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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED
06/17/2020 4:48 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Telehealth services: scope and billing procedures

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 07/28/2020 11:55 PM

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

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Filed By:
FREDERICK BRUYNS
Rules Coordinator

HEARING(S)

Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

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NEED FOR THE RULE(S):

Rule changes are needed to provide reimbursements for certain telephone and online digital evaluation and management services that are equivalent to amounts paid for in-office care. As telehealth services become more common, fair reimbursement should serve to promote access by workers to needed medical care. Additional proposed amendments should promote understanding of telehealth and telemedicine, including that telemedicine is not limited to

the services listed in Appendix "P" of CPT® 2020; however, all services must be appropriate, and the form of communication must be appropriate for the service provided.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

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

FISCAL AND ECONOMIC IMPACT:

The proposed amendments should have no fiscal or economic impacts on the Department of Consumer and Business Services, Workers' Compensation Division (agency).

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

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 result in any direct costs to state agencies for compliance with the rule.

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

c. The agency estimates that proposed rule changes will result in some impacts to the public: insurers and self-insured employers may have to pay more for the medical care of injured workers, and health care providers may receive increased payments for their services. Maximum allowable payments (MAPs) would increase for certain evaluation and management (E&M) medical services provided over the telephone or by online digital methods to levels provided for in-office services. However, to the extent these E&M telehealth services simply replace equivalent in-office services due to recent changes in care delivery, there should be little net change to costs for insurers and self-insured employers due to the COVID-19 pandemic. Still, to the extent certain telehealth services have consistently been provided over the telephone or by online digital methods, the proposed increases will raise costs for insurers and self-insured employers. The agency estimates that the net overall cost-of-compliance effect on insurers and self-insured employers to be approximately $138,000 per year.

Another way to consider the cost-of-compliance effects is to estimate the costs for these telehealth services with and without the proposed rule change, as opposed to the combined effect of the rule change and recent increases in remote medical services. The agency adopted a temporary rule change, effective March 8, 2020, in response to the COVID-19 pandemic, setting MAPs for these telehealth services equivalent to like in-office E&M services. Without the temporary rule, because the MAPs were substantially below the rates for in-office services, increased use of these E&M services

probably would have lowered payments overall. Due to lags in reporting of billing and payment data, the agency does not yet have sufficient utilization and payment data that reflects pandemic-related changes, and cannot measure the differences between what insurers and self-insured employers paid relative to what they would have paid without the temporary rule changes. Better data should be available by late summer or in the fall, and the appropriate, ongoing reimbursement rates for these telehealth services will be discussed with a rulemaking advisory committee in November or December.

2. Cost of compliance effect on small business (ORS 183.336):

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

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
The agency projects that proposed rule changes will not increase the cost of compliance for small businesses for reporting, recordkeeping, other administrative activities, or professional services.

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

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The agency notified more than 4,000 stakeholders, including representatives of small businesses possibly affected by potential rule changes, about a scheduled advisory committee meeting. Committee members attending the meeting on May 18, 2020, included representatives of small health care providers.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
436-009-0012, 436-009-0040

AMEND: 436-009-0012

RULE SUMMARY: Amended rule 0012:
- Defines "telehealth";
- States that all services must be appropriate, and the form of communication must be appropriate for the service provided;
- Clarifies that medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2020; and
- Explains that when billing for telehealth services other than telemedicine services, a distant-site provider must use the

place-of-service code “02,” and may not use modifier 95.

CHANGES TO RULE:

436-009-0012
Tele~~medicine~~health
(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.¶
(~~b~~c) "Distant site" means the place where the provider providing medical services to a patient through tele ~~medicine~~health is located.¶
(~~c~~d) "Originating site" means the place where the patient receiving medical services through tele~~medicine is located~~health is located.¶
(2) Scope of services.¶
(a) All services must be appropriate, and the form of communication must be appropriate for the service provided.¶
(b) Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those listed in Appendix P of CPT® 2020.¶
(~~2~~3) Distant site provider billing.¶
(a) When billing for telemedicine services, the distant site provider must:¶
(~~a~~A) Use the place of service (POS) code "02"; and¶
(~~b~~B) Use modifier 95 to identify the service as a synchronous medical service rendered via a real-time interactive audio and video telecommunications system.¶
(~~3) Originating site billing. T~~b) When billing for telehealth services other than telemedicine services, the distant site provider:¶
(A) Must use the POS code "02"; and¶
(B) May not use modifier 95.¶
(4) Originating site billing. When billing for telehealth services, the originating site may charge a facility fee using HCPCS code Q3014, if the site is:¶
(a) The office of a physician or practitioner; or¶
(b) A health care facility including but not limited to a hospital, rural health clinic, skilled nursing facility, or community mental health center.¶
(~~4~~5) Payment.¶
(a) Insurers must pay distant site providers at the non-facility rate.¶
(b) Equipment or supplies at the distant site are not separately payable.¶
(c) The payment amount for code Q3014 is $35.00 per unit or the provider's usual fee, whichever is lower. In calculating the units of time, 15 minutes, or any portion of 15 minutes, equals one unit.¶
(d) Professional fees of supporting providers at the originating site are not separately payable.¶
(e) Insurers are not required to pay a telehealth transmission fee (HCPCS code T1014).
Statutory/Other Authority: ORS 656.245, 656.248, 656.252, 656.254, 656.726(4)
Statutes/Other Implemented: ORS 656.245, 656.248, 656.252, 656.254

AMEND: 436-009-0040

RULE SUMMARY: Amended rule 0040 and its Appendix B, the physician fee schedule, increase maximum allowable payments for certain telephone and digital evaluation and management services.

CHANGES TO RULE:

436-009-0040
Fee Schedule ¶

(1) Fee Schedule Table.¶
(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table: {See attached table.}¶
(b) The global period is listed in the column Global Days' of Appendix B.¶
(2) Anesthesia.¶
(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.¶
(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.¶
(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier NT' (no time) must be on the bill.¶
(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.¶
(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.¶
(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $59.74. Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of:¶
(A) The maximum allowable payment amount for anesthesia codes; or¶
(B) The provider's usual fee.¶
(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.¶
(h) Payment for services billed with modifiers QY, QK, or QX is at 50 percent of the applicable fee schedule amount.¶
(3) Surgery. Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:¶
(a) One surgeon {See attached table.}¶
(b) Two or more surgeons {See attached table.}¶
(c) Assistant surgeons {See attached table.}¶
(d) Nurse practitioners or physician assistants {See attached table.}¶
(e) Self-employed surgical assistants who work under the direct control and supervision of a physician {See attached table.}¶
(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.¶
(g) If the surgery is nonelective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than

one day before surgery.¶
(4) Radiology Services.¶
(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.¶
(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component. The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.¶
(5) Pathology and Laboratory Services.¶
(a) The payment amounts in Appendix B apply only when there is direct physician involvement.¶
(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.¶
(6) Physical Medicine and Rehabilitation Services.¶
(a) Time-based CPT codes must be billed and paid per code according to this table: {See attached table.}¶
(b) Except for CPT codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168, payment for modalities and therapeutic procedures is limited to a total of three separate CPT-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT code does not count as a separate code. When a provider bills for more than three separate CPT-coded services per day, the insurer is required to pay the codes that result in the highest payment to the provider.¶
(c) For all time-based modalities and therapeutic procedures that require constant attendance, the chart notes must clearly indicate the time each modality or procedure begins and the time each modality or procedure ends or the amount of time spent providing each modality or procedure.¶
(d) CPT codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.¶
(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.¶
(7) Reports.¶
(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.¶
(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.¶
(8) Nurse Practitioners and Physician Assistants. Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.
Statutory/Other Authority: ORS 656.726(4)
Statutes/Other Implemented: ORS 656.248

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

436-009-0040 Fee Schedule

(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.

*** * * ***

(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

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount is:</th></tr>
<tr><td rowspan="3">Principal procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>The amount in Appendix B; or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">80% of billed amount</td></tr>
<tr><td rowspan="3">Any additional procedures* including:
• diagnostic arthroscopy performed prior to open surgery
• the second side of a bilateral procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>50% of the amount in Appendix B; or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">40% of the billed amount (unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 80% of the billed amount)</td></tr>
<tr><td colspan="4">*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.</td></tr>
</table>

(b) Two or more surgeons

<table>
<tr><th>Procedures</th><th>Appendix B lists:</th><th colspan="2">The payment amount for each surgeon is:</th></tr>
<tr><td rowspan="3">Each surgeon performs a principal procedure (and any additional procedures)
Any additional procedures including:
• diagnostic arthroscopy performed prior to open surgery
• the second side of a bilateral procedure</td><td rowspan="2">A dollar amount</td><td rowspan="2">The lesser of:</td><td>75% of the amount in Appendix B for the principal procedures (and 37.5% of the amount in Appendix B for any additional procedures*); or</td></tr>
<tr><td>The billed amount</td></tr>
<tr><td>80% of billed amount</td><td colspan="2">60% of the billed amount (and 30% of the billed amount for any additional procedures*)
(unless the 50% additional procedure discount has already been applied by the surgeon, then payment is 60% of the billed amount)</td></tr>
<tr><td colspan="4">*The multiple surgery discount does not apply to add-on codes listed in Appendix B with a global period indicator of ZZZ.</td></tr>
</table>

(c) Assistant surgeons

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

(d) Nurse practitioners or physician assistants

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

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

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

* * * *

(6) Physical Medicine and Rehabilitation Services.

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

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

* * * *