Jan. 24, 2023

Proposed Changes to Workers' Compensation Rules

Caption: Medical fee schedules, payments, and related procedures; protected health information; managed care organization responsibilities

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. 15, 2023, 1 p.m.

Where is the hearing? Room F, Labor & Industries Building
350 Winter St. NE, Salem, Oregon
Or
By video or telephone conference – Join ZoomGov Meeting:
https://www.zoomgov.com/j/1605267096?pwd=TXdSWUlRaUUvSmN4TXU0VjF5OWV6dz09

Meeting ID: 160 526 7096 | Passcode: 439870
Telephone: US Toll-free, 1-833-568-8864

How can I make a comment? Attend the hearing (in person or virtually) and speak, send written comments, or do both. Send written comments by:
Email – WCD.Policy@dcbs.oregon.gov, Attention: rules coordinator
Or
Attn: Rules Coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480 (for mail delivery)
Salem, OR 97309-0405
Or
Fax – 503-947-7514

The closing date for written comments is Feb. 21, 2023.

Questions? Contact Fred Bruyns, 971-286-0316.

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 971-286-0316 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 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 updates references to CPT® 2023.
- Amended rule 0012:
  - Updates reference to CPT® 2023; and
  - Specifies that the place of service (POS) code "02" is to be used for "Telehealth Provided Other than in Patient's Home," and POS code "10" is to be used for "Telehealth Provided in Patient's Home."
- Amended rule 0020:
  - Clarifies how insurers are to pay out-of-state hospitals for inpatient and outpatient services; and
  - Specifies that any agreement to pay an out-of-state hospital less than the "fee schedule," rather than the "billed amount," must be in writing and signed by the hospital and insurer representative.
- Amended rule 0023's ambulatory surgery center fee schedules, Appendices C and D, include new billing codes for 2023. While some maximum payment amounts are higher or lower, the overall reimbursement is not projected to change.
- Amended rule 0025 explains that reimbursement rates for meals, lodging expenses, and mileage listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration.
- Amended rule 0040's physician fee schedule, Appendix B:
  - Includes new billing codes for 2023;
  - Increases overall maximum payments for the Evaluation & Management (E&M) office codes category by 18 percent;
  - Increases overall maximum payments for the major surgery category by 14 percent;
  - Increases maximum payments for chiropractic manipulation treatment (CMT) codes by 10 percent; and
  - Adjusts other maximum payment amounts higher or lower, but overall reimbursement is not projected to change (except for CMT codes, and E&M office and major surgery categories).
- Amended rule 0060 increases maximum payments for certain Oregon Specific Codes for medical arbiter examinations and reports.
- Amended rule 0080's durable medical equipment, prosthetics, orthotics, and supplies fee schedule, Appendix E, increases overall maximum payments by 8.7 percent.
- Amended rule 0090 eliminates the requirement for prescribing providers to complete Form 4909, the "Pharmaceutical Clinical Justification for Workers' Compensation," and repeals related procedures and the list of relevant drugs.

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

- Amended rule 0240 clarifies that, although a medical provider is encouraged to discuss potential modified work duties with an employer, the provider may not discuss medical treatments or diagnoses with the employer or release medical records to the employer.
- Amended rule 0270 explains that, by express provision in the contract between a managed care organization (MCO) and the insurer, the insurer may delegate to the MCO the responsibility for

issuing enrollment notices; however, the insurer remains liable for any deficiencies in the notices issued by the MCO.

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

- Amended rule 0040 clarifies that MCOs are to report certain data elements to the director as "described in," rather than as "prescribed by," Bulletin 247.

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): Rule amendments are needed to adopt updated medical fee schedules and related procedures, increase maximum payments for some medical services, and to clarify responsibilities of managed care organizations. Increased payment should offset inflation in the cost of operating health care practices and promote workers' access to medical services.

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, 971-286-0316, WCD.Policy@dcbs.oregon.gov.

Fiscal and economic impact: The agency projects the proposed rule amendments, 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 increase or decrease costs to state agencies for compliance with the rules.

b. The agency estimates that proposed rule changes will not increase or decrease costs to units of local government for compliance with the rules, with the exception of self-insured cities and counties, which are addressed under part c. below.

c. The agency estimates that proposed rule changes will increase some costs to the public for compliance with the rules. Increased maximum payments under these rules will increase costs to insurers and self-insured employers and provide a corresponding benefit to health care providers. An 18 percent fee increase of the Evaluation & Management office code category will raise costs by approximately $6.22 million per year, or 2.0 percent of total annual medical costs. A 14 percent fee increase of the major surgery category will raise costs by approximately $2.46 million per year, or 0.8 percent of total annual medical costs. A 10 percent fee increase of the chiropractic manipulation treatment codes will raise costs by approximately $0.28 million per year, or 0.1 percent of total annual medical costs. An 8.7 percent increase of the DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) fee schedule will raise costs by approximately $1.12 million per year, or 0.4 percent of total annual medical costs. A fee increase for certain

medical arbiter services will raise costs by approximately $0.26 million per year, or 0.08 percent of total annual medical costs.

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 affected by the proposed rule amendments are primarily insurers, self-insured employers, and health care providers. Insurers and self-insured employers are generally larger 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 agency estimates that adoption of the proposed amendments will not increase costs to small businesses for reporting, recordkeeping, other administrative activities, or professional services required for compliance. Proposed increases in maximum allowable payments may substantially benefit some health care providers, as described in 1.c.

c. Equipment, supplies, labor and increased administration required for compliance: The agency estimates that adoption of the proposed amendments will not increase costs to small businesses for equipment, supplies, labor, or increased administration required for compliance. Proposed increases in maximum allowable payments may substantially benefit some health care providers, as described in 1.c.

How were small businesses involved in the development of this rule? The agency sent rule advisory committee invitations to more than 4,500 stakeholders, including representatives of small businesses. Health care providers, including those that are small businesses, sent representatives to the rulemaking advisory committee.

Statement identifying how adoption of the rule will affect racial equity in this state: The Workers' Compensation Division does not collect data about race or ethnicity related to workplace injuries and illness in Oregon, but the United States Bureau of Labor Statistics publishes lists of occupations and numbers of Americans employed broken down by race. Black/African Americans and Hispanic/Latino workers are represented in some of the more dangerous occupations in higher numbers than their respective shares of the U.S. workforce. To the extent Oregon workers in these racial groups suffer more on-the-job injuries and illnesses, increased access to medical care may benefit these racial groups more than others. The agency does not have sufficient data needed to estimate specific effects on racial equity in Oregon, but invites public input.

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

Authorized Signer	Sally Coen	Jan. 24, 2023
	Printed name	Date

Mailing distribution: US Mail – WCD-S, U, AT, CE, EG, NM, CI, MR, DC, DO, GR, MD, OT, PY, M1 | agency email lists

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

***Proposed** Effective April 1, 2023*

Table of Contents

***NOTE: The text in rules 0023, 0040, 0060, and 0080 has not been revised, but new billing codes or payment amounts are included in the related fee schedules (Appendices B, C, D, and E) to be effective April 1, 2023.**

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

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009

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

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide ~~2022~~2023 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide ~~2022~~2023, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumberg, IL 60173, 847-825-5586, or www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT®~~2022~~ 2023), Fourth Edition Revised, ~~2021~~2022, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® ~~2022~~2023 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® 2022 for billing by medical providers: 91306, 91307, 0003A, 0004A, 0013A, 0034A, 0064A, 0071A, 0072A, and 0074A.~~

~~**(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® 2022 for billing by medical providers: 91305, 91308, 0051A, 0052A, 0053A, 0054A, 0081A, and 0082A.~~

~~**(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.~~

(43) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 31, Issue 12, ~~2021~~2022. If there is a conflict between CPT® ~~2022~~2023 and the CPT® Assistant, CPT® ~~2022~~2023 is the controlling resource.

(54) To get a copy of the CPT® ~~2022~~2023 or the CPT® Assistant, contact the American Medical Association, AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885, 312-464-4782, or www.ama-assn.org.

(~~6~~5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS). These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

(~~7~~6) The director adopts, by reference, CDT ~~2022~~2023: 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~~7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 9.0 7/21 (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~~8) The director adopts, by reference, the Official UB-04 Data Specifications Manual ~~2021~~2022 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~~9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.4 (7/2015) and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – 5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or www.ncpdp.org.

(~~11~~10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide~~2022~~ 2023, CPT®~~2022~~ 2023, CPT® Assistant, HCPCS ~~2022~~2023, CDT ~~2022~~2023, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(~~12~~11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem, OR 97301.

Stat Auth: ORS 656.248, 656.726(4); Stats Implemented: ORS 656.248
Hist: Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 12/19/22 as Admin. Order 22-066, eff. 1/1/23 Temp
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the Index to Rule History: https://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® ~~2022~~2023 ~~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® ~~2022~~2023 (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® ~~2022~~2023~~, 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® ~~2022~~2023 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® ~~2022~~2023, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

(A) Unusually lengthy procedure;

(B) Excessive blood loss during the procedure;

(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);

(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or

(F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants or nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."

(7) Chart Notes.

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider's Bill.

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.

(9) Billing the Patient and Patient Liability.

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that they are medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(c) A provider may bill a patient for a missed appointment under section (13) of this rule.

(10) Disputed Claim Settlement (DCS).

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) Payment Limitations.

(a) Insurers do not have to pay providers for the following:

(A) Completing forms 827 and 4909;

(B) Providing chart notes with the original bill;

(C) Preparing a written treatment plan;

(D) Supplying progress notes that document the services billed;

(E) Completing a work release form or completion of a PCE form, when no tests are performed;

(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or

(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.

(c) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) Excluded Treatment.

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface electromyography (EMG) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography;

(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:

(A) The single level artificial disc replacement is between L3 and S1;

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

(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and

(D) The procedure is not found inappropriate under OAR 436-010-0230;

(h) Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration (FDA) approval for the procedure; and

(i) Platelet rich plasma (PRP) injections.

(13) Missed Appointment (No Show).

(a) In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

(b) Other than missed appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams, a provider may bill a patient for a missed appointment if:

(A) The provider has a written missed-appointment policy that applies not only to workers' compensation patients, but to all patients;

(B) The provider routinely notifies all patients of the missed-appointment policy;

(C) The provider's written missed-appointment policy shows the cost to the patient; and

(D) The patient has signed the missed-appointment policy.

(c) The implementation and enforcement of subsection (b) of this section is a matter between the provider and the patient. The division is not responsible for the implementation or enforcement of the provider's policy.

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 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 6/13/22 as Admin. Order 22-053, eff. 7/1/22
Amended 12/19/22 as Admin. Order 22-066, eff. 1/1/23 Temp
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://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® ~~2022~~2023.

(3) Distant site provider billing.

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

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

(B) Use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.

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

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

(B) May not use modifier 95.

(4) Originating site billing.

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

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

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

(5) Payment.

(a) Insurers must pay distant site providers at the non-facility rate.

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

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

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

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

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: Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 12/19/22 as Admin. Order 22-066, eff. 1/1/23 Temp
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0020 Hospitals

(1) Inpatient.

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes;

(B) When applicable, procedural codes;

(C) The hospital's NPI; and

(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code, except for:

(i) Bills from critical access hospitals, (See Bulletin 290); or

(ii) Bills containing revenue code 002x.

(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio (See Bulletin 290). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.

(2) Outpatient.

(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient bills must, when applicable, include the following:

(A) Revenue codes;

(B) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes,

(C) CPT® codes and HCPCS codes; and

(D) The hospital's NPI.

(c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows:

Revenue Code	Pay Amount:	
0320-0359 0400-0409 0420-0449 0610-0619	Lesser of:	Non-facility column in Appendix B or The amount billed
0960-0989	Lesser of:	Facility column in Appendix B or The amount billed
All other revenue codes	• For hospitals listed in Bulletin 290, the amount billed multiplied by the cost-to-charge ratio. • For in-state hospitals not listed in Bulletin 290, 80% of the amount billed. • For out-of-state hospitals, the amount billed multiplied by a cost-to-charge ratio of 1.000.	

(3) Specific Circumstances.

When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission are considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment is considered part of the hospital services subject to the hospital inpatient fee schedule.

(4) Out-of-State Hospitals.

(a) Unless otherwise agreed upon by the hospital and the insurer, insurers must pay an out-of-state hospital for inpatient services as outlined in subsection (1)(c) of this rule and for outpatient services as outlined in subsection (2)(c) of this rule.

(b) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.

(c) Any agreement for payment less than the ~~billed~~ Oregon fee schedule amount must be in writing and signed by the hospital and insurer representative.

(d) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.

(e) ~~If~~Notwithstanding OAR 436-009-0010(8), if the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, the insurer must pay

an out-of-state hospital for inpatient services as outlined in subsection (1)(c) of this rule and for outpatient services as outlined in subsection (2)(c) of this rule.~~either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.~~

(5) Calculation of Cost-to-Charge Ratio Published in Bulletin 290.

(a) Each hospital's CMS 2552 form and financial statement is the basis for determining its adjusted cost-to-charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost–to-charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost-to-charge ratio or the hospital's cost-to-charge ratio based on estimated data.

(b) The basic cost-to-charge ratio is developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A is modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the director to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio is further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost-to-charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.

(e) The basic cost-to-charge ratio is further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule are added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost-to-charge ratio. In no event will the adjusted cost-to-charge ratio exceed 1.00.

(g) The adjusted cost-to-charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of its CMS 2552 and financial statements each year within 150 days of the end of the hospital's fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost-to-charge ratio schedule will be published by bulletin yearly.

(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division determines an adjusted cost–to-charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.

(i) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost-to-charge ratio to allow equitable payment.

(j) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost-to-charge ratio to reflect the data developed subsequent to the initial calculation.

(k) Notwithstanding subsections (1)(c) and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for all Oregon critical access hospitals qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost-to-charge ratio.

Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2), 656.313(4)(d)
Stats. Implemented: ORS 656.248; 656.252; 656.256
Hist: Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20
Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 12/19/22 as Admin. Order 22-066, eff. 1/1/23 Temp
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0025 Worker Reimbursement

(1) General.

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

(A) The insurer will reimburse claim-related services paid by the worker; and

(B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use Form 3921 – Request for Reimbursement of Expenses.

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

(A) The amount of reimbursement for each type of out-of-pocket expense requested.

(B) The specific reason for nonpayment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within two days, excluding Saturdays, Sundays, and legal holidays;

(D) The following notice, Web link, and phone number:

"To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit wcd.oregon.gov or call 503-947-7606.";

(E) Space for the worker's signature and date; and

(F) A notice of right to administrative review as follows:

"If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(4), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) Timeframes.

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

(A) Two years from the date the costs were incurred or

(B) Two years from the date the claim or medical condition is finally determined compensable.

(b) The insurer may disapprove the reimbursement request if the worker requests reimbursement after two years as listed in subsection (a).

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement or disapprove the request.

(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, the insurer must, within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later, reimburse the worker if the request shows the costs are related to the accepted claim or disapprove the request if unreasonable or if the costs are not related to the accepted claim.

(A) The insurer may request additional information from the worker to determine if costs are related to the accepted claim within 30 days of receiving the reimbursement request or 14 days of claim acceptance, whichever is later.

(B) If additional information is needed, the time needed to obtain the information is not counted in the 30-day or 14-day time frame for the insurer to issue reimbursement or disapprove the request.

(e) When any action, other than those listed in subsections (c) and (d) of this section, causes the reimbursement request to be payable, the insurer must reimburse the worker within 14 days of the action.

(f) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(g) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) Meal and Lodging Reimbursement.

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location. The reimbursement rates for meals and lodging expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).

(4) Travel Reimbursement.

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker.

The insurer must inform the worker that the worker may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112. The reimbursement rates for mileage expenses listed in Bulletin 112 are based on the rates published by the U.S. General Services Administration (GSA).

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

(5) Other Reimbursements.

(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) 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 either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing 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.

(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) Advancement Request.

If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth: ORS 656.245, 656.325, 656.704, and 656.726(4); Stats. Implemented: ORS 656.245, 656.704, and 656.726(4)
Hist: Amended 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 6/13/22 as Admin. Order 22-053, eff. 7/1/22
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 $60.93.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:

(A) The maximum allowable payment amount for anesthesia codes; or

(B) The provider's usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

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

(3) Surgery.

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

(a) One surgeon

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 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 12/19/22 as Admin. Order 22-066, eff. 1/1/23 Temp
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0060 Oregon Specific Codes

(1) Multidisciplinary Services.

(a) Services provided by multidisciplinary programs not otherwise described by CPT® codes must be billed under Oregon specific codes.

(b) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:

(A) The type of service rendered,

(B) The medical provider who provided the service,

(C) Whether treatment was individualized or provided in a group session, and

(D) The amount of time treatment was rendered for each service billed.

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

Service	OSC
Addictionologist consultant services: Services requested by a managed care organization consisting of an extensive records review, a physical exam, reports, responses to letters, and urine drug screening.	D0091
Arbiter exam - level 1: A basic medical exam with no complicating factors.	AR001
Arbiter exam - level 2: A moderately complex exam that may have complicating factors.	AR002
Arbiter exam - level 3: A very complex exam that may have several complicating factors.	AR003
Arbiter exam – limited: A limited exam that may involve a newly accepted condition, or a partial exam.	AR004
Arbiter file review - level 1: A file review of a limited record.	AR021

Service	OSC
Arbiter file review - level 2: A file review of an average record.	AR022
Arbiter file review - level 3: A file review of a large record or a disability evaluation without an exam.	AR023
Arbiter file review - level 4: A file review of an extensive record.	AR024
Arbiter file review - level 5: A file review of an extensive record with unique factors.	AR025
Arbiter report - level 1: A report that answers standard questions.	AR011
Arbiter report - level 2: A report that answers standard questions and complicating factors.	AR012
Arbiter report - level 3: A report that answers standard questions and multiple complicating factors.	AR013
Arbiter report - complex supplemental report: A report to clarify information or to address additional issues.	AR032
Arbiter report - limited supplemental report: A report to clarify information or to address additional issues.	AR031
Closing exam: An exam to measure impairment after the worker's condition is medically stationary.	CE001
Closing report: A report that captures the findings of the closing exam.	CR001
Consultation – attorney: Time spent consulting with an insurer's attorney.	D0001
Consultation – insurer: Time spent consulting with an insurer.	D0030
Copies of medical records: Copies of medical records requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0001
Copies of medical records electronically: Electronic copies of medical records provided on a disc or USB drive, uploaded to an insurer's secure website, or using secure email or e-fax, requested by the insurer or its representative – does not include chart notes sent with regular billing.	R0002
Deposition time: Time spent being deposed by insurer's attorney, includes time for preparation, travel, and deposition.	D0002

Service	OSC
Director required medical exam: Services by a physician selected under ORS 656.327 to perform reasonable and appropriate tests, or examine the worker. Services must be paid at an hourly rate for exam (P0001) and record review (P0002) up to six hours combined.	P0001
Director required file review time: Time spent by a physician selected under ORS 656.327 to review the record. Services must be paid at an hourly rate for record review (P0002) and exam (P0001) up to six hours combined.	P0002
Director required medical report: Preparation and submission of the report.	P0003
Director required review - complex case fee: One time, flat fee pre-authorized by the director for an extensive review in a complex case.	P0004
Ergonomic consultation - 1 hour (includes travel): Must be preauthorized by insurer. Work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications.	97661
IME (independent medical exam): Report, addendum to a report, file review, or exam.	D0003
IME – review and response: Insurer-requested review and response by treating physician; document time spent.	D0019
Interdisciplinary rehabilitation conference - 10 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97655
Interdisciplinary rehabilitation conferences – intermediate - 20 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97656
Interdisciplinary rehabilitation conferences – complex - 30 minutes: A decision-making body composed of each discipline essential to establishing and accomplishing goals, processes, time frames, and expected benefits.	97657
Interdisciplinary rehabilitation conferences – complex - each additional 15 minutes - up to 1 hour maximum: Each additional 15 minutes complex conference - up to 1 hour maximum.	97658
Interpreter mileage	D0041
Interpreter services – provided by a noncertified interpreter, excluding American Sign Language	D0004

Service	OSC
Interpreter services – American Sign Language	D0005
Interpreter services - provided by a health care interpreter certified by the Oregon Health Authority, excluding American Sign Language	D0006
Job site visit - 1 hour (includes travel): Must be preauthorized by insurer. A work site visit to identify characteristics and physical demands of specific jobs.	97659
Job site visit - each additional 30 minutes	97660
Multidisciplinary conference – initial - up to 30 minutes	97670
Multidisciplinary conference - initial/complex - up to 60 minutes	97671
Narrative – brief: Narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status and, if requested, brief answers to one to five questions related to the current or proposed treatment.	N0001
Narrative – complex: Narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, treatment to date, current status, impairment, prognosis, and medically stationary information.	N0002
Nursing evaluation - 30 minutes: Nursing assessment of medical status and needs in relationship to rehabilitation.	97664
Nursing evaluation - each additional 15 minutes	97665
Nutrition evaluation - 30 minutes: Evaluation of eating habits, weight, and required modifications in relationship to rehabilitation.	97666
Nutrition evaluation - each additional 15 minutes	97667
PCE (physical capacity evaluation) - first level: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level generally requires 30 to 45 minutes of actual patient contact. A first level PCE is paid under OSC 99196, which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99196

Service	OSC
PCE - second level: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish residual functional capacities for claim closure. This level generally requires not less than two hours of actual patient contact. The second level PCE is paid under OSC 99197, which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes is paid under OSC 99193, which includes the evaluation and report.	99197
PCE – each additional 15 minutes	99193
Physical conditioning - group - 1 hour: Conditioning exercises and activities, graded and progressive.	97642
Physical conditioning - group - each additional 30 minutes	97643
Physical conditioning – individual - 1 hour: Conditioning exercises and activities, graded and progressive.	97644
Physical conditioning – individual - each additional 30 minutes	97645
Professional case management – individual 15 minutes: Evaluate and communicate progress, determine needs/services, coordinate counseling and crisis intervention dependent on needs and stated goals (other than done by physician).	97654
Records review: Review of medical records on an MCO-enrolled claim by a nontreating physician requested by an insurer or a managed care organization.	RECRW
Social worker evaluation - 30 minutes: Psychosocial evaluation to determine psychological strength and support system in relationship to successful outcome.	97668
Social worker evaluation – each additional 15 minutes	97669
Therapeutic education – individual 30 minutes Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97650
Therapeutic education – individual - each additional 15 minutes	97651
Therapeutic education - group 30 minutes: Medical, psychosocial, nutritional, and vocational education dependent on needs and stated goals.	97652
Therapeutic education - group - each additional 15 minutes	97653
Video Review: Review of video requested by an insurer or a managed care organization.	VIDEO
Vocational evaluation - 30 minutes: Evaluation of work history, education, and transferable skills coupled with physical limitations in relationship to return-to-work options.	97662

Service	OSC
Vocational evaluation - each additional 15 minutes	97663
WCE (work capacity evaluation): This is a residual functional capacity evaluation that generally requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE is paid under OSC 99198, which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g., cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes must be paid under OSC 99193, which includes the evaluation and report. Special emphasis should be given to: • The ability to perform essential physical functions of the job based on a specific job; • Analysis as related to the accepted condition; • The ability to sustain activity over time; and • The reliability of the evaluation findings.	99198
WCE – each additional 15 minutes	99193
Work simulation - group 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97646
Work simulation - group - each additional 30 minutes	97647
Work simulation - individual 1 hour: Real or simulated work activities addressing productivity, safety, physical tolerance, and work behaviors.	97648
Work simulation - individual - each additional 30 minutes	97649
WRME (worker requested medical exam): Exam and report.	W0001

(3) CARF / JCAHO Accredited Programs.

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(d) All job site visits and ergonomic consultations must be preauthorized by the insurer.

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 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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 3/2/22 as Admin. Order 22-050, eff. 4/1/22
Amended 12/19/22 as Admin. Order 22-066, eff. 1/1/23 Temp
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-009-0090 Pharmaceutical

(1) General.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.

(2) Pharmaceutical Billing and Payment.

(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed. This includes compounded drugs, which must be billed by

ingredient, listing each ingredient's NDC. Ingredients without an NDC are not reimbursable.

(b) All bills from pharmacies must include the prescribing provider's NPI or license number.

(c) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

(d) Unless directly purchased by the worker (see OAR 436-009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table:

If the drug dispensed is:	**Then the maximum allowable fee is:**
A generic drug	83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee
A brand name drug without a generic equivalent or the prescribing provider has specified that the drug may not be substituted with a generic equivalent	83.5 % of the dispensed drug's AWP plus a $2.00 dispensing fee
A brand name drug with a generic equivalent and the prescribing provider has not prohibited substitution	83.5 % of the average AWP for the class of generic drugs plus a $2.00 dispensing fee
A compound drug	83.5 % of the AWP for each individual ingredient plus a single compounding fee of $10.00 (The compounding fee includes the dispensing fee.)

(Note: "AWP" means the Average Wholesale Price effective on the date the drug was dispensed.)

(e) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., RED BOOK or Medi-Span.

~~**(3) Clinical Justification Form 4909.**~~

~~**(a)** The prescribing provider must fill out Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, and submit it to the insurer when prescribing more than a five day supply of the following drugs:~~

~~**(A)** Celebrex®;~~

~~**(B)** Cymbalta®;~~

~~**(C)** Fentora®;~~

~~**(D)** Kadian®;~~

~~**(E)** Lidoderm®;~~

~~**(F)** Lyrica®; or~~

~~**(G)** OxyContin®.~~

~~**(b)** Insurers may not challenge the adequacy of the clinical justification. However, they may challenge whether or not the medication is excessive, inappropriate, or ineffectual under ORS 656.327.~~

~~**(c)** The prescribing provider is not required to fill out Form 4909 for refills of medications listed on that form.~~

~~**(d)** If a prescribing provider does not submit Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, to the insurer, the insurer may file a complaint with the director.~~

(43) Dispensing by Medical Service Providers.

(a) 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 patient, up to a maximum of 10 days.

(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.

Stat. Auth.: ORS 656.726(4); Stats. Implemented: ORS 656.248, 656.252, 656.254
Hist: Amended 3/12/15 as Admin. Order 15-058, eff. 4/1/15
Amended 3/7/16 as Admin. Order 16-050, eff. 4/1/16
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://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 April 1, ~~2022~~2023]

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, ~~2022~~2023]

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, ~~2022~~2023]

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, ~~2022~~2023]

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

The five character codes included in the Oregon Workers' Compensation Maximum Allowable Payment Tables are obtained from Current Procedural Terminology (CPT), copyright ~~2021~~2022 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: https://wcd.oregon.gov/medical/Pages/disclaimer.aspx

Or, contact the division for a paper copy, ~~503-947-7717~~971-286-0316

Medical Services
Oregon Administrative Rules
Chapter 436, Division 010

***Proposed** Effective April 1, 2023*

TABLE OF CONTENTS

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

436-010-0240 Medical Records and Reporting Requirements for Medical Providers

(1) Medical Records and Reports.

(a) Medical providers must maintain records necessary to document the extent of medical services provided.

(b) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) Reports may be handwritten and must include all relevant or requested information such as the anticipated date of release to return to work, medically stationary date, etc.

(d) Diagnoses stated on all reports, including Form 827, must conform to terminology found in the appropriate International Classification of Disease (ICD).

(2) Diagnostic Studies.

When the director or the insurer requests original diagnostic studies, including but not limited to actual films, they must be forwarded to the director, the insurer, or the insurer's designee within 14 days of receipt of a written request.

(a) Diagnostic studies, including films, must be returned to the medical provider within a reasonable time.

(b) The insurer must pay a reasonable charge made by the medical provider for the costs of delivery of diagnostic studies, including films.

(3) Multidisciplinary Programs.

When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for the worker, the attending physician or authorized nurse practitioner must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Release of Medical Records.

(a) Health Insurance Portability and Accountability Act (HIPAA) rules allow medical providers to release information to insurers, self-insured employers, service companies, or the Department of Consumer and Business Services. [See 45 CFR 164.512(l).]

(b) When patients file workers' compensation claims they are authorizing medical providers and other custodians of claim records to release relevant medical records including diagnostics. The medical provider will not incur any legal liability for disclosing such records. [See ORS 656.252(4).] The authorization is valid for the life of the claim and cannot be revoked by the patient or the patient's representative. A separate authorization is required for release of information regarding:

(A) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, and

(B) HIV-related information protected by ORS 433.045.

(c) Any medical provider must provide all relevant information to the director, or the insurer or its representative upon presentation of a signed Form 801, 827, or 2476. The insurer may print "Signature on file" on a release form as long as the insurer maintains a

signed original. However, the medical provider may require a copy of the signed release form.

(d) The medical provider must respond within 14 days of receipt of a request for progress reports, narrative reports, diagnostic studies, or relevant medical records needed to review the efficacy, frequency, and necessity of medical treatment or medical services. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

(e) Patients or their representatives are entitled to copies of all medical and payment records, which may include records from other medical providers. Patients or their representatives may request all or part of the record. These records should be requested from the insurer, but may also be obtained from medical providers. A summary may substitute for the actual record only if the patient agrees to the substitution. The following records may be withheld:

(A) Psychotherapy notes;

(B) Information compiled for use in a civil, criminal, or administrative action or proceeding;

(C) Other reasons specified by federal regulation; and

(D) Information that was obtained from someone other than a medical provider when the medical provider promised confidentiality and release of the information would likely reveal the source of the information.

(f) A medical provider may charge the patient or the patient's representative for copies at the rate specified in OAR 436-009-0060. A patient may not be denied summaries or copies of the patient's medical records because of inability to pay.

(g) A medical provider is encouraged to discuss potential modified work duties with employers. However, a medical provider may not discuss medical treatments or diagnoses with employers or release medical records to employers.

(5) Release to Return to Work.

(a) When requested by the insurer, the attending physician or authorized nurse practitioner must submit verification that the patient's medical limitations related to their ability to work result from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return-to-work form, the insurer must use Form 3245.

(b) The attending physician or authorized nurse practitioner must advise the patient, and within five days, provide the insurer written notice of the date the patient is released to return to regular or modified work.

(6) Temporary Disability and Medically Stationary.

(a) When temporary disability is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report.

The provider must submit a requested progress report or narrative report within 14 days of receiving the insurer's request. If the medical provider fails to provide information under this rule within 14 days of receiving a request sent by fax or certified mail, penalties under OAR 436-010-0340 may be imposed.

(b) The attending physician or authorized nurse practitioner must, if known, inform the patient and the insurer of the following and include it in each progress report:

(A) The anticipated date of release to work;

(B) The anticipated date the patient will become medically stationary;

(C) The next appointment date; and

(D) The patient's medical limitations.

(c) The insurer must not consider the anticipated date of becoming medically stationary as a date of release to return to work.

(d) The attending physician or authorized nurse practitioner must notify the patient, insurer, and all other medical providers involved in the patient's treatment when the patient is determined medically stationary and whether the patient is released to any kind of work. The medically stationary date must be the date of the exam and not a projected date.

(7) Consultations.

When the attending physician, authorized nurse practitioner, or the MCO requests a consultation with a medical provider regarding conditions related to an accepted claim:

(a) The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for the consultation and provide the consultant with all relevant medical records. However, if the consultation is for diagnostic studies performed by radiologists or pathologists, no such notification is required.

(b) The consultant must submit a copy of the consultation report to the insurer and the attending physician, authorized nurse practitioner, or MCO within 10 days of the date of the exam or chart review. The consultation fee includes the fee for this report.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.245, 656.252, 656.254
Hist: Amended 3/11/19 as Admin. Order 19-062, eff.4/1/19
Amended 6/13/22 as Admin. Order 22-054, eff. 7/1/22

Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-010-0270 Insurer's Rights and Duties

(1) Notifications.

(a) Immediately following receipt of notice or knowledge of a claim, the insurer must notify the worker in writing about how to receive medical services for compensable injuries.

(b) Within 10 days of any change in the status of a claim, (e.g., acceptance or denial of a claim, or a new or omitted medical condition), the insurer must notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any.

(c) In disabling and nondisabling claims, immediately following notice or knowledge that the worker is medically stationary, the insurer must notify the worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable. This notice must list all benefits the worker is entitled to receive under ORS 656.245 (1)(c).

(d) When the insurer establishes a medically stationary date that is not based on the findings of an attending physician or authorized nurse practitioner, the insurer must notify all medical service providers of the worker's medically stationary status. For all injuries occurring on or after October 23, 1999, the insurer must pay all medical service providers for services rendered until the insurer provides notice of the medically stationary date to the attending physician or authorized nurse practitioner.

(2) Medical Records Requests.

(a) Insurers may request relevant medical records, using Form 2476, "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or a computer-generated equivalent of Form 2476, with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(b) Within 14 days of receiving a request, the insurer must forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner.

(3) Pre-authorization.

Unless otherwise provided by an MCO, an insurer must respond in writing within 14 days of receiving a medical provider's written request for preauthorization of diagnostic imaging studies, other than plain film X-rays. The response must include whether the service is pre-authorized or not pre-authorized.

(4) Insurer's Duties under MCO Contracts.

(a) Insurers who enter into an MCO contract under OAR 436-015, must notify the affected employers of the following:

(A) The names and addresses of all MCO panel providers within the employer's geographical service area(s);

(B) How workers can receive compensable medical services within the MCO;

(C) How workers can receive compensable medical services by non-panel providers; and

(D) The geographical service area governed by the MCO.

(b) Insurers under contract with an MCO must notify any newly insured employers as specified in subsection (4)(a) of this rule no later than the effective date of coverage.

(c) When the insurer is enrolling a worker in an MCO, the insurer must provide the name, address, and telephone number of the worker and, if represented, the worker's attorney's name, mailing address, phone number, and, if known, fax number and email address to the MCO.

(d) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical providers, and the MCO of enrollment. To be considered complete, the notice must:

(A) Provide the worker a written list of the eligible attending physicians within the relevant MCO geographic service area or provide a Web address to access the list of eligible attending physicians. If the notice does not include a written list, then the notice must also:

(i) Provide a telephone number the worker may call to ask for a written list; and

(ii) Tell the worker that they have seven days from the mailing date of the notice to request the list;

(B) Explain how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(C) Advise the worker how to obtain medical services for compensable injuries within the MCO. This includes whether the worker:

(i) Must change attending physician or authorized nurse practitioner to an MCO panel provider, or

(ii) May continue to treat with the worker's current attending physician or authorized nurse practitioner;

(D) Explain how the worker can receive compensable medical treatment from a "come-along" provider;

(E) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer, except when the employer provides a coordinated health care program. For the purpose of this rule, "coordinated health care program" means an employer program providing coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the workers with health care benefits even if a workers' compensation claim is denied; and

(F) Notify the worker of the worker's right to appeal MCO decisions and provide the worker with the title, address, and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes.

(e) When an insurer enrolls a worker in an MCO before claim acceptance, the insurer must inform the worker in writing that the insurer will pay for certain medical services even if the claim is denied. Necessary and reasonable medical services that are not otherwise covered by health insurance will be paid until the worker receives the notice of claim denial or until three days after the denial is mailed, whichever occurs first.

(f) When a worker who is not yet medically stationary must change medical providers because an insurer enrolled the worker in an MCO, the insurer must notify the worker of the right to request review before the MCO if the worker believes the change would be medically detrimental.

(g) The insurer may delegate to the MCO responsibility for issuing the enrollment notice required by ORS 656.245(4)(a) and these rules by express provision in the contract between those parties; however, the insurer remains liable for any deficiencies in the notice issued by the MCO.

(gh) If, at the time of MCO enrollment, the worker's medical service providers are not members of the MCO and do not qualify as "come-along providers," the insurer must notify the worker and providers regarding provisions of care under the MCO contract, including continuity of care as provided by OAR 436-015-0037(3).

(hi) Within seven days of receiving a dispute regarding an issue that should be processed through the MCO dispute resolution process and a copy has not been sent to the MCO, the insurer must:

(A) Send a copy of the dispute to the MCO; or

(B) If the MCO does not have a dispute resolution process for that issue, notify the parties in writing to seek administrative review before the director.

(ij) The insurer must notify the MCO within seven days of receiving notification of the following:

(A) When the worker obtains representation by an attorney, the attorney's name, mailing address, phone number, and, if known, fax number and email address;

(B) Any changes to the worker's or worker's attorney's name, address, or telephone number;

(C) Any requests for medical services from the worker or the worker's medical provider; or

(D) Any request by the worker to continue treating with a "come-along" provider.

(~~j~~k) Insurers under contract with MCOs must maintain records including, but not limited to:

(A) A listing of all employers covered by MCO contracts;

(B) The employers' WCD employer numbers;

(C) The estimated number of employees governed by each MCO contract;

(D) A list of all workers enrolled in the MCO; and

(E) The effective dates of such enrollments.

(~~k~~l) When the insurer is disenrolling a worker from an MCO, the insurer must simultaneously provide written notice of the disenrollment to the worker, the worker's representative, all medical service providers, and the MCO. The insurer must mail the notice no later than seven days before the date the worker is no longer subject to the contract. The notice must tell the worker how to obtain compensable medical services after disenrollment.

(~~l~~m) When an MCO contract expires or is terminated without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days before the date the contract expires or terminates. The notice must tell the worker how to obtain compensable medical services after the worker is no longer subject to the MCO contract.

Stat. Auth: ORS 656.726(4)
Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist: Amended 3/13/18 as Admin. Order 18-054, eff. 4/1/18
Statutory minor correction – ORS 183.335(7), filed and effective 7/6/20
Amended 6/13/22 as Admin. Order 22-054, eff. 7/1/22
Amended xx/xx/xx as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

Managed Care Organizations
Oregon Administrative Rules
Chapter 436, Division 015

***Proposed** Effective April 1, 2023*

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

436-015-0040 Reporting Requirements for an MCO

(1) In order to ensure the MCO complies with the requirements of these rules, each MCO must provide the director with a copy of the entire text of any MCO-insurer contract, signed by the insurer and the MCO, within 30 days of execution of such contracts. The MCO must submit any amendments, addenda, or cancellations to the director within 30 days of execution.

(2) When an MCO-insurer contract contains a specific expiration or termination date, the MCO must provide the director with a copy of a contract extension, signed by the insurer and MCO, no later than the contract's date of expiration or termination. If the MCO does not provide the director with a copy of the signed contract extension, workers will no longer be subject to the contract after it expires or terminates.

(3) The MCO must submit any amendments to the certified plan to the director for approval. The MCO must not take any action based on a proposed amendment until the director approves the amendment.

(4) Within 45 days of the end of each calendar quarter, each MCO must provide the following information to the director, current on the last day of the quarter, as ~~prescribed by~~ described in Bulletin 247:

(a) The quarter being reported;

(b) MCO certification number; and

(c) Membership listings by category of medical service provider (in coded form), including:

(A) Provider names;

(B) Specialty (in coded form);

(C) Tax ID number;

(D) National Provider Identifier (NPI) number; and

(E) Business address and phone number. When a medical service provider has multiple offices, only one office location in each geographic service area needs to be reported.

(5) By April 30 of each year, each MCO must provide the director with the following information for the previous calendar year:

(a) A summary of any sanctions or punitive actions taken by the MCO against its members; and

(b) A summary of actions taken by the MCO's peer review committee.

(6) By April 30 of each year, each MCO must report to the director denials and terminations of the authorization of come-along providers. The MCO's report must include the following:

(a) Provider type (primary care physician, chiropractic physician, or authorized nurse practitioner) reported by geographic service area (GSA).

(b) The number of workers affected, reported by provider type.

(c) Date of denial or termination.

(d) One or more of the following reasons for each denial or termination:

(A) Provider failed to meet the MCO's credentialing standards within the last two years;

(B) Provider has been previously terminated from serving as an attending physician within the last two years;

(C) Treatment is not according to the MCO's service utilization process;

(D) Provider failed to comply with the MCO's terms and conditions after being granted come-along privileges; or

(E) Other reasons authorized by statute or rule.

(7) An MCO must report any new board members or shareholders to the director within 14 days of such changes. These parties must submit affidavits certifying they have no interest in an insurer or other non-qualifying employer as described under OAR 436-015-0009.

(8) Nothing in this rule limits the director's ability to require information from the MCO as necessary to monitor the MCO's compliance with the requirements of these rules.

Stat. Auth.: ORS 656.260, 656.726(4)
Stats. Implemented: ORS 656.260
Hist: Amended 11/12/13 as Admin. Order 13-060, eff. 1/1/14
Amended 3/13/18, as Admin. Order 18-055, eff. 4/1/18
Amended xx/xx/xx, as Admin. Order 23-xxx, eff. xx/xx/xx
See also the *Index to Rule History*: https://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.