDs/DOs are in the same group where internal arrangements address compensation, while still addressing the legitimate need for the CRNA not financially integrated with the MD/DO to get paid for the work they have performed. Our recommendation will also reduce the number of claims needed to be processed by the Worker’s Compensation program and would reduce confusion for patients who often do not understand why they are receiving multiple bills for, what to them, is the same anesthesia service.

“The proposed rule is silent on how one should report cases personally performed by the anesthesiologist. Medicare requires use of the AA modifier for these cases. Many private payers do not require use of this modifier. OSA requests guidance on how to report personally performed cases by the anesthesiologist.

“Finally, the proposed rule also does not address how to handle teaching cases. Because Medicare helps fund graduate medical education, Medicare has established payment policies and reporting requirements for resident and nurse anesthetist teaching cases. Since the Worker’s Compensation program does not separately fund education, the OSA requests clarification on whether the proposed rule applies to teaching cases. If it does apply, we request further clarification on how to report these cases.”

Response: Thank you for your testimony. The intent of the proposed rule change is not to limit medical practice or place restrictions on anesthesia services, but rather to clarify the correct payment amounts when providers bill with modifiers QK, QY and QX. As such, the division deleted most of the proposed rule language. The only change made to OAR 436-009-0040(2),

effective April 1, 2019, is now the insertion of the following language:

(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.

Testimony: OAR 436-010-0210(6)(c) (new numbering)

Exhibit 7

“SAIF recommends adding ‘out of state’ to clarify the rule. Without track changes and SAIF’s suggested additional language is in italics:

“(c) If the insurer withdraws approval of the out of state attending physician, the insurer must notify the physician in writing.”

Response: Thank you for your testimony. The division agrees that adding “out-of-state” will clarify the proposed rule. Accordingly the division added your proposed language to OAR 436-010-0210(6)(c), effective April 1, 2019.

Testimony: OAR 436-010-0220(5)

Exhibit 4

“We support the addition of the new subsection (5)(b) to allow a worker to contact the MCO for help in locating a provider willing to provide treatment when the worker is unable on his/her own to find three willing providers in a specific medical category in the worker’s GSA. However we suggest that the last sentence in this subsection be amended to read:

“If the MCO is unable to provide a list of three providers who are willing to treat the worker **within a reasonable period of time given the worker’s condition**, the worker may choose a non-panel provider in that category.”

“We also support the addition of the new subsection (5)(c) to allow a worker to choose a non-panel provider for medical care if the MCO has fewer than three providers in the specific medical category in the worker’s GSA.”

Response: Thank you for your testimony. The division agrees that it may be beneficial to include a time period in this rule. Accordingly, the last sentence of OAR 436-010-0220(5)(b), effective April 1, 2019, reads:

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.

Testimony: OAR 436-010-0290(2)

Exhibit 4

“We support the proposed change to the NOTICE the insurer must send when disapproving a request for palliative care, but we suggest that the words “AND PROPOSED TREATING PROVIDER” be added after “ATTENDING PHYSICIAN.” We advocate the addition of the proposed treating provider to the notice of disapproval because my clients – private practice physical therapists – are often the ones who will be providing palliative care and are often the ones who prepare the written palliative request for the attending physician to sign and submit to the insurer. The current rules allow palliative care to begin once the physician submits the request, so a treating physical therapist can be at financial risk if the request is disapproved. Subparagraph (c) states that the insurer “must send written notice approving or disapproving the request to...the provider who will provide the care,” so it makes sense that the heading of the “NOTICE” of disapproval should also reference the treating provider.”

Response: Thank you for your testimony. You are correct that OAR 436-010-0290(2)(c) requires that the insurer send a notice to the provider who will provide the care whether the insurer approves or disapproves a palliative care request. However, the statute limits who may appeal to the director. ORS 656.245(1)(c)(J). Since the statute does not allow the provider who will provide the care to appeal to the director, the language of the “NOTICE” will be published as proposed.

Testimony: OAR 436-015-0030(6) *Exhibit 4*
“We support the amendments to this rule to echo the amendments to OAR 436-010-0220(5), as outlined in my testimony above. Again, however, we suggest the addition of the words ‘within a reasonable period of time given the worker’s condition’ to subparagraphs (a) and (b).”

Response: Thank you for your testimony. As indicated above, the division agrees that it may be beneficial to include a time period in this rule. Accordingly, the division inserted “within a reasonable time” in OAR 436-015-0030(6)(a) and (b), effective April 1, 2019.

Testimony: OAR 436-015-0030(6) *Exhibit 6*
“For the record, Lisa Johnson, with Majoris Health Systems. And, just had some comments on, under division 015, the proposal for requiring that if we have fewer than three practitioners of a certain type, making sure that the worker has those choices. Our concern there is with the hassle factor for providers, what we have experienced is that when a claim is new, it’s not – workers have plenty of choices. Where we run into issues are with older claims where the worker may have already gone through a number of the providers in that area or just because of the extent and litigation and other things going on with the claim, that it can sometimes be harder to get them in to see a doctor. And, under this we would need to make sure there are three providers willing to see them, meaning we would be sending out a big, fat packet of chart notes and asking the providers to review those for a worker that they may never see – the worker may not even contact them or want to schedule with them. And so I think that is going to create barriers for some of the providers who currently are willing to treat injured workers.”

Response: Thank you for your testimony. The division appreciates your concern regarding hassle factors. However, the division believes that the requirement of not less than three willing providers will ultimately afford workers better access to care. This requirement also had the support of the rules advisory committee. Accordingly, the requirement that workers may choose a non-panel provider when the MCO has less than three willing providers in a category will be published in OAR 436-015-0030(6), effective April 1, 2019.

Testimony: OAR 436-015-0030(6) *Exhibit 7*
This subsection requires MCOs to allow workers to treat off the MCO’s panel when the MCO has fewer than three providers within a GSA willing to treat an injured worker. SAIF recommends that clarifying language be added specifying that the worker’s off panel provider selection must be a provider available within the GSA where the MCO does not have three providers willing to treat the worker. SAIF suggests adding “within the same GSA” as follows for both subsections (a) and (b):

- (a) ...For categories where the MCO has fewer than three providers within a GSA willing to treat a worker, the MCO must allow the worker to seek treatment outside the MCO from providers, within the same GSA,

SAIF believes this is consistent with the rule's intent to allow the worker to choose a physician within the worker's GSA, thus eliminating travel because there is not an available panel provider within the worker's GSA.

Response: Thank you for your testimony. The rule's intent, when the MCO has fewer than three willing providers, is not to limit the worker's choice to a specific GSA. If an MCO is unable to find an adequate number of willing providers in a GSA, a worker may also not be able to find a provider in that GSA. It therefore seems unreasonable to limit the worker's choice to that GSA. Not limiting the worker's choice to a specific GSA is also consistent with the current rule when the MCO has less than three contracted providers in a category. Nothing in the current rule prohibits a worker from choosing a provider outside the GSA, when the MCO has fewer than three providers in a category.

As far as travel is concerned, there is already a mechanism in OAR 436-009-0025(4)(b) that allows an insurer to limit travel reimbursement for a visit to an attending physician.

Hence the division will not limit workers' choice to a specific GSA.

Testimony: OAR 436-015-0037(3)

Exhibit 4

“We support the change in subparagraph (c)(A) of subsection (3) to allow a worker to continue treatment with his/her medical provider for at least 14 days – instead of 7 days – after the mailing date of a notice of enrollment in an MCO. As was discussed in the December 17, 2018 meeting of the Rulemaking Advisory Committee, the current rule allowing a worker to continue treating with a current provider for only 7 days after mailing can mean that a worker may have only one or two days after *receiving* the notice of MCO enrollment to find and move his/her care to a new provider among the panel of MCO contracted providers.”

Response: Thank you for your testimony.

Dated this 11th day of March, 2019.

BRUYNS Fred H * DCBS

Subject: Proposed physicians fee schedule changes

From: John Richardson [REDACTED]
Sent: Friday, January 25, 2019 3:57 PM
To: DCBS MedicalQuestions WCD * DCBS <WCD.Medicalquestions@oregon.gov>
Subject: Proposed physicians fee schedule changes

To whom it may concern,

I took a second to review the proposed changes to the OR worker's comp fee schedule and was shocked to see massage units reduced by nearly 10%. That, and nearly every other rehab-centered CPT code has been reduced. I run a successful rehab-based chiropractic, physiotherapy, and massage clinic in Hillsboro. Most of our patients' care is reimbursed through PIP coverage or work comp insurance.

I bend over backwards to provide healthy, living wages, cover 100% of my staff's medical, vision, and dental premiums, and am in the process of instituting a 401K plan. A loss of 10% collections could literally be 100% of what I take home for the year. I guarantee the proposed fee changes will cost the jobs and/or benefits of, and shorten the hours of, hundreds or thousands of workers, across Oregon.

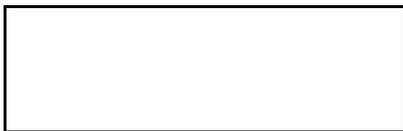
Small businesses trying to create a better world for everyone should never be squeezed in exchange for extending the profits of SAIF and State Farm.

Thank you for your time. I will be monitoring the situation, closely.

Yours in service,
John C. Richardson, D.C.

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- Graduate of Spine Research Institute of San Diego: Whiplash and Brain Injury Traumatology
- Whiplash Biometrics & Injury Traumatology, Advanced Certification, Spine Research Institute of San Diego, 2013
- Registered Independent and Worker-Requested Medical Examiner, State of Oregon
- Oregon License: DC-3934





MEMORANDUM

February 14, 2019

To: Fred Bruyns, Rules Coordinator

From: Juerg Kunz, Medical Policy Analyst

Subject: Appendix B

Proposed Appendix B erroneously lists CPT[®] codes 80300 and 80301 as valid CPT[®] codes. However, these two codes are no longer listed as valid codes in CPT[®] 2019.

WCD intends to correct this error by removing CPT[®] codes 80300 and 80301 from Appendix B when filing notice of the permanent OAR 436-009 with the secretary of state.

Juerg Kunz
Medical Policy Analyst



TO: Fred Bruyns
Rules Coordinator, DCBS

FR: Kate Ropp, MD
President, Oregon Society of Anesthesiologists

RE: Proposed rulemaking on Chapter 436,
Amendment of rules governing medical fees and payment, medical services, and managed care.

The Oregon Society of Anesthesiologists (OSA), which is a professional statewide organization of physician anesthesiologists committed to promoting the highest level of safety and value for our patients and the highest quality of anesthesia care in Oregon through access to physicians in the medical specialty of anesthesiology, would like to submit the below comments in response to the proposed rulemaking on Chapter 436, Amendment of rules governing medical fees and payment, medical services, and managed care.

Our comments are specific to the amendments to 436-009-0040 and the requirements for billing QK, QY and QX modifiers.

There are existing restrictions as to what anesthesiologists can and cannot do while medically directing in the Medicare Claims Processing Manual in Chapter 12, Section 50:

A physician who is concurrently furnishing services that meet the requirements for payment at the medically directed rate cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, periodic (rather than continuous) monitoring of an obstetrical patient, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling scheduling matters, do not substantially diminish the scope of control exercised by the physician and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met.

Notably, the proposed rules are much more restrictive. For example, “services” is not defined. If this refers to billable services it does not account for services necessary for the performance of an anesthetic (arterial line, CVP, etc.), or routine or emergent care in the post-anesthesia care unit. Services like evaluating a patient or performing a procedure on a patient in a pain clinic while simultaneously medically directing is not considered to be an allowable activity. The OSA suggests aligning these rules with those in the Medicare Claims Processing Manual in Chapter 12, Section 50.

Additionally, these proposed rules state that payment for modifiers QK, QY and QX are at 50% of the applicable fee schedule amounts, but this does not account for the rare cases where it is medically necessary for a CRNA and a physician anesthesiologist to be actively engaged and treating a patient through all or part of a procedure. For cases like this, CMS allows for full payment of each provider if the physician uses the AA modifier and the CRNA uses the QZ modifier and each submit the proper documentation (Section 140.4.2 in <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf>). The OSA suggest that a similar exception is made here.

The OSA is unclear as to the intent for this rule. If the intent is to make sure that the CRNAs get paid separately for their contributions, then we recommend that it only apply to CRNAs who have a different tax ID than the medically directing physician. This would certainly simplify things for groups where the CRNAs and MDs/DOs are in the same group where internal arrangements address compensation, while still addressing the legitimate need for the CRNA not financially integrated with the MD/DO to get paid for the work they have performed. Our recommendation will also reduce the number of claims needed to be processed by the Worker’s Compensation program and would reduce confusion for patients who often do not understand why they are receiving multiple bills for, what to them, is the same anesthesia service.

The proposed rule is silent on how one should report cases personally performed by the anesthesiologist. Medicare requires use of the AA modifier for these cases. Many private payers do not require use of this modifier. OSA requests guidance on how to report personally performed cases by the anesthesiologist.

Finally, the proposed rule also does not address how to handle teaching cases. Because Medicare helps fund graduate medical education, Medicare has established payment policies and reporting requirements for resident and nurse anesthetist teaching cases. Since the Worker’s Compensation program does not separately fund education, the OSA requests clarification on whether the proposed rule applies to teaching cases. If it does apply, we request further clarification on how to report these cases.



Diana Godwin, *Of Counsel*
D: (503) 224-0019
F: (971) 275-1218

ADMITTED TO PRACTICE IN
OREGON AND WASHINGTON

February 11, 2019

TO THE WORKERS' COMPENSATION DIVISION

Via e-mail to: fred.h.bruyns@oregon.gov

RE: PROPOSED CHANGES TO OAR 436-009, OAR 436-010, and OAR 436-015

FROM: Diana Godwin on behalf of OREGON PHYSICAL THERAPISTS IN
INDEPENDENT PRACTICE

Thank you for the opportunity to provide testimony to the Workers' Compensation Division on the proposed changes to OAR 436-009, Oregon Medical Fee and Payment rules, OAR 436-010, Medical Services rules, and OAR 436-015, Managed Care Organizations (MCOs) rules.

I represent Oregon Physical Therapists in Independent Practice (OPTIP), a trade association of approximately 100 physical therapist-owned out-patient clinics located throughout Oregon. They provide substantial rehabilitation services to Oregon injured workers.

Proposed Amendment to OAR 436-009-0010(9) "Billing the Patient/Patient Liability", and OAR 436-009-0010(13) "Missed Appointment (No Show)."

We support the addition of language in subsections (9) and (13) to permit a provider to bill a workers' compensation patient for a missed appointment if the provider complies with the new requirements set out in subsection (13)(b). Currently – and for too long – the Division 9 rules have not allowed a medical provider to charge a "no show" fee to a workers' compensation patient when the patient fails to show up for a scheduled appointment without any prior notice. And except for instances where a worker fails to show for an appointment for an arbiter exam, director required medical exam, IME, worker requested medical exam or a closing exam, the insurer has not provided any compensation to a provider when the worker fails to show for a scheduled medical treatment. When a worker "no shows" without any notice the provider has no opportunity to schedule another paying patient in that time slot, but the provider still incurs all the costs of maintaining and running a medical clinic, including staff costs and overhead. Moreover, if there is no financial downside, the worker may be more careless in attending medical appointments, and failing to show up for care can delay the worker's return to work.

Proposed Amendment to OAR 436-010-0220(5) “Managed Care Organization (MCO) Enrolled Workers.”

We support the addition of the new subsection (5)(b) to allow a worker to contact the MCO for help in locating a provider willing to provide treatment when the worker is unable on his/her own to find three willing providers in a specific medical category in the worker's GSA. However we suggest that the last sentence in this subsection be amended to read:

“If the MCO is unable to provide a list of three providers who are willing to treat the worker **within a reasonable period of time given the worker's condition**, the worker may choose a non-panel provider in that category.”

We also support the addition of the new subsection (5)(c) to allow a worker to choose a non-panel provider for medical care if the MCO has fewer than three providers in the specific medical category in the worker's GSA.

Proposed Amendment to OAR 436-010-0290(2) “Palliative Care.”

We support the proposed change to the NOTICE the insurer must send when disapproving a request for palliative care, but we suggest that the words “AND PROPOSED TREATING PROVIDER” be added after “ATTENDING PHYSICIAN.” We advocate the addition of the proposed treating provider to the notice of disapproval because my clients – private practice physical therapists – are often the ones who will be providing palliative care and are often the ones who prepare the written palliative request for the attending physician to sign and submit to the insurer. The current rules allow palliative care to begin once the physician submits the request, so a treating physical therapist can be at financial risk if the request is disapproved. Subparagraph (c) states that the insurer “must send written notice approving or disapproving the request to...the provider who will provide the care,” so it makes sense that the heading of the “NOTICE” of disapproval should also reference the treating provider.

Proposed Amendment to OAR 436-015-0030(6) “MCO Plan – Choice of Provider.”

We support the amendments to this rule to echo the amendments to OAR 436-010-0220(5), as outlined in my testimony above. Again, however, we suggest the addition of the words “**within a reasonable period of time given the worker's condition**” to subparagraphs (a) and (b).

Proposed Amendment to OAR 436-015-0037(3) “MCO-Insurer Contracts.”

We support the change in subparagraph (c)(A) of subsection (3) to allow a worker to continue treatment with his/her medical provider for at least 14 days – instead of 7 days – after the mailing

date of a notice of enrollment in an MCO. As was discussed in the December 17, 2018 meeting of the Rulemaking Advisory Committee, the current rule allowing a worker to continue treating with a current provider for only 7 days after mailing can mean that a worker may have only one or two days after *receiving* the notice of MCO enrollment to find and move his/her care to a new provider among the panel of MCO contracted providers.

Again, thank you for the opportunity to submit this testimony and for the Division's consideration of our proposed changes.

Diana E. Godwin
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Portland, OR 97201
Phone: (503) 224-0019
Fax: (971) 275-1218
E-mail: [REDACTED]

Cc: Client

(h) Modifiers QY, QK, and QX.¶

(A) Anesthesiologists medically directing non-physician providers must bill using modifier QY (medical direction of one qualified non-physician anesthetist by an anesthesiologist) or QK (medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals).¶

(B) Anesthesiologists may not perform other services while medically directing anesthesia procedures.¶

(C) Qualified non-physicians must bill using modifier QX (qualified non-physician anesthetist with medical direction by a physician) for anesthetist services with medical direction by a physician.¶

(D) 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

Mr. Bruyns,

Regarding the proposed regulatory changes as shown in the above screen shot, specifically stating:

“B. Anesthesiologists may not perform other services while medically directing anesthesia procedures”

We are questioning whether this is specifically regards to billing (ie: cannot bill for two services provided at the same time) or limiting medical practice (ie: cannot do a preop in the preop area while being available for a CRNA in a case).

Are you able to help clarify?

Thank you.

Colin Cave, MD

**BEFORE THE DIRECTOR OF THE
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
OF THE STATE OF OREGON**

PUBLIC RULEMAKING HEARING

In the Matter of the Amendment of OAR:		
436-001, Procedural Rules, Rulemaking, Hearings, and Attorney Fees)	TRANSCRIPT OF TESTIMONY
436-009, Oregon Medical Fee and Payment Rules)	
436-010, Medical Services)	
436-015, Managed Care Organizations)	
)	

The proposed amendment to the rules was announced in the Secretary of State’s Oregon Bulletin dated Feb. 1, 2019. On Feb. 19, 2019, a public rulemaking hearing was held as announced at 10 a.m. in Room F of the Labor and Industries Building, 350 Winter Street NE, Salem, Oregon. Fred Bruyns, from the Workers’ Compensation Division, acted as hearing officer. The record will be held open for written comment through Feb. 25, 2019.

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TRANSCRIPT OF PROCEEDINGS

Hearing officer:

Good morning and welcome. This is a public rulemaking hearing. My name is Fred Bruyns, and I’ll be the presiding officer for the hearing.

The time is 10 AM on Tuesday, Feb. 19, 2019. We are in Room F of the Labor and Industries Building, 350 Winter St. NE, in Salem, Oregon. We are making an audio recording of today’s hearing.

If you wish to present oral testimony today, please sign in on the testimony sign-in sheet on the table by the entrance. If you plan to testify over the telephone, I will sign in for you.

The Department of Consumer and Business Services, Workers’ Compensation Division proposes to amend chapter 436 of the Oregon Administrative Rules, specifically:

- Division 1, Procedural Rules, Rulemaking, Hearings, and Attorney Fees;
- Division 9, Oregon Medical Fee and Payment Rules;
- Division 10, Medical Services; and
- Division 15, Managed Care Organizations.

Transcript of public rulemaking hearing
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The department has summarized the proposed rule changes and prepared an estimate of fiscal and economic impacts in the notices of proposed rulemaking. These notices and proposed rules with marked changes are on the table by the entrance. Testimony received to date is also available on the table. Additional written testimony will be posted to the division's website as it arrives.

The Workers' Compensation Division: filed the notices of proposed rulemaking with the Oregon Secretary of State on Jan. 24 and 25, 2019; mailed the notices to its postal and electronic mailing lists; notified Oregon legislators as required by ORS chapter 183; and posted public notice and the proposed rules to its website.

The Oregon Secretary of State published the hearing notice in its Oregon Bulletin dated Feb. 1, 2019.

This hearing gives the public the opportunity to provide comment about the proposed rules. In addition, the division will accept written comment through and including Feb. 25, 2019, and will make no decisions until all of the testimony is considered.

We are ready to receive testimony. When I read your name, please come up to the table at my right. Lisa Johnson, would you like to testify?

Lisa Johnson:

Thank you. For the record, Lisa Johnson, with Majoris Health Systems. And, just had some comments on, under division 015, the proposal for requiring that if we have fewer than three practitioners of a certain type, making sure that the worker has those choices. Our concern there is with the hassle factor for providers, what we have experienced is that when a claim is new, it's not – workers have plenty of choices. Where we run into issues are with older claims where the worker may have already gone through a number of the providers in that area or just because of the extent and litigation and other things going on with the claim, that it can sometimes be harder to get them in to see a doctor. And, under this we would need to make sure there are three providers willing to see them, meaning we would be sending out a big, fat packet of chart notes and asking the providers to review those for a worker that they may never see – the worker may not even contact them or want to schedule with them. And so I think that is going to create barriers for some of the providers who currently are willing to treat injured workers.

Hearing officer:

Thank you very much Lisa.

Would anyone else like to testify this morning? If there is anyone on the telephone, would you like to testify? Hearing no one, it's our policy to keep hearings at least open and available to the public for a minimum of one-half hour in case someone arrives late. So, we will – I will suspend the hearing in a moment, but if you'd like to remain you are welcome to do so. Or if you leave, you can know that the transcript of this hearing will be posted to our website probably within a day or two. And, also, additional written testimony will be posted as it arrives.

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So, let me just let you know that you may submit testimony in any written form. I encourage you to submit testimony by email or as attachments to email. However, you may also use fax, USPS mail, courier, or you may hand deliver testimony to Workers' Compensation Division Central Reception on the second floor of this building. On the table by the entrance are business cards that include my contact information. I will acknowledge all testimony received.

This hearing is recessed at 10:05 a.m.

This hearing is resumed at 10:30 a.m.

Is there anyone here present or on the telephone who'd like to testify this morning? Hearing no one, the time is still 10:30, and this hearing is adjourned. Thank you for coming.

Transcribed from a digital audio recording by Fred Bruyns, Feb. 19, 2019.

February 25, 2019

Fred Bruyns, Rules Coordinator
Workers' Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

RE: SAIF Testimony on proposed changes to OAR Chapter 436 Divisions 01,
10, and 15

Dear Fred:

As always SAIF appreciates the opportunity to participate in the advisory committee process and to provide its comments on the proposed rules.

OAR 436-001 – Multilingual notification

SAIF supports WCD's effort to ensure that workers understand the critical documents about their claims. SAIF is concerned, however, that the proposed April 1 implementation date for the proposed "multilingual notice" help page outlined in Division 001. SAIF's review of the proposed rules identified over 150 documents (e.g. letters and worker notifications) that will require inclusion of a multilingual notice. Before it can begin its programming, SAIF needs a final version of the "multilingual notice" (Form 440-5377). SAIF's information services division estimates it will take a minimum of 2-3 weeks of development time to program SAIF systems to generate the "multilingual notice", and an additional 3 weeks to test the programming changes; however, until SAIF's information services divisions reviews the final document these estimates, are just estimates. Additionally, if we are unable to recreate the form we will need to purchase additional technology to recreate the required fonts.

SAIF recommends a July 1, 2019 effective date to provide insurers and self-insured employers the opportunity to program company systems.

OAR 436-010-0210(6)(c) (new numbering)

SAIF recommends adding "out of state" to clarify the rule. Without track changes and SAIF's suggested additional language is in italics:

(c) If the insurer withdraws approval of the *out of state* attending physician, the insurer must notify the physician in writing:"

OAR 436-015-0030(6) This subsection requires MCOs to allow workers to treat off the MCO's panel when the MCO has fewer than three providers within a GSA willing to treat an injured worker. SAIF recommends that clarifying language be added specifying that the worker's off panel provider selection must be a provider available within the

GSA where the MCO does not have three providers willing to treat the worker. SAIF suggests adding "within the same GSA" as follows for both subsections (a) and (b):

- (a) ...For categories where the MCO has fewer than three providers within a GSA willing to treat a worker, the MCO must allow the worker to seek treatment outside the MCO from providers, *within the same GSA*,

SAIF believes this is consistent with the rule's intent to allow the worker to choose a physician within the worker's GSA, thus eliminating travel because there is not an available panel provider within the worker's GSA.

Please let me know if you have any questions regarding this testimony. Thank you for your consideration.

Sincerely,

Jaye C. Fraser

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