



Oregon

Kate Brown, Governor

Department of Consumer and Business Services
Workers' Compensation Division
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July 10, 2020

Proposed Changes to Workers' Compensation Rules

Caption: New Current Procedural Terminology (CPT®) codes for COVID-19 testing

The Workers' Compensation Division proposes to amend OAR 436-009, "Oregon Medical Fee and Payment."

When is the hearing? Aug. 17, 2020, 2 p.m.

Where is the hearing? Teleconference only:
541-465-2805 or toll free 844-766-2282

PIN: 863504 *Enter number when prompted.*

How can I make a comment? You may listen to the hearing and provide oral testimony by telephone.

Send written comments to:

Email – fred.h.bruyns@oregon.gov

Fred Bruyns, rules coordinator

Workers' Compensation Division

350 Winter Street NE (for courier or in-person delivery)

PO Box 14480, Salem, OR 97309-0405

Fax – 503-947-7514

The closing date for written comments is Aug. 21, 2020.

Questions? Contact Fred Bruyns, 503-947-7717.

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

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

Summary of proposed changes:

- Amended rule 0004 adopts new CPT® codes for COVID-19 testing and lists the effective dates for the new codes.
- Amended rule 0010 allows providers to use the new CPT® codes for COVID-19 testing.
- Amended rule 0040 and its Appendix B, the physician fee schedule, adopts new COVID-19 CPT® codes for testing: 86328, 86769, 87426, 87635, 0202U, 0223U, and 0224U.

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 changes are needed to allow health care providers and payers to use the new CPT® codes established by the American Medical Association for billing for COVID-19 medical tests. Current permanent rules do not provide the codes for billing or a basis for payment.

Documents Relied Upon, and where they are available: Stakeholder advice in response to published draft rules; [“COVID-19 coding and guidance,”](#) published by the American Medical Association. This document is 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).

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 result in any costs to state agencies for compliance with the rule.
- b. The agency estimates that proposed rule changes will not result in any significant direct costs to units of local government for compliance with the rule.
- c. The agency estimates that proposed rule changes will not result in significant direct impacts to the public. Under ORS 656.245(1)(c)(H), compensable medical services include “Services that are necessary to diagnose the worker’s condition.” Adoption of COVID-19 CPT® billing codes will facilitate billing and payment for diagnostic services. Without the codes there is potential for denial of payments, which could be harmful to health care providers. To the extent that an insurer or self-insured employer might have denied payment in the absence of COVID-19 CPT® billing codes, adoption of the codes could increase the insurer’s costs; however, costs related to payment disputes and other consequences of nonpayment could exceed any savings. The agency does not have data to show how often COVID-19 testing occurs, but questions about how to bill or pay for testing have been infrequent, so there is no basis to project significant costs. The agency requests testimony regarding costs for compliance with the proposed adoption of COVID-19 CPT® codes.

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 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:

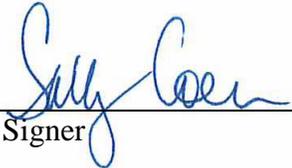
The agency projects that proposed rule changes will not increase the cost of compliance for small businesses for reporting, recordkeeping, other administrative activities, or professional services.

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.

How were small businesses involved in the development of this rule? The agency notified the rulemaking advisory committee, which includes representatives of small businesses, of its intent to propose adoption of COVID-19 CPT® codes, and asked for the members' advice. The agency also requested advice from approximately 4,000 additional stakeholders.

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

	Sally Coen	July 10, 2020
Authorized Signer	Printed name	Date

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

Proposed Effective Sept. 21, 2020

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***NOTE:** The text of rule 0040 has no proposed changes. However, Appendix B, the Physician Fee Schedule, adopted under rule 0040, includes proposed new CPT® billing codes for COVID-19 testing.

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

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 009**

436-009-0004 Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA, Relative Value Guide 2020 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2020, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumburg, IL 60173, 847-825-5586, or www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2020), Fourth Edition Revised, 2019, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® 2020 govern the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts the following CPT® codes not listed in CPT® 2020 for billing by medical providers: 86328, 86769, 87426, 87635, 0202U, 0223U, and 0224U.

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

(45) To get a copy of the CPT® 2020 or the CPT® Assistant, contact the American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, 800-621-8335, or www.ama-assn.org.

(56) 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.

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(67) The director adopts, by reference, CDT 2020: 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, or www.ada.org.

(78) The director adopts, by reference, the 02/12 1500 Claim Form and Version 7.0 7/19 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, PO Box 74008935, Chicago, IL 60674-8935, or www.nucc.org.

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

(910) 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.

(1011) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2020, CPT® 2020, CPT® Assistant, HCPCS 2020, CDT 2020, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(1112) 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 3/11/19 as Admin. Order 19-051, eff. 4/1/19

Amended 12/16/19 as Admin. Order 19-056, eff. 1/1/20 (temp)

Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20

[Amended 7/10/20 as Admin. Order 20-059, eff. 7/13/20 \(temp\)](#)

[Amended xx/xx/xx as Admin. Order 20-XXX, eff. 9/21/2020](#)

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

436-009-0010 Medical Billing and Payment

(1) General.

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim.

Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner.

Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The director may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

(f) When rebilling, medical providers must indicate that the charges have been previously billed.

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

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(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.

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(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	<p>The provider must use the following codes to accurately describe the services rendered:</p> <ul style="list-style-type: none"> • CPT® codes listed in CPT® 2020 or in OAR 436-009-0004(3); • Oregon Specific Codes (OSCs); or • HCPCS codes, only if there is no specific CPT® or OSC. If there is no specific code for the medical service: • The provider should use an appropriate unlisted code from CPT® 2020 (e.g., CPT® code 21299) or an unlisted code from HCPCS (e.g., HCPCS code E1399); and • The provider should describe the service provided. <p>Nurse practitioners and physician assistants must use modifier "81" when billing as the surgical assistant during surgery.</p>
24I (shaded area)	See under box 24J shaded area.
24J (nonshaded area)	The rendering provider's NPI.
24J (shaded area)	<p>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.</p> <p>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.</p>
32	If the facility name and address are different than the billing provider's name and address in box 33, fill in box 32.
32a	If there is a name and address in box 32, box 32a must be filled in even if the NPI is the same as box 33a.

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2020 [or in OAR 436-009-0004\(3\)](#), or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service.

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If there is no specific CPT[®] code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service.

If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT[®] 2020 or the appropriate unlisted HCPCS code, and provide a description of the service provided.

A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT[®] 2020, 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."

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(7) Chart Notes.

- (a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.
- (b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.
- (c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider's Bill.

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

(9) Billing the Patient and Patient Liability.

- (a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436, and a medical provider must not attempt to collect payment for any medical service from a patient, except as follows:
 - (A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;
 - (B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by nonattending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;
 - (C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;
 - (D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

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- (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.

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

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

(12) Excluded Treatment.

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

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

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface electromyography (EMG) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography;

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

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

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

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

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

(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:

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

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

(C) The patient underwent unsuccessful conservative treatment;

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

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

(i) Platelet rich plasma (PRP) injections.

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(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 3/11/19 as Admin. Order 19-051, eff. 4/1/19

Amended 12/16/19 as Admin. Order 19-056, eff. 1/1/20 (temp)

Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20

[Amended 7/10/20 as Admin. Order 20-059, eff. 7/13/20 \(temp\)](#)

[Amended xx/xx/xx as Admin. Order 20-XXX, eff. 9/21/2020](#)

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

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NOTE: The text of rule 0040 has no proposed changes. However, Appendix B, the Physician Fee Schedule, adopted under rule 0040, includes proposed new CPT® billing codes for COVID-19 testing.

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.

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(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:

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(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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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

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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.

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(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.

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(6) Physical Medicine and Rehabilitation Services.

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

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

(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.

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(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 3/11/19 as Admin. Order 19-051, eff. 4/1/19

Amended 12/16/19 as Admin. Order 19-056, eff. 1/1/20 (temp)

Amended 3/4/20 as Admin. Order 20-053, eff. 4/1/20

Amended 4/1/20 as Admin. Order 20-056, eff. 4/1/20 (temp)

[Amended 7/10/20 as Admin. Order 20-059, eff. 7/13/20 \(temp\)](#)

[Amended xx/xx/xx as Admin. Order 20-XXX, eff. 9/21/2020](#)

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

**Appendices B through E
Oregon Workers' Compensation Maximum Allowable Payment Amounts**

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

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

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

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

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

Note: If the above links do not connect you to the division's website, click:
<http://wcd.oregon.gov/medical/Pages/disclaimer.aspx>

If you have questions, call the Workers' Compensation Division, 503-947-7606.

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

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

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