Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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Jan. 28, 2021

Proposed Changes to Workers' Compensation Rules

Caption: Workers' compensation medical fees and payments, medical services, and managed care organizations

The Workers' Compensation Division proposes to amend:

- OAR 436-009, Oregon Medical Fee and Payment
- OAR 436-010, Medical Services
- OAR 436-015, Managed Care Organizations

When is the hearing?	Feb. 17, 2021, 2 p.m.
Where is the hearing?	Telephone only: 1-844-766-2282 | PIN: 886166
How can I make a comment?	Dial in to the hearing and speak, send written comments, or do both. Send written comments to: Email – fred.h.bruyns@oregon.gov Fred Bruyns, rules coordinator Workers' Compensation Division 350 Winter Street NE (for courier or in-person delivery) PO Box 14480, Salem, OR 97309-0405 Fax – 503-947-7514 **The closing date for written comments is Feb. 22, 2021**.
Questions?	Contact Fred Bruyns, 503-947-7717.

Proposed rules and public testimony are available on the Workers' Compensation Division's website: **http://wcd.oregon.gov/laws/Pages/proposed-rules.aspx**. Or, call 503-947-7717 to get paper copies.

Auxiliary aids for persons with disabilities are available upon advance request.

Summary of proposed changes to OAR 436-009, "Oregon Medical Fee and Payment":

- Amended rule 0001:
  - Has a title revised from "Administration" to "Purpose and Applicability";
  - Is revised to remove the description of statutory authority, because the relevant statutes are listed below the rule; and
  - Is reorganized to be consistent with equivalent rules in other divisions of OAR chapter 436.
- Amended rule 0004:
  - Adopts, by reference, new medical billing codes and related references; and
  - Adopts, in rule or by reference, CPT® codes and descriptors published by the American Medical Association.
- Amended rule 0010:
  - Has updated references to CPT® 2021;
  - No longer excludes two-level contiguous cervical artificial disc replacement (ADR) from compensability if the device has Food and Drug Administration approval for the procedure; and
  - Removes a list of contraindications to cervical ADR.
- Amended rule 0012 explains that medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2021.
- Amended rule 0023's ambulatory surgery center fee schedules, Appendices C and D, include new billing codes for 2021; some maximum payment amounts are higher or lower, but overall reimbursement is not projected to change.
- Amended rule 0040's physician fee schedule, Appendix B, includes new billing codes for 2021; maximum allowable payments for office visits are increased by 10%, and all other physician fee schedule services are increased by 2%, for an overall increase of approximately $7.2 million per year.
- Amended rule 0080's durable medical equipment, prosthetics, orthotics, and supplies fee schedule, Appendix E, increases maximum allowable payments by approximately $24,000 per year, or 0.2 percent.

Summary of proposed changes to OAR 436-010, "Medical Services":

- Amended rule 0001:
  - Has a title revised from "Administration" to "Purpose and Applicability";
  - Is revised to remove the description of statutory authority, because the relevant statutes are listed below the rule; and
  - Is reorganized to be consistent with equivalent rules in other divisions of OAR chapter 436.
- Amended rule 0230:
  - Requires that when a health care provider sends a written request for pre-authorization of diagnostic imaging studies (other than plain X-rays) to an insurer, the request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies; and

- Removes absolute and relative contraindications to cervical artificial disc replacement.

Summary of proposed changes to OAR 436-015, "Managed Care Organizations":

- Amended rule 0001:
  - Has a title revised from "Administration" to "Purpose and Applicability"; and
  - Is reorganized to be consistent with equivalent rules in other divisions of OAR chapter 436.

The agency requests public comment on whether other options should be considered for achieving the rules' substantive goals while reducing the negative economic impact of the rules on business.

Need for the Rule(s): Primarily, rule amendments are needed to adopt updated medical fee schedules, including increases to maximum allowable payments based on substantial increases in CMS' Relative Value Units (RVUs) for office visits and broad support from stakeholders for a general increase of the physician fee schedule amounts; allow reimbursement for two-level cervical artificial disc replacement (ADR); repeal absolute and relative contraindications to cervical ADR; and require that a written request for pre-authorization of diagnostic imaging studies is sent to the insurer separate from chart notes, clearly stating that it is a request for pre-authorization of diagnostic imaging studies.

Documents Relied Upon, and where they are available: Rulemaking advisory committee records and written advice. These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Fred Bruyns, rules coordinator, 503-947-7717, fred.h.bruyns@oregon.gov.

Fiscal and Economic Impact: The agency projects the proposed amendments to these rules, if adopted, will not affect the agency's cost to carry out its responsibilities under ORS chapter 656 and OAR chapter 436. Possible impacts on stakeholders are included under "Statement of Cost of Compliance" below.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

a. The agency estimates that proposed rule changes will not affect costs to state agencies for compliance with the rule.

b. The agency estimates that proposed rule changes will not result in any direct costs to units of local government for compliance with the rule, with the exception of cities and counties that are self-insured. Possible impacts to self-insured cities and counties are described in part c. with costs to the public.

c. The agency estimates that proposed rule changes will result in some impacts to the public:

The proposed increases in maximum allowable payments would result in higher costs for insurers and self-insured employers, while there would be a corresponding benefit to health care providers. The agency estimates that the net overall cost-of-compliance effect on insurers and self-insured employers will be approximately $7.2 million per year.

The proposed requirement that a health care provider's written request for pre-authorization of diagnostic imaging studies must be separate from chart notes and clearly state that it is a request for pre-authorization may slightly increase costs for providers that currently use chart notes to request

pre-authorization. However, these handling costs may be offset by faster responses from insurers and more imaging studies provided overall. Workers should benefit if faster responses result in more timely diagnosis and treatment. The percentage of providers that would have to modify current practice is not known, so the cost-of-compliance effect cannot be estimated, but the agency invites testimony regarding the extent of any impacts.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

The businesses most affected by the proposed rule changes are workers' compensation insurers, self-insured employers, and health care providers. Insurers and self-insured employers are generally large businesses. The agency does not have exact data on the number of health care providers in Oregon, but estimates that more than 5,000 Oregon medical providers are small businesses.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
The proposed requirement that a health care provider's written request for pre-authorization of diagnostic imaging studies must be separate from chart notes may slightly increase costs for providers that currently use chart notes to request pre-authorization. See additional information under 1.c.

c. Equipment, supplies, labor and increased administration required for compliance:
The agency projects that proposed rule changes will not increase the cost of compliance for small businesses for equipment, supplies, labor, or increased administration except as described under 1.c. and 2.b.

How were small businesses involved in the development of this rule? The agency notified more than 4,000 stakeholders, including small business representatives, of its intent to review the rules affecting medical fee and payment, medical services, and managed care organizations. This notice included a request for advice and for volunteers to serve on a rulemaking advisory committee.

Administrative Rule Advisory Committee consulted?: Yes. **If not, why?**

Sally Coen	Jan. 28, 2021
Authorized Signer	Printed name	Date

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Oregon Medical Fee and Payment Rules
Oregon Administrative Rules
Chapter 436, Division 009

Proposed, to be Effective April 1, 2021

Table of Contents

***NOTE: The text in rules 0023, 0040, and 0080 has not been revised, but new billing codes or reimbursement amounts are included in the related proposed fee schedules (Appendices B, C, D, and E) effective April 1, 2021.**

Historical rules: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

Revisions are marked as follows: new text | ~~deleted text~~.

436-009-0001 ~~Administration~~ Purpose and Applicability of These Rules

~~**(1)** Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.~~

~~(2) Authority for Rules.~~

~~These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) and specific authority under ORS 656.248.~~

(~~3~~1) Purpose.

The purpose of these rules is to establish uniform standards for administering the payment for medical benefits to workers within the workers' compensation system.

(~~4~~2) Applicability of Rules.

(a) These rules apply to all services rendered on or after the effective date of these rules.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist: Amended 3/12/14 as Admin. Order 14-052, eff. 4/1/14
Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide ~~2020~~ 2021 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide ~~2020~~2021, 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® ~~2020~~2021), Fourth Edition Revised, ~~2019~~2020, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® ~~2020~~2021 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)(a) The director adopts the following CPT® codes not listed in CPT® ~~2020~~2021 for billing by medical providers: ~~86328,~~ 86408, 86409, 86413, ~~86769,~~ 87426, ~~87635,~~ 87428, 87636, 87637, 87811, 91300, 91301, 99072, ~~0202U,~~ 0001A, 0002A, 0011A, 0012A, 0223U, 0224U, 0225U, ~~and~~ 0226U, 0240U, and 0241U.

(b) Effective upon receiving emergency use authorization or approval from the Food and Drug Administration, the director adopts the following CPT® codes and their descriptors not listed in CPT® 2021 for billing by medical providers: 91302, 91303, 0021A, 0022A, and 0031A.

(c) The director adopts, by reference, descriptors published by the AMA in "COVID-19 CPT coding and guidance," at https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance, for the CPT® codes listed in subsections (a) and (b) of this section.

(4) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume ~~29~~30, Issue 12, ~~2019~~2020. If there is a conflict between CPT® ~~2020~~2021 and the CPT® Assistant, CPT® ~~2020~~2021 is the controlling resource.

(5) To get a copy of the CPT® ~~2020~~2021 or the CPT® Assistant, contact the American Medical Association, ~~PO Box 74008935~~ AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL ~~60674-8935~~ 60611-5885, ~~800-621-8335~~ 312-464-4782, or www.ama-assn.org.

(6) 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.

(7) The director adopts, by reference, CDT ~~2020~~2021: 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.

(8) The director adopts, by reference, the 02/12 1500 Claim Form and Version 7.0 7/19 (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.

(9) The director adopts, by reference, the Official UB-04 Data Specifications Manual ~~2020~~2021 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.

(10) 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.

(11) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide ~~2020~~2021, CPT® ~~2020~~2021, CPT® Assistant, HCPCS ~~2020~~2021, CDT ~~2020~~2021, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(12) 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.

Stat Auth: ORS 656.248, 656.726(4); Stats Implemented: ORS 656.248
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/20
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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.

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® ~~2020~~2021 or in OAR 436-009-0004(3); • 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® ~~2020~~2021 (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.

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® ~~2020~~2021 or in OAR 436-009-0004(3), 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® ~~2020~~2021 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® ~~2020~~2021, 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 he or she is 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 ~~it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device~~ 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~~:~~

~~**(A)** The single level artificial disc replacement is between C3 and C7;~~

~~**(B)** The patient is 16 to 60 years old;~~

~~**(C)** The patient underwent unsuccessful conservative treatment;~~

~~**(D)** There is intraoperative visualization of the surgical implant level; and~~

~~**(E)** The procedure is not found inappropriate under OAR 436-010-0230; 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.

Stat. Auth.: ORS 656.726(4), 656.245, 656.248, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/20
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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® ~~2020~~2021.

(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"; 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"; 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 $35.00 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).

Stat. Auth.: ORS 726(4), 656.245, 656.248, 656.252, 656.254
Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254
Hist: Filed 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/20
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21

NOTE: The text in rule 0023 has not been revised, but new billing codes and dollar amounts are included in the proposed ASC fee schedules (Appendices C and D), to be effective April 1, 2021.

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.

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

(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.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245; 656.248; 656.252
Hist: Amended 3/11/19 as Admin. Order 19-051, eff. 4/1/19
Amended 12/16/19 as Admin. Order 19-056, eff. 1/1/20 (temp)
Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

NOTE: The text in rule 0040 has not been revised, but new billing codes and dollar amounts are included in the proposed physician fee schedule (Appendix B), to be effective April 1, 2021.

436-009-0040 Fee Schedule

(1) Fee Schedule Table.

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

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

(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 $59.74.

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

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

(b) Two or more surgeons

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

(c) Assistant surgeons

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

(d) Nurse practitioners or physician assistants

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

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

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

(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:

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

(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.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 8/28/20 as Admin. Order 20-060, eff. 9/21/20
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

NOTE: The text in rule 0080 has not been revised, but new dollar amounts are included in the proposed DMEPOS fee schedule (Appendix E), to be effective April 1, 2021.

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:

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

(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.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the *Index to Rule History*: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Appendices B through E

Oregon Workers' Compensation Maximum Allowable Payment Amounts

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

Appendix B (physician fee schedule) containing the maximum allowable payment amounts for services provided by medical service providers. [Effective ~~September 21, 2020~~ April 1, 2021]

Appendix C (ambulatory surgery center fee schedule amounts for surgical procedures), containing the maximum allowable payment amounts for surgical procedures including packaged procedures. [Effective April 1, ~~2020~~2021]

Appendix D (ambulatory surgery center fee schedule amounts for ancillary services) containing the maximum allowable payment amounts for ancillary services integral to the surgical procedure. [Effective April 1, ~~2020~~2021]

Appendix E (durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)) containing the maximum allowable payment amounts for durable medical equipment, prosthetics, orthotics, and supplies. [Effective April 1, ~~2020~~2021]

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

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright ~~2019~~/2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

The responsibility for the content of Oregon Workers' Compensation Maximum Allowable Payment Tables is with State of Oregon and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Oregon Workers' Compensation Maximum Allowable Payment Tables. Fee schedules, relative value units, conversion factors and related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Oregon Workers' Compensation Maximum Allowable Payment Tables should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

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

Or, contact the division for a paper copy, 503-947-7717

Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

Proposed to be Effective April 1, 2021

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OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 010

Revisions are marked as follows: new text | ~~deleted text~~.

436-010-0001 ~~Administration~~ Purpose and Applicability of These Rules

~~**(1)** Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.~~

~~**(2) Authority for Rules.**~~

~~These rules are promulgated under the director's general rulemaking authority of ORS 656.726(4) for administration of and pursuant to ORS chapter 656, particularly: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794.~~

(~~3~~1) Purpose.

The purpose of these rules is to establish uniform standards for administering the delivery of and payment for medical services to workers within the workers' compensation system.

(~~4~~2) Applicability of Rules.

(a) These rules apply on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service under ORS chapter 656.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325,

656.327, 656.331, 656.704, 656.794
Hist: Amended 3/11/19 as Admin. Order 19-062, eff.4/1/19
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 practitioner 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.

~~**(16) Cervical Artificial Disc Replacement Guidelines.**~~

~~**(a)** Cervical artificial disc replacement is always inappropriate for patients with any of the following conditions (absolute contraindications):~~

~~**(A)** Instability in the cervical spine which is greater than 3.5 mm of anterior motion or greater than 20 degrees of angulation;~~

~~**(B)** Significantly abnormal facets;~~

~~**(C)** Osteoporosis defined as a T-score of negative (-)2.5 or more negative (e.g., -2.7);~~

~~**(D)** Allergy to metal implant;~~

~~**(E)** Bone disorders (any disease that affects the density of the bone);~~

~~**(F)** Uncontrolled diabetes mellitus;~~

~~**(G)** Active infection, local or systemic;~~

~~**(H)** Active malignancy, primary or metastatic;~~

~~**(I)** Bridging osteophytes (severe degenerative disease);~~

~~**(J)** A loss of disc height greater than 75 percent relative to the normal disc above;~~

~~**(K)** Chronic indefinite corticosteroid use;~~

~~**(L)** Prior cervical fusion at two or more levels; or~~

~~**(M)** Pseudo-arthrosis at the level of the proposed artificial disc replacement.~~

~~**(b)** Cervical artificial disc replacement that is not excluded from compensability under OAR 436-009-0010(12)(h) may be inappropriate for patients with any of 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)** Multilevel degenerative disc disease -- cervical -- moderate to severe, as shown radiographically;~~

~~**(C)** Osteopenia -- based on bone density test with a T-score range of negative (-)1.5 to negative (-)2.5;~~

~~**(D)** Prior cervical fusion at one level;~~

~~**(E)** A loss of disc height of 50 percent to 75 percent relative to the normal disc above; or~~

~~**(F)** Psychosocial disorders -- diagnosed as significant to severe.~~

Stat. Auth: ORS 656.726(4); Stats. Implemented: ORS 656.245, 656.248, 656.252
Hist: Amended 3/11/19 as Admin. Order 19-062, eff.4/1/19
Amended xx/xx/xx as Admin. Order 21-xxx, eff. 4/1/21
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Managed Care Organizations
Oregon Administrative Rules
Chapter 436, Division 015

Revisions are marked as follows: new text | ~~deleted text~~.

436-015-0001 ~~Administration~~ Purpose and Applicability of These Rules

~~(1) Any orders issued by the division in carrying out the director's authority to enforce ORS chapter 656 and these rules are considered orders of the director.~~

(~~2~~1) Purpose.

The purpose of these rules is to establish and provide policies, procedures, and requirements to administer, evaluate, and enforce statutes relating to the delivery of medical services by managed care organizations (MCOs) to workers within the workers' compensation system.

(~~3~~2) Applicability of Rules.

(a) These rules apply on and after the effective date and govern all MCOs and insurers contracting with an MCO.

(b) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

(c) Any orders issued by the division in carrying out the director's authority to enforce Oregon Revised Statute (ORS) chapter 656 and Oregon Administrative Rule (OAR) chapter 436, are considered orders of the director of the Department of Consumer and Business Services.

(~~4~~3) Timeliness of Documents.

Timeliness of any document required by these rules to be filed with or submitted to the division is determined as follows:

(a) If a document is mailed, it will be considered filed on the date it is postmarked.

(b) If a document is faxed or emailed, it must be received by the division by 11:59 p.m. Pacific Time to be considered filed on that date.

(c) If a document is delivered, it must be delivered during regular business hours to be considered filed on that date.

(d) The date and time of receipt for electronic filings is determined under ORS 84.043.

(e) Time periods allowed for a filing or submission to the division are calculated in calendar days. The first day is not included. The last day is included unless it is a Saturday, Sunday, or legal holiday. In that case, the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Legal holidays are those listed in ORS 187.010 and 187.020.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 3/11/19, as Admin. Order 19-053, eff. 4/1/19
Amended xx/xx/xx, as Admin. Order 21-xxx, eff. 4/1/21
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.